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ALABAMA
Maternity Care Program

CONTACT INFORMATION

State Medicaid Contact:

Laura Hamilton
Alabama Medicaid Agency
(334) 353-4301

State Website Address:

http://www.medicaid.alabama.gov

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Approval Date:
October 01, 2004

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
September 23, 2005

Statutes Utilized:
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Waiver Expiration Date:
December 31, 2012

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State
Plan

For All Areas Phased-In:
No

**Sections of Title XIX Costs Not Otherwise Matchable
Granted:**
None

Guaranteed Eligibility:
None

SERVICE DELIVERY

Medical-only PAHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Family Planning, Home Visits, Outpatient
Hospital, Physician

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Rural Health Centers (RHCs)

Enrollment

ALABAMA
Maternity Care Program

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-American Indian/Alaska Native
-Poverty-Level Pregnant Women
-Refugees
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-SSI over 19 eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Illegal aliens
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Department of Human Resources
-Developmental Disabilities Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Maternity Care Program

ADDITIONAL INFORMATION

The reimbursement methodology for the maternity program is capitated "at risk" to a health entity assigned in each district throguhout the State. State contracts with a primary contractor that enters into a contractual agreement with each maternity subcontractor serving the district. The providers are paid a fee once the woman delivers. The primary contractor is responsible for submitting a claim for payment. Upon receipt of payment from Medicaid, the primary contractor pays all subcontractors involved in the womans care.

Maternity Care primary contractors are reimbursed by a contracted global fee.

ALABAMA
Maternity Care Program

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Must meet normal editing/auditing processes as other claims

Collections - Submission Specifications:
None

Collection: Standardized Forms:
None

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Access to subcontractors who are 50 miles/50 minutes of recipient

Use of Services/Utilization:
-Percentage of women who began prenatal care during first 13 weeks of pregnancy
-Percentage of women who enroll when already pregnant, who begin prenatal care within 6 weeks after enrolling
-Percentage of women with live births who had post-partum visit between 21-56 days after delivery
-Percentage who have recommended number of pre-natal visits per ACOG

ALABAMA
Maternity Care Program

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-Individual PAHPs are required to conduct a project
prescribed by the State Medicaid agency

Clinical Topics:

-Low birth-weight baby
-Pre-natal care
-Smoking prevention and cessation

Non-Clinical Topics:

-Appeals, grievances and other complaints
-Availability, accessibility & cultural competency of services
-Interpersonal aspects of care

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

ALABAMA
Patient 1st

CONTACT INFORMATION

State Medicaid Contact:

Chris McInnish
Alabama Medicaid Agency
(334) 353-3512

State Website Address:

http://www.medicaid.alabama.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(3), Sharing of Cost Savings

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
October 01, 2004

Implementation Date:
December 01, 2004

Waiver Expiration Date:
May 31, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Infants of SSI Mothers
-Refugees
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Foster Care Children
-Medicare Dual Eligibles
-Other Insurance
-Poverty Level Pregnant Woman
-Recipient is a lock-in
-Recipient is determined to be medically exempt
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Self Referrals
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Patient 1st

ADDITIONAL INFORMATION

The 12 months guaranteed eligibility applies to children born to Medicaid eligible mothers and if child remains in mother's home.

ALABAMA
Patient 1st

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Independent assessment of program impact, access, quality
& cost-effectiveness
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-State-developed Survey

Performance Measures

Process Quality:
-Asthma Related ER Visits
-Covered and Non-covered Days Per 1000
-Emergency room visits
-EPSDT screening rate
-HBA1C test performance
-Office visits per unique enrollee
-Pharmacy utilization

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of patients with PMP vs. referral rate

Access/Availability of Care:
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case
manager

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiaries

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

ARKANSAS
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

ANDREW ALLISON
Medicaid Agency
(501) 682-8292

State Website Address:

http://medicaid.state.ar.us

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Approval Date:
December 04, 1997

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
March 01, 1998

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Waiver Expiration Date:
September 30, 2013

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State
Plan

For All Areas Phased-In:
No

**Sections of Title XIX Costs Not Otherwise Matchable
Granted:**
None

Guaranteed Eligibility:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Breast and Cervical Cancer Prevention and Treatment
-Foster Care Children
-Medically Needy
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women

ARKANSAS
Non-Emergency Transportation

-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-SOBRA children
-Tax Equity and Fiscal Responsibility Act-Like Demonstration

Subpopulations Excluded from Otherwise Included Populations:

-ARKids First-B
-Eligibility only Retroactive
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Special Low Income Beneficiaries
-Tuberculosis
-Women Health (FP)

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
Persons with full Medicaid eligibility

Medicare Dual Eligibles Excluded:
QMBs for whom Medicaid pays only the Medicare premium and/or Medicare coinsurance and deductibles
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

Special Needs Children (State defined) are children with special needs due to physical and/or mental illnesses and foster care children who are categorically eligible.

QUALITY ACTIVITIES FOR PAHP

ARKANSAS
Non-Emergency Transportation

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Requirements for PAHPs to collect and maintain encounter data
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
None

Collection: Standardized Forms:
None

Validation - Methods:
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across PAHPs

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility

State conducts general data completeness assessments:
Yes

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

CALIFORNIA
Medi-Cal Specialty Mental Health Services Consolidation

CONTACT INFORMATION

State Medicaid Contact:

Dina Kokkos-Gonzales
Department of Health Care Services
(916) 552-9422

State Website Address:

http://www.dmh.ca.gov

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Approval Date:
March 17, 1995

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
March 17, 1995

Statutes Utilized:
1915(b)(4), Sel

Waiver Expiration Date:
June 30, 2013

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State
Plan

For All Areas Phased-In:
No

**Sections of Title XIX Costs Not Otherwise Matchable
Granted:**
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

Mental Health Plans - Fee-for-Service

Service Delivery

Included Services:
Inpatient Mental Health, Outpatient Mental Health, Targeted
Case Management

Allowable PCPs:
-Not applicable

Contractor Types:
-None

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations

CALIFORNIA
Medi-Cal Specialty Mental Health Services Consolidation

-Section 1931 Children and Related Populations
-State-Only Medi-Cal and Emergency Services only populations

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Medicaid eligibles who meet medical necessity criteria are automatically enrolled.

Agencies with which Medicaid Coordinates the Operation of the Program:

-Department of Mental Health

ADDITIONAL INFORMATION

All Medicaid eligibles that meet medical necessity criteria are automatically enrolled. This program covers specialty mental health services. County mental health departments have first right of refusal to serve as the mental health plan.

COLORADO
Colorado Medicaid Community Mental Health Services Program

CONTACT INFORMATION

State Medicaid Contact:

Marceil Case
Department of Health Care and Financing
(303) 866-3054

State Website Address:

http://www.colorado.gov/hcpf

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
October 04, 1993

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2011

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Assertive Community Treatment, Clinic, Case Management, Home Based Services for Children and Adolescents, IMD, Inpatient Mental Health, Intensive Case Management, Medication Management, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Peer Support for Mental Health, Prevention Programs (MH), Psychiatrist, Psychosocial Rehabilitiation, Recovery, School Based

Contractor Types:
-Behavioral Health MCO (Private)

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

COLORADO
Colorado Medicaid Community Mental Health Services Program

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Department of Behavioral Health
-Developmental Disabilities Agency
-Mental Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Behavioral Care

Behavioral Healthcare, Inc.

Colorado Health Partnerships

Foothills Behavioral Health Partners

Northeast Behavioral Health Partnership

ADDITIONAL INFORMATION

None

COLORADO
Colorado Medicaid Community Mental Health Services Program

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-Mental Health Statistics Improvement Program (MHSIP)
-Youth Services Survey for Families (YSSF)

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-HCPF also use the Flat File encounter specification

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across PIHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

COLORADO
Colorado Medicaid Community Mental Health Services Program

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Penetration Rates

Use of Services/Utilization:
-Average length of stay
-Average number of visits to MH/SUD providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing
-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Coordination of primary and behavioral health care
-Emergency Room service utilization

Non-Clinical Topics:

-Improving Use and Documentation of Clinical Guidelines

Standards/Accreditation

PIHP Standards:
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group, Inc

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Review of PIHP compliance with the BBA (Balanced Budget Act)
-Technical Report
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of encounter data

CONNECTICUT
HUSKY

CONTACT INFORMATION

State Medicaid Contact:

Richard Spencer
State of CT Department of Social Services
(860) 424-5913

State Website Address:

http://www.huskyhealth.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Enrollment Broker:
Affiliated Computer Systems

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 20, 1995

Implementation Date:
July 01, 2009

Waiver Expiration Date:
December 31, 2011

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Intermediate Care Facilities, Laboratory, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants

Enrollment

CONNECTICUT
HUSKY

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-American Indian/Alaska Native
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

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HUSKY

Dental ASO - Fee-for-Service

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

CONNECTICUT
HUSKY

Mental Health ASO - Fee-for-Service

Service Delivery

Included Services:

Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Outpatient Mental Health, Outpatient Substance Use Disorders

Allowable PCPs:

-Not Applicable

Contractor Types:

None

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

CONNECTICUT
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PCCM Provider - Fee-for-Service

Service Delivery

Included Services:

Case Management, Chiropractic, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-American Indian/Alaska Native
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Title CHIP XXI

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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Strategies Used to Identify Persons with Complex (Special) Needs:

-Receive client file indicated Title V from Public Health Department
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna Better Health

Benecare

HUSKY Primary Care

Americhoice by United HealthCare

Community Health Network of Connecticut

Value Options

ADDITIONAL INFORMATION

Mental Health ASO and Dental ASO are strictly Fee-for-Service. Administrative fees are paid to the ASOs.

Children at elevated risk for (biologic or acquired) chronic physical, developmental, behavioral, or emotional conditions and who also require health and related (not educational or recreational) services of a type and amount not usually required by children of the same age.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-State Conducts multiple critical edits to ensure data accuracy

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Ace Inhibitor/ARB Therapy
-Adolescent immunization rate
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Child Developmental Screening
-Chlamydia screening rate
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Number of children with diagnosis of rubella(measles)/1,000 children
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization

-Emergency room visits/1,000 beneficiary
-EPSDT Visit Rates
-Inpatient admissions/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent Well Care/EPSDT
-Breast cancer screening (Mammography)
-Diabetes management
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics:

None

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Mercer

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities:
-Assessment of MCO information systems
-Calculation of performance measures
-Conduct of performance improvement projects
-On site operations review

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

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Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-Disenrollment Survey

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
None

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
-Obesity Monitoring

FLORIDA
Florida Coordinated Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Susan Hamrick
Florida Agency for Health Care Administration
(850) 412-4210

State Website Address:

http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
June 07, 2001

Implementation Date:
November 01, 2004

Waiver Expiration Date:
March 31, 2014

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Flat Rate Per Ride

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medically Needy
-Presumptively Eligible Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Populations Mandatorily Enrolled:
None

-SOBRA Children and Pregnant Women
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Enrollees in a Medicaid MCO that provides transportation
-Legal Aliens
-Medicaid Beneficiaries enrolled in Medicare-funded MCOs
-Medicaid Beneficiaries that are domiciled or residing in an institution or facility
-Medicaid Beneficiaries who are enrolled in Family Planning Waiver or PACE
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

The Commission for the Transportation of the Disadvantaged

ADDITIONAL INFORMATION

The 1915(b) authority is used to selectively contract for non-emergency transportation services with the Commission for the Transportation Disadvantaged. The commission subcontracts with a single community transportation coordinator in each county. The reimbursement arrangement is given in a lump sum, twice a month for non-emergency transportation. This program does not meet the

definition of capitation because the fixed rate is not tied to the number of riders, but rather is a fixed rate over a period of time regardless of the number of riders. Foster Care Children receiving medical care are voluntarily enrolled. Special Needs Children (State defined) are children classified as SSI. Under included populations SOBRA Pregnant Women is different than Presumptively Eligible Pregnant Women (PEPW). SOBRA and PEPW are two different programs. SOBRA is a program for women who are not pregnant. PEPW is for women who may be pregnant, but who have not confirmed their pregnancy yet (ie waiting to see a doctor, etc).

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Monitoring of PAHP Standards

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Procedure Codes

State conducts general data completeness assessments:
Yes

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

FLORIDA
Managed Health Care

CONTACT INFORMATION

State Medicaid Contact:

Linda Macdonald
Florida Agency for Health Care Administration
(850) 412-4031

State Website Address:

http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Enrollment Broker:
Automated Health Systems, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1990

Implementation Date:
October 01, 1992

Waiver Expiration Date:
January 31, 2014

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Community Mental Health, Crisis, Inpatient Mental Health Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Physician (MH), Targeted Case Management

Allowable PCPs:
-Not Applicable

Contractor Types:
-Partnership between private managed care and local community MH inc.
-PIHP Subcontracting with local community health providers and an Administrative service

Enrollment

FLORIDA
Managed Health Care

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Children in Residnetial Treatment Facilities
-Eligibles in Residential Group Care
-HIV/AIDS Waiver Recipients
-Hospice
-Medically Complex Children in CMS Program
-Medically Needy
-Medicare Dual Eligibles
-Mediciad Eligibles in Residential Commitment Facilities
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman (SOBRA)
-Prescribed Pediatric Extended Care Center Residents
-Reside in Nursing Facility or ICF/MR
-Residents in ADM Residential Treatment Facilities
-Share of Cost (Medically Needy Beneficiaries)
-State Hospital Services

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Disease Management PAHP - Risk-based Capitation

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Children in Residential Treatment Facilities
-Eligibles in Residential Group Care
-Hospice
-Medicaid Eligibles in Residential Commitment Facilities
-Medically Complex Children in CMS Program
-Medically Needy
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Prescribed Pediatric Extended Care Center Residents
-Reside in Nursing Facility or ICF/MR
-Residents in ADM Residential Treatment Facilities
-Share of Cost (Medically Needy Beneficiaries)
-State Hospital Services

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

FLORIDA
Managed Health Care

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:

Adult Health Screenings, Advanced Registered Nurse Practioner, Ambulatory Surgical, Birth Center, Child Health Check-Up (EPSDT), Chiropractic, County Health Department, Durable Medical Equipment, Federally Qualified Health Center (FQHC), Home Health, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Midwive, Obstetrical, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Physician assistant, Podiatry, Respiratory Therapy, Speech Therapy, X-Ray

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Children and Related Populations

Populations Mandatorily Enrolled:

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

FLORIDA
Managed Health Care

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Advanced Registered Nurse Practitioner Services, Ambulatory Surgical Centers, Birth Center Services, Child Health Check-Up (EPSDT), Chiropractic Services, Community Mental Health, County Health Department Services, Dental Services-Adult, Dental Services-Children, Dialysis Services, Durable Medical Equipment, Emergency Services, Family Planning, Federally Qualified Health Centers, Free Standing Dialysis Centers, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Hospital Services, Laboratory, Licensed Midwife Services, Mental Health Targeted Case Management, Occupational Therapy, Optometric Services, Outpatient Hospital, Physical Therapy, Physician Assistant Services, Physician Services, Podiatry, Prescribed Drugs, Respiratory Therapy, Rural Health Clinic, Speech Therapy, Visual Services, X-Ray

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

-Foster Care Children
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-Childrens Medical Services Network Enrollees
-Enrolled in Another Managed Care Program
-Other Insurance
-Poverty Level Pregnant Woman (SOBRA)
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

Yes

Provides Part D Benefits:

No

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

FLORIDA
Managed Health Care

Dental PAHP - Risk-based Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaska Native

Populations Mandatorily Enrolled:
-Blind/Disabled Adults abd Related Populations (18-20 years old)
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare dual eligibles aged 18-20 yrs.
-Residents in nursing home facility under 21 years of age
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Children in a Residential Treatment Facility
-Eligibility Less Than 3 months
-Eligibles in Residential Group Care
-Enrolled in Another Managed Care Program
-HIV/AIDS waiver Enrollees
-Hospice
-Medicaid Eligibles in Residential Commitment Facilities
-Medically Complex Children in CMS Program
-Medically Needy
-Medicare Dual Eligibles
-Other Insurance
-Over 21 years of age
-Poverty Level Pregnant Woman (SOBRA)
-Prescribed Pediatric Extended Care Center Residents
-Reside in Nursing Facility or ICF/MR
-Residents in ADM Residential Treatment Facilities
-Retroactive Eligibility
-Share of Cost (Medically Needy Beneficiaries)
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-State Hospice Services

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Include all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

FLORIDA
Managed Health Care

Shared Savings Model - FFS/Some Risk Capitation

Service Delivery

Included Services:

Advanced Registered Nurse Practitioner Service, Ambulatory Surgical Centers, Birth Centers, Child Health Check-up, Chiropratic, Community Mental Health, County Health Department Services, Dental Services-Adults, Dental Services-Children, Dialysis, Durable Medical Equipment, Emergency room, Family Planning, Federally Qualified Health Centers, Freestanding Dialysis Centers, Hearing, Home Health, Immunization, Independent Lab, Inpatient Hospital, Licensed Midwive, Occupational Therapy, Optometric Services, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Physician Assistant Services, Podiatry, Rural Health Clinic Services, Speech Therapy, Targeted Case Management, Therapy Services-Respiratory, Transplant (Organ and Bone Marrow), Vision, X-Ray

Allowable PCPs:

-Community Health Departments
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Psychiatrists
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

-Foster Care Children
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-Children in residential treatment facility
-Eligibility Less Than 3 Months
-Eligibles in residential group care
-Enrolled in Another Managed Care Program
-HIV/AIDS waiver enrollees
-Hospice
-Medicaid eligibles in residential commitment facilities
-Medically Complex Children in CMS program
-Medically Needy
-Other Insurance
-Poverty Level Pregnant Woman
-Prescribed Pediatric Extended Care Center Residents
-Reside in Nursing Facility or ICF/MR
-Residents in ADM residential treatment facilities
-Retroactive Eligibility
-Share of Cost (Medically Needy Beneficiaries)
-Special Needs Children (State defined)
-State Hospital Services

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

FLORIDA
Managed Health Care

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Medical-only PAHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Adult Health Screenings, Advanced Registered Nurse Practitioner, Ambulatory Surgical, Birth Center, Case Management, Chiropractic, County Health Department, Durable Medical Equipment, EPSDT, Family Planning, FQHCs, Home Health, Immunization, Laboratory, Midwife, Obstetrical, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Physician Assistant, Podiatry, Respiratory Therapy, Speech Therapy, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

FLORIDA
Managed Health Care

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Community-based care providers
-Department of Juvenile Justice
-Education Agency
-Family Safety Program
-Florida Department of Children and families
-Forensic/Corrections System
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AIDS Healthcare Foundation, Inc.	Amerigroup of Florida, Inc.
Caremark	Community Based Care Partnership, Ltd.
Coventry Health Care of Florida, Inc. d/b/a Buena Vista	Coventry Health Care of Florida, Inc. d/b/a Vista
DentaQuest of FL, Inc d/b/a Dentaquest	Florida Health Partners, Inc.
Freedom Health Plan, Inc.	HealthEase of Florida, Inc.
Hemophilia of the Sunshine State (Lynnfield Drug, Inc.)	Humana Medical Plan, Inc.
Integral Health Plan	JMH Health Plan, Inc. d/b/a Public Health Trust of Miami-Dade County
Lakeview Center, Inc. d/b/a Access Behavioral Health	Magellan Behavioral Health of Florida
Managed Care of North America d/b/a MCNA Dental Plans	Medica Health Plans of Florida, Inc.
MediPass	Molina Healthcare of Florida, Inc.
North Florida Behavioral Health Partnership	Personal Health Plan d/b/a Healthy Palm Beaches, Inc
Preferred Care Partners Inc. d/b/a Care Florida	Preferred Medical Plan, Inc.
Prestige Health Choice	Public Health Trust of Dade County
Simply Healthcare Plans, Inc.	South Florida Community Care Network
Sunshine State Health Plan, Inc.	UnitedHealthcare of Florida, Inc.
Universal Health Care, Inc.	WellCare of Florida, Inc. d/b/a Staywell Health Plan of Florida

ADDITIONAL INFORMATION

Under the Prestige Health Choice Plan Case Management and Community Mental Health Services are not applicable.

The Disease Management PAHP is specifically for persons with one or more of the following diseases: HIV/AIDS, Sickle Cell disease, Renal disease, Chronic Obstructive Pulmonary Disorder, Congestive Heart Failure, Diabetes, Asthma, and Hypertension. The Disease Management program reimbursement arrangement is per member per month.

PCCM enrollees receive mental health services through a capitated arrangement. Dental and Transportation services are provided at the option of the Plan and the Agency.

The Shared Savings Model is mostly Fee-for-Service but administrative costs and transportation services are risk captitation. Excluded Populations: Under 21 residing in a Nursing Facility or ICF/MR. Community mental health services are provided in area 6 only. Reimbursement is varied throughout the program. Some vendors are paid on a per member per month basis, others are paid on a nurse FTE basis, and some are paid based on contract deliverables.

All elligible children 18 to 20 years of age are mandatory for the prepaid dental health plans.

Quality Activities are not performed under the Medical-only PAHP section of this program.

QUALITY ACTIVITIES FOR MCO/HIO

FLORIDA
Managed Health Care

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Child Medicaid AFDC Questionnaire
    Child Medicaid SSI Questionnaire
-MCO Member Satisfaction Surveys
-State-developed Survey

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment

State conducts general data completeness assessments:
Yes

Performance Measures

FLORIDA
Managed Health Care

Process Quality:
-Adolescent well-care visit rate
-Adults Access to Preventive/Ambulatory Health Services (AAP)
-Ambulatory Care
-Annual Dental Visits
-Antidepressant Medication Management (AMM)
-Appropriate Testing for Pharyngitis
-BMI Assessment (ABA)
-Breast Cancer Screening (BCS)
-Cervical Cancer Screening Rate
-Childhood Immunization Status (CIS) - Combo 2 and 3
-Chlamydia Screening for Women
-Controlling High Blood Pressure (CBP)
-Diabetes management/care
-Follow-up After Hospitalization for Mental Illness
-Follow-up Care for Children Prescribed ADHD Medication (ADD)
-Frequency of HIV Disease Monitoring Lab Tests (CD4 and VL)
-Highly Active Antiretroviral Treatment (HAART)
-HIV-Related Medical Visits (HIVV)
-Immunizations for Adolescents (IMA)
-Lead Screening in Children (LSC)
-Lipid Profile Annually (LPA)
-Mental Health Readmission Rate (RER)
-Prenatal and Postpartum Care
-Prenatal Care Frequency (PCF)
-Transportation Availability
-Transportation Timeliness
-Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blocker (ARB) Therapy (ACE)
-Use of Appropriate Medications for People with Asthma (ASM)
-Well-Child Care Visit Rates and 3, 4, 5, and 6-years of Life
-Well-Child Care Visit Rates in First 15 Months of Life

Health Status/Outcomes Quality:
-Controlling High Blood Pressure (CBP)
-Patient satisfaction with care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Annual Dental Visits (ADV)

Use of Services/Utilization:
-Adolescent well-care visit (AWC)
-Emergency Room visits/10,000 beneficiary
-Inpatient Admission/10,000 beneficiary
-Well-Child care visit rates in 3,4,5, and 6 yrs of life
-Well-Child care visit rates in first 15 months of life

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Breast Cancer Screening
-Child Heath Checkups
-Clinical Health Care Disparities - Blood Lead Screening African American Children
-Follow-up After Discharge From Mental Health Acute Care Facility
-Improving Ambulatory Follow-up Appointments After Discharge from Inpatient Mental Health Treatment
-Improving Annual Dental Visits
-Seven and 30-day Follow-ups for Hospitalization for Mental Health
-Timeliness of Prenatal Care

-Well Child Visits in the First 15 Months of Life - Six or More Visits

Non-Clinical Topics:

-Behavioral Health Discharge Planning
-ER Utilization
-First Call Resolution
-Improving Member Satisfaction with Customer Service
-Language and Culturally Appropriate Access to Preventive Health Care Services
-Member Balance-Billing
-Member Service Call Answer Timeliness and Call Abandonment Rate
-Quality Assessment and Performance Improvement (QAPI)
-Timeliness of Service

Standards/Accreditation

MCO Standards:
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
-AAAHC (Accreditation Association for Ambulatory Health Care)
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-URAC

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Organization:
-Health Services Advisory Group

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Evaluation of AHCA Quality Strategy
-Focused Studies
-Strategic HEDIS Analysis Reports
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

FLORIDA
Managed Health Care

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Annual Compliance Monitoring
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data
-Quarterly Desk Reviews

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data:
-Consumer/Beneficiary Focus Groups
-State-approved Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

FLORIDA
Managed Health Care

Process Quality:
-Follow-up after hospitalization for mental illness
-Mental Health Readmission Rate
-Mental Health Utilization

Health Status/Outcomes Quality:
-Change in level of functioning
-Patient satisfaction with care

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing
-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Follow-up within Seven Days after Acute Care Discharge for a Mental Health Diagnosis

Non-Clinical Topics:
-Decreasing the Time From Claims Receipt to Claims Payment
-FARS/CFARS Submission Rates
-Improvement of Documentation related to Coordination of Care between Mental Health Providers and PCPs within a Prepaid Mental Health Plan
-Improving Access to Care by Reducing Abandoned Call Rate

Standards/Accreditation

PIHP Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-None

EQRO Organization:
-Not Applicable

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting

quality activities
-Validation of client level data, such as claims and encounters

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Monitoring of PAHP Standards
-PAHP Standards (see below for details)

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
None

Use of Collected Data:
None

Consumer Self-Report Data:
None

FLORIDA
Statewide Inpatient Psychiatric Program

CONTACT INFORMATION

State Medicaid Contact:

Devona Pickle
Florida Agency for Health Care Administration
(850) 412-4646

State Website Address:

http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4), Selective Contracting

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
March 23, 1998

Implementation Date:
April 01, 1999

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

This program is a fee-for-service per diem all inclusive rate.

IOWA
Iowa Plan For Behavioral Health

CONTACT INFORMATION

State Medicaid Contact:

Dennis Janssen
Department of Human Services
(515) 256-4643

State Website Address:

http://www.dhs.state.ia.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
December 09, 1998

Implementation Date:
January 01, 1999

Waiver Expiration Date:
June 30, 2016

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Ambulance, Clinic, Detoxification, Home Health, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mental Health Outpatient, Outpatient Substance Use Disorders, X-ray

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native

IOWA
Iowa Plan For Behavioral Health

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicaid eligibility for persons with disability (MEPD)
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Eligible for Limited Benefit Package
-Medically Needy with cash spenddown
-Medicare Dual Eligibles
-PACE Enrollees
-Presumptively Eligible
-Reside in State Hospital-School

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Iowa Plan For Behavioral Health

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PIHP

IOWA
Iowa Plan For Behavioral Health

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Inpatient Facility Safety Survey
-Outpatient penetration rate

Use of Services/Utilization:
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

IOWA
Iowa Plan For Behavioral Health

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics:

-Co-Occurring Disorders Services
-Intensive Care Management
-Substance Use Disorders treatment after detoxification service

Non-Clinical Topics:

-Cultural Differences in Access to Services

Standards/Accreditation

PIHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Iowa Foundation for Medical Care

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of encounter data

KENTUCKY
Human Service Transportation Delivery Program

CONTACT INFORMATION

State Medicaid Contact:

Kerry Conlee
Division of Provider Operations
(502) 564-6890

State Website Address:

http://www.chfs.ky.gov/dms

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
November 01, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
September 30, 2012

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State
Plan

**Sections of Title XIX Costs Not Otherwise Matchable
Granted:**
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

KENTUCKY
Human Service Transportation Delivery Program

Subpopulations Excluded from Otherwise Included Populations:
-CHIP Above 150%
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
SLMB, QI, and QDWI

Medicare Dual Eligibles Excluded:
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Human Service Transportation

ADDITIONAL INFORMATION

TITLE XXI CHIP is included up to 150% of FPL. Program converted from 1902(a)(70) to 1915(b).

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Track Health Service provision

-Ombudsman

Consumer Self-Report Data:
-CAHPS
   Adult Medicaid AFDC Questionnaire
   Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Encounter Data

Collection: Requirements:
-State DID NOT provide any requirements for encounter data collection

Collections - Submission Specifications:
None

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Comparison to plan claims payment data
-Per member per month analysis and comparisons across PAHPs

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

MICHIGAN
Comprehensive Health Plan

CONTACT INFORMATION

State Medicaid Contact:

Kathleen Stiffler
Michigan Department of Community Health
(517) 241-7933

State Website Address:

http://www.michigan.gov/mdch

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Approval Date:
May 30, 1997

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
July 01, 1997

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Waiver Expiration Date:
October 31, 2015

Enrollment Broker:
Michigan Enrolls

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Ambulance, Blood Lead Testing, Case Management, Certified Mid-wife Services, Certified Pediatric and Family Nurse Practitioner, Chiropractic, Diagnostic Lab, X-Ray, and other imaging services, Disease Management, Durable Medical Equipment and Supplies, Emergency, End Stage Renal Disease Services, Family Planning, Health Education, Hearing, Hearing Aid for enrollee under 21 years of age, Home Health, Hospice, Immunization, Inpatient Hospital, Intermittent or Short-term Restorative or Rehab Skilled Nursing Care, Medically Necessary Weight Reduction Services, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outreach, Parenting and Birthing Classes, Pharmacy, Physical Therapy, Physician/Practitioner, Podiatry, Prosthetics and Orthotics, Speech/Language Therapy, Tobacco Cessation Treatment, Transplant, Transportation, Treatment for STDs, Vision, Well

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician assistants

MICHIGAN
Comprehensive Health Plan

Child/EPSDT

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Children in child care institutions
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other insurance (HMO or PPO only)
-Participate in HCBS Waiver
-Persons disenrolled due to special disenrollment or medical exception
-Persons enrolled in CSHCS
-Persons in PACE
-Persons in Repatriate Assistance Program
-Persons in Traumatic Brain Injury Program
-Persons incarcerated
-Persons on Refugee Assistance
-Persons without full medicaid coverage, including those in the state medical program or pluscare
-Reside in Nursing Facility or ICF/MR
-Spenddown

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Children who age out of CSHCS are identified to health plans by staff monthly

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency

MICHIGAN
Comprehensive Health Plan

-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

BlueCaid of Michigan

Great Lakes Health Plan

HealthPlus Partners, Inc.

Midwest Health Plan

Omnicare Health Plan

Priority Health Government Programs, Inc.

Total Health Care

CareSource of Michigan

Health Plan of Michigan

McLaren Health Plan

Molina Healthcare of Michigan

Physicians Health Plan of Mid-Michigan - Family Care

ProCare Health Plan

Upper Peninsula Health Plan

ADDITIONAL INFORMATION

Outpatient Mental Health services are limited to twenty (20) visits per contract year.

As of January 1, 2012 Great Lakes Health Plan changed its name to UnitedHealthcare Community Plan.
As of January 1, 2012 Health Plan of Michigan changed its name to Meridian Health Plan.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for participation, member or applied for membership
-Complaint and Grievance Monitoring
-Compliance Reviews
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-EQR and HEDIS
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Timely and Accurate Provider File Submissions
-Timely and Compliant Claims Reporting

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Health Services Research
-Monitor quality improvement efforts
-Program Evaluation
-Public Reporting/Incentives
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to promote completeness, accuracy and timeliness of encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter

Collections: Submission Specifications:
-837 Implementation Guidelines
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)

data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

-Encounters to be submitted based upon national standardized forms (e.g. NCPDP, ASC X12 837)
-Guidelines for frequency of encounter data submission
-NCPDP Manual
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Bill Type
-National Drug Code
-Place of Service

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Childhood immunization rates
-Chlamdyia screening in women
-Comprehensive Diabetic Care
-Controlling high blood pressure
-Lead screening rate
-Prenatal and Postpartum care rates
-Tobacco prevention and cessation

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Adult access to preventative/ambulatory health services
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Adolescent well-care visit rates
-Well-child care visit rates in 3, 4, 5 and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs

Performance Measures - Others:
None

MICHIGAN
Comprehensive Health Plan

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Access to Care Children and Adult
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Childhood obesity
-Diabetes management
-Lead toxicity
-Post-natal Care
-Pre-natal care
-Tobacco prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics:

-Children's access to primary care practitioners
-Health information technology (e.g. state implementation of immunization and other registries, telemedicine initiatives, etc…)
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

Standards/Accreditation

MCO Standards:

-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:

-NCQA (National Committee for Quality Assurance)
-URAC

Non-Duplication Based on Accreditation:

None

EQRO Name:

-Health Services Advisory Group (HSAG)

EQRO Organization:

-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of Performance Measures

EQRO Optional Activities:

-CAHPS - Consumer Survey
-Conduct studies on quality and access that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activites
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by disease and medical condition
Covers all MCO members

Rewards Model:
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs

MICHIGAN
Comprehensive Health Plan

Clinical Conditions:
Asthma
Blood Lead
Child Immunizations
Diabetes
Perinatal Care
Tobacco Cessation
Well-child visits

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing levels of technology adoption
Assessing patient satisfaction measures
Assessing the adoption of systematic quality improvement processes
Assessing the timely submission of complete and accurate electronic encounter/claims data
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2001

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

MICHIGAN
Healthy Kids Dental

CONTACT INFORMATION

State Medicaid Contact:

Mary Kay Valenzio
Michigan Department of Community Health
(517) 335-5285

State Website Address:

http://www.michigan.gov/mdch

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
April 01, 2009

Implementation Date:
April 01, 2009

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(4) Proper and Efficient Administration of the State Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Dental PAHP - Non-risk Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Dental Hygenists
-Dentists

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

Populations Mandatorily Enrolled:
-All Title 19-Eligible Children Under 21

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

MICHIGAN
Healthy Kids Dental

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Kids Dental

ADDITIONAL INFORMATION

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-This Program does not collect any quality data

Use of Collected Data:
-None

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

MINNESOTA
Consolidated Chemical Dependency Treatment Fund

CONTACT INFORMATION

State Medicaid Contact:

David Godfrey
Minnesota Department of Human Services
(651) 431-2319

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1998

Implementation Date:
January 01, 1998

Waiver Expiration Date:
June 30, 2013

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

County Case Manager - Fee-for-Service

Service Delivery

Included Services:
Extended Rehabilitation (Extended Care), Inpatient
Substance Use Disorders, Outpatient Substance Use
Disorders, Transitional Rehabilitation (Halfway House)

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Special Needs Children (BBA defined)

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Foster Care Children
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

MINNESOTA
Consolidated Chemical Dependency Treatment Fund

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ADDITIONAL INFORMATION

All Medicaid recipients are eligible to participate in this program.

MINNESOTA
Minnesota 1915(b)(4) Case Management Waiver

CONTACT INFORMATION

State Medicaid Contact:

David Godfrey
Minnesota Department of Human Services
(651) 431-2319

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4), Selective Contracting

Solely Reimbursement Arrangement:
Yes

Initial Waiver Approval Date:
December 28, 2006

Implementation Date:
January 01, 2007

Waiver Expiration Date:
March 31, 2013

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

ADDITIONAL INFORMATION

This waiver applies to recipients who receive case management services paid fee-for-service under a 1915(c) Home and Community Based Services waiver. 1915(b)(4) authority is used to limit case management providers to county and tribal entities.

MISSOURI
MO HealthNet Managed Care/1915b

CONTACT INFORMATION

State Medicaid Contact:

Shelley Farris
Department of Social Services, MO HealthNet Division
(573) 526-4274

State Website Address:

http://www.dss.mo.gov

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Enrollment Broker:
WIPRO INFOCROSSING

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 01, 1995

Implementation Date:
September 01, 1995

Waiver Expiration Date:
June 30, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Adult Day Care, Ambulatory Surgical Care, Case Management, Comprehensive Day Rehabilitation, Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, FQHC, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Physician, Prenatal Case Management, RHC, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-PCP Clinics
-PCP Teams
-Pediatricians

MISSOURI
MO HealthNet Managed Care/1915b

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Autism Waiver participants
-Children in the Legal Custody of Department of Social Services
-Developmentally Disabled (DD) Waiver participants
-Foster Care Children
-MO HealthNet for Pregnant Women
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Aid to the Blind and Blind Pension Individuals
-AIDS Waiver program participants
-Breast and Cervical Cancer Control Project (BCCCP)
-Children with Developmental Disabilities Program
-Enrolled in Another Managed Care Program
-Individuals eligible under Voluntary Placement Agreement for Children
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Permanently and totally disabled individuals
-Presumptive Eligibility for Children
-Presumptive Eligibility Program for Pregnant Women
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Data Match with Other State Agencies
-Health Risk Assessment
-Helpline
-MCO uses ER Encounters
-MCOs use Drug Usage
-MCOs use Hospital Admissions
-MCOs use Hospital Encounters
-Reviews grievances and appeals to identify members of

Agencies with which Medicaid Coordinates the Operation of the Program:

-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Other State Agencies as necessary
-Public Health Agency
-Social Security Administration

these groups
-Surveys medical needs of enrollee to identify members
of these groups
-Uses provider referrals to identify members of these
groups

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Advantage Plus of Kansas City	Childrens Mercy Family Health Partners
Harmony Health Plan of Missouri	HealthCare USA Central
HealthCare USA Eastern	HealthCare USA Western
Missouri Care Central	Missouri Care Eastern
Missouri Care Western	Molina Healthcare of Missouri Eastern
Molina Healthcare of Missouri Western	Molina Helathcare of Missouri Central

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ADDITIONAL INFORMATION

PCP Clinics can include FQHCs/RHCs. Vision services for members 21 and over are limited to one eye examination every two years, services related to trauma or treatment of disease/medical condition, and one pair of eyeglasses every two years. Vision services for pregnant women 21 and over are limited to one eye examination per year, services related to trauma or treatment of disease/medical condition, and one pair of eyeglasses per year. Dental services for members 21 and older are limited to treatment of trauma to the mouth, jaw, teeth or contiguous sites as a result of injury or services when the absence of dental treatment would adversely affect a pre-existing medical condition. Dental services for pregnant women 21 and older are limited to dentures and treatment of trauma to the mouth, jaw, teeth or contiguous sites as a result of injury and all other Medicaid State Plan dental services for pregnant members with ME Codes 18, 43, 44, 45, and 61.   Medicaid eligibles in the included populations who are receiving Supplemental Security Income (SSI), who meet the SSI medical disability definition, or who receive adoption subsidy may choose to voluntarily disenroll from the MO HealthNet Managed Care Program at any time. Enrollment is mandatory for special needs children but individuals may request to opt out. HealthCare USA, Missouri Care Health Plan, and Molina Healthcare of Missouri health plans participate in Eastern, Central, and Western Regions. Blue-Advantage Plus of Kansas City does not serve Bates, Cedar, Polk, and Vernon counties.   MO is a 209(b) State and has no specific eligibility categories for the special needs populations. Advocates for Family Health is an ombudsman service serving the Eastern, Central, and Western regions. Legal Services of Eastern Missouri serves the following counties/city: Franklin, Jefferson, Lincoln, Macon, Madison, Marion, Monroe, Montgomery, Perry, Pike, Ralls, Shelby, St. Charles, St. Francois, St. Louis, Ste. Genevieve, Warren, Washington, and St. Louis City. Legal Aid of Western Missouri serves the following counties: Bates, Benton, Camden, Cass, Clay, Henry, Jackson, Johnson, Lafayette, Linn, Morgan, Pettis, Platte, Ray, Saline, St. Clair, and Vernon.   Mid Missouri Legal Services serves the following counties: Audrain, Boone, Callaway, Chariton, Cole, Cooper, Howard, Miller, Moniteau, Osage, and Randolph. Legal Services of Southern Missouri serves the following counties: Cedar, Gasconade, Laclede, Maries, Phelps, Polk, and Pulaski.

Individuals with special health care needs include those with needs due to physical and/or mental illnesses, foster care children, homeless individuals, individuals with serious and persistent mental illness and/or substance abuse, and individuals who are disabled or chronically ill with developmental or physical disabilities.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Ombudsman

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/revised state managed care Medicaid quality strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal

MISSOURI
MO HealthNet Managed Care/1915b

-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Additional Payments
-Admission Date
-Amount Paid
-Capitation Indicator
-Charges
-Patient Status
-Place of Service
-Rendering Provider ID
-Statement From Date
-Statement Through Date
-Type of Admission
-Type of Bill
-Units of Service

State conducts general data completeness assessments:
Yes

MISSOURI
MO HealthNet Managed Care/1915b

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Ambulatory Care
-Antidepressant medication management
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Avoidance of antibiotic treatment in adults with acute bronchitis
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-Chlamdyia screening in women
-Cholesterol screening and management
-Comprehensive diabetes care HBA1C poor control (>9.0%)
-Comprehensive diabetes care(eye exam, LDL-C screening, HBA1C testing, medical attention for nephropathy)
-Controlling high blood pressure
-Dental services
-Depression management/care
-Diabetes medication management
-Follow up for children prescribed ADHD medication
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Medical assistance with smoking and tobacco use cessation
-Mental Health Utilization
-Postpartum Care
-Use of imaging studies for low back pain
-Use of spirometry testing in the assessment and diagnosis of COPD
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Case management satisfaction for behavioral health
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Appointment availability for psychiatrists for children =<6 years old, children 7 to 12 years old, adolescents 13 to 17 years old and adults => 18 years old(non HEDIS)
-Average distance to PCP
-Average wait time for an appointment with PCP
-Open-closed panels for psychiatrists for children =<6 years old, children 7 to 12 years old, adolescents 13 to 17 years old and adults => 18 years old (Non HEDIS)
-Open-closed panels for psychiatrists treating children, adolescents and adults (Non HEDIS)
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Alternative services/1000 for behavioral health
-Emergency room visits/1,000 beneficiaries under the age of 19
-For mental health > outpatient visits/1000 and > emergency room visits/1000
-Identification of alcohol and other drug services(HEDIS)
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Mental health utilization(HEDIS)
-Number of PCP visits per beneficiary
-Re-admission rates of MH/SUD
-Residential days/1000 for behavioral health

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Missouri Department of Insurance, Financial Institutions, and Professional Registration monitors and tracks Health Plan Stability/Financial/Cost of Care

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Beneficiary need for interpreter

Performance Measures - Others:
-Effectiveness of Care

-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

-Satisfaction with Experience of Care

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent Well Care/EPSDT
-Asthma management
-Cervical Cancer Screening
-Cesarean Wound Infection
-Childhood Immunization
-Chlamydia
-Dental Utilization
-Depression management
-Diabetes management
-Emergency Room service utilization
-Follow-up with primary care providers
-Hospital Readmission
-Lead toxicity
-Obesity
-Perinatal Care
-Seven and thirty day follow-up after behavioral health admission
-Women, Infant, and Children Collaboration

Non-Clinical Topics:

-ADHD coordinated care
-Encounter acceptance rates
-Grievance/Appeals
-Improved Medical Record Documentation
-Member Satisfaction
-Physical/Behavioral care coordination
-Primary care provider assignment

Standards/Accreditation

MCO Standards:

-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:

-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Behavioral Health Concepts (BHC)

EQRO Organization:
-QIO-like entity

EQRO Mandatory Activities:

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:

-Assessment of MCO information systems
-Calculation of performance measures
-Case management record review
-Evaluate performance improvement projects

MISSOURI
MO HealthNet Managed Care/1915b

-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by beneficiary age

Rewards Model:
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
State measures MCO achievement in reaching established standards of outcome measures

Initial Year of Reward:
2001

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

MONTANA
Passport to Health

CONTACT INFORMATION

State Medicaid Contact:

Mary Noel Noel
Department of Health and Human Services
(406) 444-4146

State Website Address:

http://www.medicaid.mt.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Enrollment Broker:
Affiliated Computer Services, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
1 month guaranteed eligibility

Initial Waiver Approval Date:
August 31, 1993

Implementation Date:
January 01, 1994

Waiver Expiration Date:
March 31, 2014

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Dialysis, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Home Infusion Therapy, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Geriatrics
-Indian Health Service (IHS) Providers
-Internists
-Nephrologist
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

MONTANA
Passport to Health

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Team Care

Subpopulations Excluded from Otherwise Included Populations:
-Clients who cannot find a PCP willing to provide case management.
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medically Needy
-Medicare Dual Eligibles
-Only Retroactive Eligibility
-Participate in HCBS Waiver
-Resides in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (State defined)
-Subsidized Adoption

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

MONTANA
Passport to Health

Nurse First- Selective Contracting - Fee-for-Service

Service Delivery

Included Services:
Nurse Advice Line

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaskan Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

MONTANA
Passport to Health

Enhanced PCCM - Primary Care Case Management Fee

Service Delivery

Included Services:
Case Management

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Tribal Health Centers

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency

MONTANA
Passport to Health

-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Improvement Program   Nurse First

Passport to Health

ADDITIONAL INFORMATION

Nurse First - Nurse Advice Line (sub program of Passport) is under waiver for Selective Contracting, is fee for service reimbursement and a voluntary program for recepients.

Health Improvement Program - an enhanced primary care case management program offers clinical case managment for high risk, high cost recepients, a per member per month payment and is a voluntary program for recepients.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Network Data
-On-Site Reviews
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-State-developed Survey

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Appropriate treatment for children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamydia screening in women
-Colorectal Cancer Screening
-Depression medication management
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult access to preventive/ambulatory health services

Use of Services/Utilization:
None

-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of primary care case managers to beneficiaries

Provider Characteristics:
None

Beneficiary Characteristics:
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Measures - Others:
None

QUALITY ACTIVITIES FOR OTHER

Quality Oversight Activities:
-Consumer Self-Report Data
-Network Data
-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-State-developed Survey

Performance Measures

Process Quality:
-Client contacts

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
None

Provider Characteristics:
None

Beneficiary Characteristics:
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Measures - Others:
None

NORTH DAKOTA
Experience Health ND

CONTACT INFORMATION

State Medicaid Contact:

Tania Hellman
Department of Human Services Medical Services Division
(800) 755-2604

State Website Address:

http://www.nd.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 01, 2007

Implementation Date:
October 01, 2007

Waiver Expiration Date:
September 30, 2011

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Disease Management PAHP - Risk-based Capitation

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Populations Mandatorily Enrolled:
None

NORTH DAKOTA
Experience Health ND

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Receiving services related to transplants, HIV/AIDS, cancer, end stage renal disease and hospice
-Recipients with spend-down
-Reside in Nursing Facility or ICF/MR
-Those that are incarcerated

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ExperienceHealth ND

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-On-Site Reviews
-Performance Measures (see below for details)

Use of Collected Data:
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Program Evaluation

NORTH DAKOTA
Experience Health ND

Consumer Self-Report Data:
-Recipient knowledge survey (developed by PAHP and approved by State)
-Recipient Satisfaction survey developed by PAHP and approved by State

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-State uses/requires PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Results of progress toward defined performance indcators

Access/Availability of Care:
None

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Number of hospital admissions
-Number of inpatient days

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards
-URAC Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1915(b)

CONTACT INFORMATION

State Medicaid Contact:

Heather Leschinsky
Nebraska Medicaid
(402) 471-9337

State Website Address:

http://www.dhhs.ne.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Enrollment Broker:
The Medicaid Enrollment Center

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
June 05, 1995

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness - MCO/PCCM only
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians

Enrollment

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1915(b)

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-American Indian/Alaska Native
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Children with disabilities receiving in-home services
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Clients Participating in the State Disability Program
-Clients Participating in the Subsidized Adoption Program
-Clients receiving Medicaid Hospice Services
-Clients with Excess Income
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Presumptive Eligibles
-Reside in Nursing Facility or ICF/MR
-Retroactively Eligible
-Transplant Recipients

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1915(b)

Specialty Physician Case Management (SPCM) Program - Fee-for-Service

Service Delivery

Included Services:

Case Management, Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, Outpatient Substance Use Disorders

Allowable PCPs:

-Psychiatrists
-Psychologists

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Children with disabilities receiving in-home services
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Clients Participating in the State Disability Program
-Clients receiving Medicaid Hospice Services
-Clients with Excess Income
-Participate in HCBS Waiver
-Presumptive Eligibility
-Reside in Nursing Facility or ICF/MR
-Retroactively Eligible
-Transplant Recipients

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1915(b)

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Title V Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coventry Nebraska

Share Advantage

Magellan Behavioral Health

ADDITIONAL INFORMATION

For MCO, and Specialty Physician Case Management (SPCM), the State defines Special Needs Children as Blind/Disabled Children and Related Populations, Children Receiving Title V Services and State Wards.

MCO operates county wide. SPCM operates statewide. The children with Special Health Care Needs (CSHCN) or American Indians/Alaskan Natives (AI/AN) are the only two groups enrolled into the MCO program through 1915(b) authority.

Children under 19 years of age who are-1) Eligible for SSI under title XVI; 2) In foster care or other out-of-state home placement; 3) Receiving foster care or adoption assistance; or 4) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V.

Children under 19 years of age who are-1) Eligible for SSI under title XVI; 2) In foster care or other out-of-state home placement; 3) Receiving foster care or adoption assistance; or 4) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Network Data
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Fraud and Abuse
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837,

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1915(b)

ADA)
-Encounters to be submitted based upon national standardized forms (e.g. NCPDP, ASC X12 837)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Immunizations for two year olds
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Childhood Immunization
-Diabetes management
-Pediatric Obesity
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1915(b)

MCO Standards:
-NCQA (National Committee for Quality Assurance)
Standards

Accreditation Required for Participation:
-Department of Insurance Certification
-NCQA (National Committee for Quality Assurance)
-URAC

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)
-URAC

EQRO Name:
-Island Peer Review Organization (IPRO)

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
None

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance
program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

NEW JERSEY
NJ FamilyCare - 1915(b)

CONTACT INFORMATION

State Medicaid Contact:

Karen Brodsky
Office of Managed Health Care
(609) 588-2705

State Website Address:

http://www.state.nj.us/humanservices/dmahs/index.h

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker

Enrollment Broker:
Affiliated Computer Services, Incorporated (ACS)

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 18, 2000

Implementation Date:
October 01, 2000

Waiver Expiration Date:
March 31, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Audiology, Chiropractic, Dental, Durable Medical Equipment, Emergency Medical Care, EPSDT, Family Planning, Hearing Aid Service, Home Health, Hospice, Immunization, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medical Day Care, Medical Supplies, Optical Appliances, Optometry, Organ Transplants, Outpatient Hospitals, Outpatient Mental Health, Outpatient Rehabilitation Therapies, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physician, Podiatry, Post-acute Care, Preventive Health Care, Counseling, and Health Prevention, Prosthetics, Orthotics, Rehabilitation and Special Hospitals, Transportation, Vision, X-Ray

Allowable PCPs:
-Certified Nurse Specialists
-Family Practitioners
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants

Enrollment

NEW JERSEY
NJ FamilyCare - 1915(b)

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicaid Eligible Blind/Disabled Children Receiving Services
Through Title V

**Subpopulations Excluded from Otherwise
Included Populations:**
-DYFS Children in Institutional Settings
-Full Time Students Attending School and Residing Out of the
Country
-Individuals Enrolled in PACE
-Individuals in Out Of State Placements
-Individuals who are Institutionalized in an Inpatient Psychiatric
Facility
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid
Managed Care Contracts:**
-Barbituates
-Benzodiazepines
-Prescription vitamins and mineral products, except prenatal
vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex
(Special) Needs:**
Yes

**Strategies Used to Identify Persons with
Complex (Special) Needs:**
-Self-Referral
-Surveys medical needs of enrollee to identify members
of these groups
-Use of Data Mining
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these
groups
-Uses provider referrals to identify members of these
groups

**Agencies with which Medicaid Coordinates the
Operation of the Program:**
-Developmental Disabilities Agency
-Division of Youth and Family Services Agency
-Education Agency
-Family Centered Care Services Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMERIGROUP New Jersey, Inc.

NEW JERSEY
NJ FamilyCare - 1915(b)

Healthfirst Health Plan of New Jersey, Inc.

Horizon NJ Health   UnitedHealthCare Community Plan

ADDITIONAL INFORMATION

A number of changes were made in the 1915(b) and were effective with our amendment effective 7/1/11:

Personal care, medical day care, home health, and outpatient rehabilitation therapies were added as covered services 7/1/11.

Dual eligibles were removed from eligible group.

Special needs children (BBA defined) redefined as Medicaid eligible blind/disabled children receiving services through Title V.

Non dual DDD individuals and DDD children under 19 served by Community Care Waiver no longer eligible.

Lock-in period is 12 months.

AmeriChoice rebranded as UnitedHealthCare Community Plan.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Appointment Availability Studies
-Care Management
-Consumer Self-Report Data (see below for details)
-Data Analysis
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Geographic Mapping
-Independent Assessment
-MCO Marketing Material Approval Requirement
-Medical and Dental Provider Spot Checks
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Utilization Review

Use of Collected Data:
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
    Child Medicaid AFDC Questionnaire
-Disenrollment Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national

data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Reported changes of reasonable and customary fees

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Appropriate Testing for Children with Pharyngitis
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical Cancer Screening
-Check-ups after delivery
-Childhood Immunizations
-Comprehensive Diabetes Care
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Quality and utilization of dental services
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-BMI Assessment for Children/Adolescents
-Children with Special Needs Focused Study including DYFS Children
-Chlamydia Screening
-EPSDT Quality Study/Dental and Lead
-Follow-up after Hospitalization for Mental Illness (Clients of DDD only)
-Prenatal and Postpartum Care

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiaries
-Inpatient days per 1000 members
-Percentage of beneficiaries with at least one dental visit
-Percentage of Children who received one or more visits with a PCP during the measurement year
-Percentage of enrollees who receive appropriate immunizations
-Percentage of enrollees who received a blood lead test
-Percentage of enrollees who received one or more dental

-Ratio of pharmacies to number of beneficiaries

services during the measurement year
-Percentage of enrollees with one or more emergency room visit
-Percentage of enrollees with one or more inpatient admissions
-Pharmacy services per member
-Physician visits per 1000 members

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs

Performance Measures - Others:
-EPSDT Performance
-Lead Screening

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent Well Care/EPSDT
-Birth Outcomes
-Child/Adolescent Dental Screening and Services
-Lead Screenings
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics:

-Children's access to primary care practitioners
-Encounter Data Improvement
-Health information technology (e.g. state implementation of immunization and other registries, telemedicine initiatives, etc…)
-Medical Home Demonstration

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation:
-Department of Banking and Insurance Certificate of Authority

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization (IPRO)

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures
-Conduct studies on access that focus on a particular aspect of

clinical and non-clinical services
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Medical Record review
-Technical assistance to MCOs to assist them in conducting quality improvement activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

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CONTACT INFORMATION

State Medicaid Contact:

Paula McGee
NM HSD/Medical Assistance Division
(505) 827-6234

State Website Address:

http://www.state.nm.us/hsd/mad/CSalud.html

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 13, 1997

Implementation Date:
July 01, 1997

Waiver Expiration Date:
June 30, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Ambulatory Surgical, Anesthesia, Case Management, Dental, Diagnostic Imaging and Therapeutic Radiology Services, Dialysis, Durable Medical Equipment and Medical Supplies, EPSDT, EPSDT Private Duty Nursing, Family Planning, Federally Qualified Health Center, Hearing and Audiology, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Medical Services Providers, Midwife, Nutritional, Occupational Therapy, Outpatient Hospital, Personal Care - EPSDT, Pharmacy, Physical Therapy, Physician, Podiatry, Pregnancy Termination (State Funded), Prosthetics and Orthotics, Rehabilitation, Reproductive Health, Rural Health Clinic, School Based, Speech Therapy, Telehealth, Transplant, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Gerontologists
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives, certified
-Nurse Practioners, certified
-Obstetricans/Gynecologists or Gynecologists
-Other Providers who meet the MCO credentialing requirements for PCP
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Primary Care Teams at Teaching Facilities
-Rural Health Clinics (RHCs)

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Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations unless also covered by Medicare.
-Blind/Disabled Adults and Related Populations unless covered by Medicare or under CoLTS Waiver
-Blind/Disabled Children and Related Populations unless covered by Medicare or under CoLTS Waiver
-Foster Care Children except when recipient is out-of-state placement
-Home and Community Based Waiver except for D&E waiver or approved for MiVia waiver due to brain inju
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-American Indian/Alaska Native (may opt in to Salud)
-Children in Out-of-State Foster Care or Adoption Placement
-Clients approved for Adult Personal Care Options Program
-Clients eligible for State Coverage Insurance.
-Clients in Breast and Cervical Cancer Program
-Clients in Family Planning Waiver
-Clients in Health Insurance Premium Payment Program
-Enrolled in another Managed Care Program (CoLTS)
-Medicare Dual Eligibles
-Participating in D&E Waiver or MiVia Waiver due to Brain Injury
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Individuals identified by service utilization, clinical assessment, or diagnosis
-Referal by family, a public, or community program
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging and Long Term Services Department
-Children, Youth, and Families Department
-Coordinates with schools
-Department of Health

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-Statewide Entity for Behavioral Health

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross Blue Shield of New Mexico

Lovelace Community Health Plan

Molina Healthcare of New Mexico

Presbyterian Health Plan

ADDITIONAL INFORMATION

OptumHealth New Mexico provides behavioral services through BH providers through a PIHP waiver. Lovelace Community Health Plan, Molina Health Care, Blue Cross Blue Shield of New Mexico, and Presbyterian Salud! provide physical health services and those BH services provided by non-BH provider/practitioners. Native Americans have the choice of "opt-in" to managed care, but receive benefits under Fee for Service programs by default.

An Individual with Special Health Care Needs (ISHCN) require a broad range of primary, specialized medical, behavioral health and related services. ISHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition and who require health and related services of a type or amount beyond that required by other individuals. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO/SE can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

Native Americans within other covered categories have the option of choosing to participate in managed care due to tribal agreements.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national

data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient,

Health Plan/ Provider Characteristics:
-Board Certification
-Provider turnover

ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Adolescent Immunization
-Asthma management
-Childhood Immunization

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-HealthInsight dba New Mexico Medical Review Association

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by disease and medical condition
Covers all MCO members

Rewards Model:
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs
Public reporting to reward MCOs
Withholds as an incentive

Clinical Conditions:
Asthma
Childhood immunizations
Diabetes
Well-child visits

Measurement of Improved Performance:
Assessing levels of technology adoption
Assessing the adoption of systematic quality improvement processes
Using clinically-based outcome measures (e.g., HEDIS,

NQF, etc.)

Initial Year of Reward:
1997

Member Incentives:
Not Applicable

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

NEW MEXICO
Salud! Behavioral Health

CONTACT INFORMATION

State Medicaid Contact:

Paula McGee
NM HSD/Medical Assistance Division
(505) 827-6234

State Website Address:

http://www.state.nm.us/hsd/HMedicaid.html

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
June 23, 2005

Implementation Date:
July 01, 2005

Waiver Expiration Date:
June 30, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State
Plan

**Sections of Title XIX Costs Not Otherwise Matchable
Granted:**
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Inpatient Mental Health, Inpatient Substance Use Disorders
Services, Mental Health Outpatient, Mental Health
Rehabilitation, Mental Health Residential, Mental Health
Support, Outpatient Substance Use Disorders, Peer Support
for Substance Use Disorders, Peer Support Services for
Mental Health, Pharmacy, Residential Substance Use
Disorders Treatment Programs, Substance Use Disorders
Support

Allowable PCPs:
-Addictionologists
-Clinical Social Workers
-Federally Qualified Health Centers (FQHCs)
-Indian Health Service (IHS) Providers
-Nurse Practitioners
-Other Addiction Professionals (i.e. Substance Use Disorder
counselors, alcohol and drug counselors,
-Psychiatrists
-Psychologists
-Rural Health Clinics (RHCs)

Contractor Types:
-Behavioral Health MCO (Private)
-CMHC Operated Entity (Public)

NEW MEXICO
Salud! Behavioral Health

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-American Indian/Alaskan Native (may Opt-in)
-Breast and cervical cancer medical programs.
-Children in out-of-state foster care or adoption program.
-Clients eligible for family planning services only.
-Clients participating in Health Insurance Premium program.
-Medicare Dual Eligibles
-Retroactive Eligibility
-State Coverage Initiative (SCI) ages 19-64

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
Medicaid Only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Housing Agencies
-Mental Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

OptumHealth New Mexico

NEW MEXICO
Salud! Behavioral Health

ADDITIONAL INFORMATION

The Salud! Behavioral Health waiver is managed as a Prepaid Inpatient Hospital Plan (PIHP). It operates as a Medicaid Managed Care program with mandatory enrollment with the exception of Native Americans.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires PIHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across PIHPs

NEW MEXICO
Salud! Behavioral Health

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Antidepressant medication management
-Depression management/care
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality:
-Mortality rates
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Ratio of addictions professionals to number of beneficiaries
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of specialist visits per beneficiary
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Provider turnover

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Followup after hospitalization (7day, 30 day)
-RTC Follow-up care/readmissions

Non-Clinical Topics:

Not Applicable - PIHPs are not required to conduct common project(s)

Standards/Accreditation

NEW MEXICO
Salud! Behavioral Health

PIHP Standards:
-NCQA (National Committee for Quality Assurance)
Standards

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-HealthInsight dba New Mexico Medical Review Association

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Independent Assessment
-Review of PIHP compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting
quality activities

NEW YORK
Selective Contracting - Bariatric Surgery

CONTACT INFORMATION

State Medicaid Contact:

Joseph Anarella
Division of Quality Improvement and Evaluation
(518) 486-9012

State Website Address:

http://www.nyhealth.gov

PROGRAM DATA

Program Service Area:
City

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4), Selective Contracting

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 01, 2009

Implementation Date:
December 01, 2010

Waiver Expiration Date:
August 31, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(13)(A) rate setting procedure
-1902(a)(23) Freedom of Choice
-1902(a)(30)(A) Reimbursement

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

Negotiated rate with eligible providers. Program Service Area is New York City only.

OREGON
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Don Ross
Division of Medical Assistance Programs
(503) 945-6084

State Website Address:

http://www.oregon.gov/DHS/healthplan/index.shtml

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
September 01, 1994

Implementation Date:
September 01, 1994

Waiver Expiration Date:
September 30, 2011

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

FFS Transportation Brokers - Fee-for-Service

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-QMB Plus, SLMB Plus, and Medicaid only
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

OREGON
Non-Emergency Transportation

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Not Applicable

ADDITIONAL INFORMATION

The State contracts with transportation brokers on a FFS basis. All enrollees under the Oregon Health Plan Plus are enrolled in this program.

PENNSYLVANIA
ACCESS Plus Program

CONTACT INFORMATION

State Medicaid Contact:

Jennifer Basom
Pennsylvania Department of Welfare
(717) 772-6149

State Website Address:

http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 2005

Implementation Date:
March 01, 2005

Waiver Expiration Date:
December 31, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Disease
Management, Durable Medical Equipment, EPSDT, Family
Planning, Hearing, Home Health, Hospice, Immunization,
Inpatient Hospital, Laboratory, Occupational Therapy,
Outpatient Hospital, Pharmacy, Physical Therapy, Physician,
Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Hospital Based Medical Clinic
-Independent Medical/Surgical Clinic
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)
-Specialist Who Meets Special Needs of Client

PENNSYLVANIA
ACCESS Plus Program

Enrollment

Populations Voluntarily Enrolled:

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Populations Mandatorily Enrolled:

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Enrolled in Health Insurance Premium Payment (HIPP)
-Enrolled in Long Term Care Capitated Program (LTCCP)
-Incarcerated Recipients
-Medicare Dual Eligibles age 21 and over
-Reside in Nursing Facility or ICF/MR
-Residents of State Institutions
-State Blind Pension Recipients

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only (under age 21)

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI (age 21 and older)
QMB (age 21 and older)

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PENNSYLVANIA
ACCESS Plus Program

Disease Management PAHP - Risk-based Capitation

Service Delivery

Included Services:

Disease Management

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Independent Medical/Surgical Clinic
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Enrolled in Health Insurance Premium Payment (HIPP)
-Enrollen in Long Term Care Capitated Payment (LTCCP)
-Incarcerated Recipients
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Residence in a State Facility

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only (under age 21)

Populations Mandatorily Enrolled:

None

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Excluded:

QMB (age 21 and over)
SLMB, QI, and QDWI (age 21 and over)

Part D Benefit

MCE has Medicare Contract:

No

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

PENNSYLVANIA
ACCESS Plus Program

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Department of Public Welfare Offices
-Enrollment Contractor
-Legislative Offices
-Reviews complaints and grievances to identify members of these groups
-Self-Referral
-Surveys medical needs of enrollee to identify members of these groups
-Uses claims to identify special needs
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Juvenile Justice Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Plus Program   APS Healthcare

ADDITIONAL INFORMATION

Under PCCM, the reason for multiple enrollment basis for the included populations: ACCESS Plus is the default; with exceptions. If a voluntary managed care is in a county with ACCESS Plus, the recipient can choose which delivery system they want. If no choice is made, the recipient is auto-assigned to ACCESS Plus. However, in counties where there is no voluntary managed care program, recipients are mandatorily enrolled into ACCESS Plus. Special Needs Children is broadly defined as non-categorical to include all children.

Reimbursement Arrangement: The providers in the network are reimbursed on a FFS basis. The Access Plus contractor receives a capitation for EPCCM Services and capitation for Disease Management Services.

Enrollees are assigned to the Disease Management program if they have one of the following qualifying chronic diseases: Asthma, Diabetes, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, and Congestive Heart Failure. However, enrollees can choose to opt out of this program.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Consumer Surveys
-Focused Studies
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards (see below for details)
-Performance Measures (see below for details)
-Provider Surveys

Use of Collected Data:

-Contract Standard Compliance
-Data Mining
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Target areas for new quality improvement activities

PENNSYLVANIA
ACCESS Plus Program

Consumer Self-Report Data:
-Contractor developed survey for chronic illness satisfaction
-Contractor developed survey for satisfaction

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-State use/requires PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Chronic Care Satisfaction
-Health Status Reports from Contractors
-Patient satisfaction with care

Access/Availability of Care:
-Adolescent access to preventive/ambulatory health services
-Childhood access to preventive/ambulatory health services

Use of Services/Utilization:
-Call Abandonment
-Call Timeliness
-Emergency room visits/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Administrative Costs
-Pay for performance reports on payouts and reserve and withhold
-Total revenue

Health Plan/ Provider Characteristics:
-Geo Mapping Report
-Number of Providers Following Standard Practice Guidelines for Chronic Illnesses
-Number of Providers Participating in Disease Management

Beneficiary Characteristics:
None

Performance Measures - Others:
-Other

Standards/Accreditation

PAHP Standards:
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Target New Areas for Quality Improvement

Consumer Self-Report Data:
-CAHP Survey
-Consumer Complaints

Performance Measures

PENNSYLVANIA
ACCESS Plus Program

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Adolescent well child visits
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization:
-Call Abandonment
-Call Timeliness
-Emergency room visits/1,000 beneficiaries
-Hospital Readmission Rates
-Inpatient admissions/1,000 beneficiaries
-Number of field staff case manager visits for prenatal maternity care
-Number of OB/GYN visits per adult female beneficiary
-Number of telephonic case manager calls for prenatal maternity care

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
-Enrollee Outreach Activities
-Maternity Care

Performance Improvement Projects

Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Cervical Cancer Screening initiative to increase screening rates
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Coordination of primary and behavioral health care
-Coronary artery disease prevention
-Depression Screening
-Diabetes management
-Domestic violence
-Emergency Room service utilization
-Post-natal Care
-Pre-natal care
-Sexually transmitted disease screening
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics:
-Availability of language interpretation services
-Children's access to primary care practitioners
-ER initiative to reduce ER visit rate

PENNSYLVANIA
HealthChoices

CONTACT INFORMATION

State Medicaid Contact:

Joan Morgan
Pennsylvania Department of Welfare
(717) 772-6300

State Website Address:

http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 31, 1996

Implementation Date:
February 01, 1997

Waiver Expiration Date:
December 31, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Centers (RHCs)

PENNSYLVANIA
HealthChoices

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in a Long Term Care Capitated Program
-Enrolled in Health Insurance Premium Payment (HIPP) with HMO Coverage
-Incarcerated Recipients
-Medicare Dual Eligibles
-Monthly Spend Downs
-Reside in Nursing Facility
-Residence in a State Facility
-State Blind Pension Recipients

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only (under age 21)

Medicare Dual Eligibles Excluded:
QMB (age 21 and over)
SLMB, QI, and QDWI (age 21 and over)

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Self Reported
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Housing Agencies
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PENNSYLVANIA
HealthChoices

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna Better Health

AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan

Community Care Behavioral Health - North Central

Community Care Behavioral Health - Northeast

Counties of Armstrong/Indiana - Value Behavioral Health of PA

Counties of Bedford/Somerset - Community Behavioral Healthcare Network of PA

Counties of Carbon/Monroe/Pike - Community Care Behavioral Health

Counties of Crawford/Mercer/Venango - Value Behavioral Health

Counties of Franklin/Fulton - Community Behavorial Healthcare Network of PA

Counties of Lycoming/Clinton - Community Behavioral Healthcare Network of PA

County of Adams - Community Care Behavioral Health

County of Allegheny - Community Care Behavioral Health

County of Beaver - Value Behavioral Health of PA

County of Berks - Community Care Behavioral Health

County of Blair County - Community Behavioral Healthcare Network of PA

County of Bucks - Magellan Behavioral Health

County of Butler - Value Behavioral Health of PA

County of Cambria - Value Behavioral Health

County of Chester - Community Care Behavioral Health

County of Cumberland - Community Behavioral Healthcare Network of PA, Inc.

County of Dauphin - Community Behavioral Healthcare Network of PA, Inc.

County of Delaware - Magellan Behavioral Health

County of Erie - Value Behavioral Health

County of Fayette - Value Behavioral Health of PA

County of Lancaster - Community Behavioral Healthcare Network of PA, Inc.

County of Lawrence - Value Behavioral Health of PA

County of Lebanon - Community Behavioral Healthcare Network of PA, Inc.

County of Lehigh - Magellan Behavioral Health

County of Montgomery - Magellan Behavioral Health

County of Northampton - Magellan Behavioral Health

County of Perry - Community Behavioral Healthcare Network of PA, Inc.

County of Philadelphia - Community Behavioral Health

County of Washington - Value Behavioral Health of PA

County of Westmoreland - Value Behavioral Health of PA

County of York - Community Care Behavioral Health

Coventry Care

Gateway Health Plan, Inc.

Health Partners of Philadelphia

Keystone Mercy Health Plan

United Healthcare of PA

UPMC Health Plan, Inc./UPMC for You

Value Behavioral Health of PA (Greene County)

ADDITIONAL INFORMATION

Skilled Nursing Facility is for the first 30 days. Special Needs Children: (state defined) Broadly defined non-categorical to include all children. All consumers receiving behavorial health services are considered to be persons with special needs.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

PENNSYLVANIA
HealthChoices

Consumer Self-Report Data:
-CAHPS
    4.0H adult

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use

Health Status/Outcomes Quality:
-Patient satisfaction with care

PENNSYLVANIA
HealthChoices

-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their
ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient,
ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Number of years Health Plan in business and total membership
-Provider turnover

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for
women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-All MCOs participating in the managed care program are
required to conduct a common performance improvement
project(s) prescribed by State Medicaid agency

Clinical Topics:
-Adolescent Pregnancy
-Asthma management
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Hypertension management
-Smoking prevention and cessation

PENNSYLVANIA
HealthChoices

Non-Clinical Topics:

-Adult's access to dental care
-Children's access to dental care

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care
(QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of
Healthcare Organizations) Standards
-NAIC (National Association of Insurance
Commissioners) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization (IPRO)

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of
clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting
quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance
program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS,
NQF, etc.)

Initial Year of Reward:
2006

Evaluation Component:
The State has conducted an evaluation of the
effectiveness of its P4P program

Member Incentives:
Not Applicable

TEXAS
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Sheryl Woolsey
Texas Health and Human Services Commission
(512) 706-4901

State Website Address:

http://www.hhsc.state.tx.us/QuickAnswers/index.shtml

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 25, 2011

Implementation Date:
April 01, 2011

Waiver Expiration Date:
March 31, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Other - Fee-for-Service

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Special Needs Children (BBA defined)

Populations Mandatorily Enrolled:
-Medicaid Qualified Medicare Beneficiary
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-SSI Medicaid

TEXAS
Non-Emergency Transportation

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Title CHIP XXI

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles except Medicaid QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Not Applicable

ADDITIONAL INFORMATION

NEMT services are provided in accordance with the federal regulations 42 CFR §§ 431.53, 440.170. NEMT services are arranged through competitively procured contracts with public and private transportation providers. NEMT also provides mileage reimbursement to persons enrolled as Individual Transportation Provider (ITPs). Eligible beneficiaries through age 20, may receive advance funds for meals and lodging when an overnight stay is medically necessary. The beneficiary's parent or guardian may also qualify for meals and lodging. The beneficiary or the beneficiary's parent or guardian may also receive funds in advance for mileage, when necessary.

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NorthSTAR

CONTACT INFORMATION

State Medicaid Contact:

Betsy Johnson
Texas Health and Human Services Commission
(512) 491-1199

State Website Address:

http://www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Enrollment Broker:
Maximus

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
November 01, 1999

Implementation Date:
November 01, 1999

Waiver Expiration Date:
September 30, 2013

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Single PIHP
-1932(a)(3) More than one PIHP

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Other-FFS/some Risk Based

Service Delivery

Included Services:
Assertive Community Treatment Team, Crisis, Day Treatment Services, Detoxification, Dual Diagnosis, Emergency Behavioral Health Services, Inpatient Mental Health, Inpatient Substance Use Disorders, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Use Disorders, Psych Practitioner, Psychiatric or Behavioral Health Physician, Psychologist, Residential Substance Use Disorders Treatment Programs, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCP

Contractor Types:
-Behavioral Healthcare Organization (BHO)

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Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Children in Protective Foster Care
-Individuals Eligible as Medically Needy
-Individuals receiving inpatient Medicaid IMD services over age 65
-Individuals Residing Outside of the Service Region
-Medicare Dual Eligibles
-Other Insurance
-Qualified Medicare Beneficiaries
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
All clients with full Medicare and Medicaid eligibility

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DADS
-DFPS
-DSHS
-Local School Districts
-Protective and Regulatory Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ValueOptions

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NorthSTAR

ADDITIONAL INFORMATION

Individuals on SSI and QMB plus are the only Medicare dual eligibles that are eligibled to enroll. The program is mostly fee-for-service but on occasions there are some risk based arrangement.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Geographic Mapping
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-Modified MHSIP survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires PIHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries
-Use of unique NorthSTAR ID # (which includes Medicaid # for the Medicaid enrollees) for beneficiaries

Collection: Standardized Forms:
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service

State conducts general data completeness assessments:
Yes

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NorthSTAR

-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Performance Measures

Process Quality:
-Depression management/care
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality:
-Clinical outcomes as measures by clinical assessments
-Patient satisfaction with care
-Recidivism to intensive/acute levels of care

Access/Availability of Care:
-Average distance to mental health provider
-Number and types of providers
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient,
ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Behavioral Health Specialty Network
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-All PIHPs participating in the managed care program are
required to conduct a common performance improvement
project(s) prescribed by State Medicaid agency

Clinical Topics:

-Coordination of primary and behavioral health care

Non-Clinical Topics:

None

Standards/Accreditation

PIHP Standards:
-CMS's Quality Improvement System for Managed Care
(QISMC) Standards for Medicaid and Medicare
-NCQA Standards for Treatment Records

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Institute for Child Health Policy (ICHP)

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NorthSTAR

EQRO Organization:
-QIO-like entity

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

TEXAS
PCCM Negotiated Hospital Contracting

CONTACT INFORMATION

State Medicaid Contact:

Terri Frazier
Texas Health and Human Services Commission
(512) 491-1832

State Website Address:

http:// www.hhsc.state.tx.us/medicaid/care_case_pr

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4), Selective Contracting

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 01, 2008

Implementation Date:
January 01, 2008

Waiver Expiration Date:
February 28, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

Negotiated hospital rates by the Texas Medicaid claims administrator, Texas Medicaid & Healthcare Partnership (TMHP).

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CONTACT INFORMATION

State Medicaid Contact:

Joe Vesowate
Texas Health and Human Services Commission
(512) 491-1379

State Website Address:

http://www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
August 01, 1993

Implementation Date:
August 01, 1993

Waiver Expiration Date:
June 30, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Advanced Practice Registered Nurses(APRNs)
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

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Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
-Childen Under 1 (Proverty Level Infants)
-Children Age 1-5
-Children Age 6-18
-Newborn Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicaid Beneficiaries Who Participate in the STAR+PLUS 1915(c) Waiver Program
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna	Amerigroup (STAR)
Community First	Community Health Choice
Cook Children's	Driscoll
El Paso First Premier	First Care
Molina (STAR)	Parkland Community Health Plan
Superior HealthPlan (STAR)	Texas Children Health Plan
Unicare	United

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STAR

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Child Medicaid AFDC Questionnaire
    Child Medicaid SSI Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-837 transaction format
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-837 transacton format
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-Behavioral health layout
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to submitted bills)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

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MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Preparing HEDIS and risk adjustment software

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Cervical cancer screening rate
-Childhood Immunization Status
-Chlamdyia screening in women
-Depression management/care
-Diabetes care and control
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Good access to behavioral treatment or counseling
-Good access to routine care
-Good access to special therapies
-Good access to specialist referral
-Good access to urgent care
-High blood pressure control
-Initiation of prenatal care - timeliness of
-No delays for approval
-No exam room wait > 15 minutes
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Prenatal/postnatal care
-Smoking prevention
-Wellcare visits
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)
-Provider turnover

TEXAS
STAR

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Measures - Others:
-Member use of services/utilization/satisfaction

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics:
-Improve treatment for Ambulatory Care Sensitive Conditions (ACSC) through reduction of emergency department visits.
-Improve treatment for Ambulatory Care Sensitive Conditions (ACSC) through reduction of inpatient admissions.

Non-Clinical Topics:
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Institute for Child Health Policy, University of Florida

EQRO Organization:
-QIO-like entity

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Assess performance of improvement projects.
-Calculation of performance measures
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of encounter data
-Validation of performance improvement projects

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO, but plans to implement one in the future

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
1% At-risk Premium. HMO at risk for 1% of the capitation

rate(s) dependent on the outcome of pre-identified performance measures
Payment incentives/differentials to reward MCOs
Quality challenge pool award. Based on specific pre-identified clinical performance measures

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
1% At-risk Premium. Standards are established for the SFY time period that must be met in order to retain the point value and percentage of the 1% At-Risk Premium dollars.
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing patient satisfaction measures
Assessing the timely submission of complete and accurate electronic encounter/claims data
Quality Challenge Pool Award is based on a point value and performance standard assigned to the clinical performance measures and overall ranking of managed care organization score.
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
Not Applicable

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

Member Incentives:
Not Applicable

TEXAS
Texas Medicaid Wellness Program

CONTACT INFORMATION

State Medicaid Contact:

Betsy Johnson
Texas Health and Human Services Commission
(512) 491-1199

State Website Address:

http://www.hhsc.state.tx.us/medicaid

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
March 01, 2011

Implementation Date:
March 01, 2011

Waiver Expiration Date:
February 28, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State
Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Disease Management PAHP - Risk-based Capitation

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Populations Mandatorily Enrolled:
None

TEXAS
Texas Medicaid Wellness Program

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Enrollees in hospice, STAR, STAR+PLUS, or STARHealth programs, as wellas undocumented aliens
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-SCHIP Title XXI Children

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

QMB Plus, SLMB Plus, and Medicaid only
QMB
SLMB, QI, and QDWI
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses other means to identify members of these groupsl Vendor uses claims data to identify clients w

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

McKesson Health Solutions

ADDITIONAL INFORMATION

Only clients enrolled in Primary Care Case Management and Traditional Medicaid (FFS) are included in this program. Technology, such as use of predictive modeling software, uses claims data to help identify potential program eligibles who are high-cost or high-risk and impactable.

QUALITY ACTIVITIES FOR PAHP

TEXAS
Texas Medicaid Wellness Program

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Data Analysis
-Enrollee Hotlines
-Independent Assessment
-Measure Disparities
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Utilization Review

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data:
-SF-12 and SF-10 Health Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-State use/requires PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Influenza Vaccination

Access/Availability of Care:
None

Use of Services/Utilization:
-Admission Rate (adult) for: Diabetes (short and long term complications), DOPD, Hypertension, COPD, CHF, uncontrolled Diabetes, and Asthma
-Admission Rate (Pediatric): Asthma, Diabetes (short-term complications)

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
-Provider Satisfaction Survey

Beneficiary Characteristics:
None

Performance Measures - Others:
-HEDIS

Performance Improvement Projects

Project Requirements:
-All PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Asthma management
-Coordination of primary and behavioral health care
-Diabetes management
-Emergency Room service utilization
-Hospital discharge planning

Non-Clinical Topics:
-Enrollment and engagement initiative
-Health and wellness initiative
-Tobacco Cessation
-Weight Watchers

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

UTAH
Choice Of Health Care Delivery

CONTACT INFORMATION

State Medicaid Contact:

Emma Chacon
Utah State Department of Health
(801) 538-6577

State Website Address:

http://www.health.utah.gov/medicaid

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
March 23, 1982

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
July 01, 1982

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Waiver Expiration Date:
December 31, 2016

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Diabetes self-management, Durable Medical Equipment, Enhanced Services to Pregnant Women, EPSDT, ESRD, Family Planning, Hearing, HIV Prevention, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient medical detoxification, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Private Duty Nursing, Speech Therapy, Vision, Well-adult care, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians

UTAH
Choice Of Health Care Delivery

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medically Needy Children
-Medicare Dual Eligibles
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-1931 Adults
-During Retroactive Eligibility Period
-Eligibility Less Than 3 Months
-Eligible only for TB-related Services
-If Approved as Exempt from Mandatory Enrollment
-Medically Needy Adults
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

UTAH
Choice Of Health Care Delivery

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Case Management, Diabetes self-management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility if less than 30 days, Vision, X-Ray

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Individuals who qualify for Medicaid by paying a spenddown and are aged or disabled
-Individuals who qualify for Medicaid by paying a spenddown and are under age 19
-Medicare Dual Eligibles
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Less Than 3 Months
-Eligible only for TB-related Services
-Have an eligibility period that is only retroactive
-Individuals residing in the Utah State Hospital of the Utah Developmental Center
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Section 1931 non-pregnant adults age 19 and older and related poverty level populations

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

Yes

Provides Part D Benefits:

Yes

Scope of Part D Coverage:

Standard Prescription Drug

Part D - Enhanced Alternative Coverage:

Not Applicable

UTAH
Choice Of Health Care Delivery

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Medical-only PAHP (risk or non-risk, non-comprehensive) - Non-risk Capitation

Service Delivery

Included Services:
Case Management, Diabetes self-management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Laboratory, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Less Than 3 Months
-Eligible only for TB-related Services
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

UTAH
Choice Of Health Care Delivery

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Employment Agencies
-Housing Agencies
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy U

Select Access

Molina Healthcare of Utah (Molina)

ADDITIONAL INFORMATION

Children with specieal needs means children under 21 who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and requires health and related services of a type or amount beyond that required by children generally, including a child who, consistent with 1932(a)(2)(A) of the Social Security Act, 42 U.S.C., Section 1396u-2(a)(2)(A): (1) is blind or disabled or in a related population (eligible for SSI under title XVI of the Social Security Act), (2) is in foster care or other out-of-home placement, (3) is receiving foster care or adoption assistance; or (4) is receiving services through a family-centered, community-based coordinated care system that receives grant funds described in section 501(a)(1)(D) of title V.

Children with specieal needs means children under 21 who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and requires health and related services of a type or amount beyond that required by children generally, including a child who, consistent with 1932(a)(2)(A) of the Social Security Act, 42 U.S.C., Section 1396u-2(a)(2)(A): (1) is blind or disabled or in a related population (eligible for SSI under title XVI of the Social Security Act), (2) is in foster care or other out-of-home placement, (3) is receiving foster care or adoption assistance; or (4) is receiving services through a family-centered, community-based coordinated care system that receives grant funds described in section 501(a)(1)(D) of title V.

Children with specieal needs means children under 21 who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and requires health and related services of a type or amount beyond that required by children generally, including a child who, consistent with 1932(a)(2)(A) of the Social Security Act, 42 U.S.C., Section 1396u-2(a)(2)(A): (1) is blind or disabled or in a related population (eligible for SSI under title XVI of the Social Security Act), (2) is in foster care or other out-of-home placement, (3) is receiving foster care or adoption assistance; or (4) is receiving services through a family-centered, community-based coordinated care system that receives grant funds described in section 501(a)(1)(D) of title V.

The contract is non-risk. Medicaid reimburses the PAHP the amount the PAHP pays its providers plus an administrative fee.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)

Use of Collected Data:

-Beneficiary Plan Selection

UTAH
Choice Of Health Care Delivery

-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Possible Duplicate Encounter

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of adults 50 and older who received an influenza vaccine

-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Use of imaging studies for low back pain
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Diabetes management

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-HCE Quality Quest
-Utah Department of Health's Office of Health Care Statistics

EQRO Organization:
-QIO-like entity
-State entity

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

UTAH
Choice Of Health Care Delivery

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance
program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement
Activities:**
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the
HEDIS measure listed for Medicaid
-State use/requires PAHPs to follow NCQA specifications for all
of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may
have been clarified or revised over time)
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter
data
-Specifications for the submission of encounter data to the
Medicaid agency
-Standards to ensure complete, accurate, timely encounter
data submission

Collections - Submission Specifications:
-Data submission requirements including documentation
describing set of encounter data elements, definitions, sets
of acceptable values, standards for data processing and
editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national
standardized forms (e.g. UB-04, NCPDP, ASC X12 837,
ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting
health care claims data

Validation - Methods:
-Automated analysis of encounter data submission to help
determine to data completeness (e.g. frequency
distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g.
codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons
to State FFS utilization rates, comparisons to PAHP

commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Duplicate encounter

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Influenza vaccinationa rate
-Initiation of prenatal care - timeliness of
-Us of imaging studies for low back pain
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-All PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Diabetes management

Non-Clinical Topics:
None

Standards/Accreditation

UTAH
Choice Of Health Care Delivery

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
None

Use of Collected Data:
None

Consumer Self-Report Data:
None

UTAH
Non-Emergency Medical Transportation

CONTACT INFORMATION

State Medicaid Contact:

Anita Hall
Utah State Department of Health
(801) 538-6483

State Website Address:

http://www.health.utah.gov/medicaid

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 19, 2000

Implementation Date:
July 01, 2001

Waiver Expiration Date:
June 30, 2013

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

UTAH
Non-Emergency Medical Transportation

Subpopulations Excluded from Otherwise Included Populations:

-1115 non-traditional Medicaid
-Medicare Dual Eligibles
-Mental Health Services
-Reside in Nursing Facility or ICF/MR
-Reside in the State Hospital or in the State Developmental Center

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Pick Me Up Transportation

ADDITIONAL INFORMATION

Children with specieal needs means children under 21 who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and requires health and related services of a type or amount beyond that required by children generally, including a child who, consistent with 1932(a)(2)(A) of the Social Security Act, 42 U.S.C., Section 1396u-2(a)(2)(A): (1) is blind or disabled or in a related population (eligible for SSI under title XVI of the Social Security Act), (2) is in foster care or other out-of-home placement, (3) is receiving foster care or adoption assistance; or (4) is receiving services through a family-centered, community-based coordinated care system that receives grant funds described in section 501(a)(1)(D) of title V.

QUALITY ACTIVITIES FOR PAHP

UTAH
Non-Emergency Medical Transportation

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards

Use of Collected Data:
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

PAHP conducts data accuracy check(s) on specified data elements:
None

State conducts general data completeness assessments:
No

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

UTAH
Prepaid Mental Health Program

CONTACT INFORMATION

State Medicaid Contact:

Emma Chacon
Division of Medicaid and Health Financing
(801) 538-6577

State Website Address:

http://www.health.utah.gov/medicaid

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
July 01, 1991

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
July 01, 1991

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Waiver Expiration Date:
December 31, 2016

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State
Plan

For All Areas Phased-In:
Yes

**Sections of Title XIX Costs Not Otherwise Matchable
Granted:**
None

Guaranteed Eligibility:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, Inpatient Mental Health, Mental Health Outpatient,
Mental Health Rehabilitation, Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Contractor Types:
-CMHC - some private, some governmental

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

UTAH
Prepaid Mental Health Program

-Medicare Dual Eligibles
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-1925 Adults
-1931 Adults
-Medically Needy Adults
-Medicare Dual Eligibles
-Outpatient services for foster children
-Resident of the State Developmental Center (DD/MR facility)
-Resident of the Utah State Hospital (IMD)

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Employment Agencies
-Housing Agencies
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Bear River Mental Health Services, Inc

Davis Behavioral Health

Northeastern Counceling Center

Southwest Center Behavioral Health Services

Wasatch Mental Health

Central Utah Counseling Center

Four Corners Community Behavioral Health, Inc.

Salt Lake County Behavioral Health

Valley Mental Health

Weber Human Services

ADDITIONAL INFORMATION

Community Mental Health Centers serve as Prepaid Mental Health Plan (PMHP) contractors to provide/coordinate all mental health

services in 9 of the 11 mental health service areas. Under the PMHP foster children receive inpatient services only.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-MHSIP satisfaction surveys are used by the PMHPs.
-OQ/YOQ outcomes instruments are used by the PMHPs.

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across PIHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission
-State monitoring of consistency in encounters over time

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

UTAH
Prepaid Mental Health Program

-Duplicate encounters

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Average time for intake

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
-State minimum reserve requirements

Health Plan/ Provider Characteristics:
-Information on providers by designated provider groupings

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

-Coordination of primary and behavioral health care

Non-Clinical Topics:

Not Applicable - PIHPs are not required to conduct common project(s)

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-HCE Quality Quest

EQRO Organization:
-QIO-like entity

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting quality activities

VIRGINIA
MEDALLION/Medallion II

CONTACT INFORMATION

State Medicaid Contact:

Mary Mitchell
Department of Medical Assistance Services
(804) 786-3594

State Website Address:

http://www.dmas.virginia.gov/

PROGRAM DATA

Program Service Area:
City
County

Initial Waiver Approval Date:
April 01, 2005

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
April 01, 2005

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Waiver Expiration Date:
June 30, 2013

Enrollment Broker:
MAXIMUS, Inc.

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family
Planning, Hearing, Home Health, Immunization, Inpatient
Hospital, Inpatient Mental Health, Laboratory, Occupational
Therapy, Outpatient Hospital, Outpatient Mental Health,
Outpatient Substance Use Disorders, Pharmacy, Physical
Therapy, Physician, Podiatry, Speech Therapy,
Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

VIRGINIA
MEDALLION/Medallion II

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Foster Care
-Hospice
-Medicare Dual Eligibles
-Other Insurance
-Participate in 1915(c) Home & Community Based Waiver
-Refugees enrolled in Refugee Medical Assistance
-Reside in Nursing Facility or ICF/MR
-Spenddown
-Subsidized Adoption

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

VIRGINIA
MEDALLION/Medallion II

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Case Management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Foster Care
-Hospice
-Medicare Dual Eligibles
-Other Insurance
-Participate in Tech Waiver
-Refugees enrolled in Refugee Medical Assistance
-Reside in Nursing Facility or ICF/MR
-Spend-down
-Subsidized Adoption

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

VIRGINIA
MEDALLION/Medallion II

**Program Includes People with Complex
(Special) Needs:**

Yes

**Strategies Used to Identify Persons with
Complex (Special) Needs:**

-Asks advocacy groups to identify members of these
groups
-Initial Interviews with new Medallion II enrollees
-Review claims activity of all new enrollees for special
indicators
-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the
Operation of the Program:**

-Education Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Community Care

MEDALLION

Southern Health CareNet

Anthem Healthkeepers Plus

Optima Family Care

Virginia Premier Health Plan

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement
Activities:**
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Performance Measures Validation

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the
HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of
the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may
have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter
data
-Specifications for the submission of encounter data to the
Medicaid agency
-Standards to ensure complete, accurate, timely encounter
data submission

Collections: Submission Specifications:
-Data submission requirements including documentation
describing set of encounter data elements, definitions, sets
of acceptable values, standards for data processing and
editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national
standardized forms (e.g. UB-04, NCPDP, ASC X12 837,
ADA)
-Guidelines for frequency of encounter data submission

VIRGINIA
MEDALLION/Medallion II

-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Amount of Payment

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Ambulatory Care
-Antidepressant medication management
-Asthma care - medication use
-Breast Cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management for people with cardivascular disease
-Controlling high blood pressure
-Diabetes management
-Enrollee rights and protection
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Pharmacology Management of COPD
-Quality Assessment and Performance Improvement
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Average distance to PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

VIRGINIA
MEDALLION/Medallion II

Performance Improvement Projects

Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Childhood Immunization
-Well Child Care

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Delmarva Foundation for Medical Care

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Annual Technical Report
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

VIRGINIA
MEDALLION/Medallion II

Quality Oversight Activities:
-Enrollee Hotlines

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data:
None

WASHINGTON
The Integrated Mental Health Services

CONTACT INFORMATION

State Medicaid Contact:

Cyndi LaBrec
Divison of Behavioral Health and Recovery
(360) 725-2029

State Website Address:

http://www.dshs.wa.gov/dbhr/mh_information.shtml

PROGRAM DATA

Program Service Area:
County
Region

Initial Waiver Approval Date:
April 27, 1993

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
July 01, 1993

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Waiver Expiration Date:
September 30, 2012

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan
-42 CFR 438.52 Choice
-42 CRF 438.52 Non-competitive Procurement

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Brief Intervention Treatment, Crisis Services, Day Support, EPSDT, Evaluation and Treatment/Community Hospitalization, Family Treatment, FQHC, Group Treatment Services, High Intensity Treatment, Individual Treatment Services, Inpatient Hospital Psychiatric, Inpatient Mental Health Services, Intake Evaluation, Medication Management, Mental Health Services Provided in Residential Settings, Peer Support Services for Mental Health, Psychological Assessment, Rehabilitation Case Management, Rural Clinic Services, Special Population Evaluation, Stabilization Services, Therapeutic Psychoeducation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

WASHINGTON
The Integrated Mental Health Services

Contractor Types:
-Regional Authority Operated Entity (Public)
-13 Regional Support Networks

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Individuals with Serious and Persistent Mental Health and/or Substance Abuse
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICR/MR
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Homeless People not Enrolled in Medicaid
-Medicare Dual Eligibles
-PACE
-Pregnant Women included in Family Planning Waiver
-Residents of State-owned institutions
-Washington Medicaid Integration Partnership (WMIP)

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-All Enrollees served by the RSNs meet this criteral

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Dental Providers
-Education Agency
-HIS - Indian Health Services
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

WASHINGTON
The Integrated Mental Health Services

-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Regional Support Network

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Quality Review Team

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-Consumer/Beneficiary Focus Groups
-MHSIP Child, Family, and Adult Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

WASHINGTON
The Integrated Mental Health Services

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Data quality and completeness
-Follow-up after hospitalization for mental illness
-Timeliness of assessment
-Timeliness of routine care

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Access to Appointment
-Availability of MHPs
-Average Distance to Service

Use of Services/Utilization:
-Crisis Contacts
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Outpatient Mental Health Hours

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics:

-Consumer Partnership in Treatment Planning
-Decrease in the Days to Medication Evaluation Appointment After Request for Service
-Employment Outcomes for Adult Consumers
-Follow-up Appointment Within Seven Days of Discharge from Eastern State Hospital
-Impact of Implementing the PACT Model on the Use of Inpatient Treatment
-Improved Access to Children's Long-Term Inpatient Care
-Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder
-Metabolic Syndrome Screening and Intervention
-Multisystemic Therapy
-Permanent Supported Housing
-Using Dialectical Behavorial Therapy to Decrease Inpatient Psychiatric Admissions

Non-Clinical Topics:

-Improved Access to Community-Based Least Restrictive Care for Children with Intensive Needs
-Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
-Improving Coordination of Care and Outcomes
-Improving Early Engagement in Outpatient Services

-Increased Incident Reporting Compliance
-Increased Penetration Rate for Older Adults Enrolled in the
Medicaid Program
-Increasing Percentage of Medicaid Clients who receive an
Intake Service within 14 days of service request
-Reauthorization Timelines
-Resident Satisfaction in Transfer to Integrated Permanent
Housing

Standards/Accreditation

PIHP Standards:
-JCAHO (Joint Commission on Accreditation of
Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance)
Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
-EQRO Contractor/QIO

Non-Duplication Based on Accreditation:
-Compliance with Performance Measurements
-Compliance with QAPI and Program Integrity
-Encounter Data Validation

EQRO Name:
-Acumentra Health

EQRO Organization:
-External qualtiy review organization (Acumentra)

EQRO Mandatory Activities:
-Information systems capability assessment
-Review of PIHP compliance with structural and operational
standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities
-Encounter validation training
-PIP Training

WEST VIRGINIA
Mountain Health Trust

CONTACT INFORMATION

State Medicaid Contact:

Brandy Pierce
Office of Managed Care, Bureau for Medical Service
(304) 356-4912

State Website Address:

http://www.wvdhhr.org

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Enrollment Broker:
Automated Health Systems, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
Continuous eligibility for children under age 19

Initial Waiver Approval Date:
July 01, 2010

Implementation Date:
July 01, 2010

Waiver Expiration Date:
June 30, 2014

Sections of Title XIX Waived:
-1902(a)(17) Comparability of Eligibility Standards
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

WEST VIRGINIA
Mountain Health Trust

Populations Voluntarily Enrolled:

-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Populations Mandatorily Enrolled:

-Poverty-Level Pregnant Women
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Title CHIP XXI

Lock-In Provision:

1 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

WEST VIRGINIA
Mountain Health Trust

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:

Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:

-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:

1 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carelink Health Plan

Physician Assured Access System

Health Plan of the Upper Ohio Valley

Unicare Health Plan of WV

ADDITIONAL INFORMATION

Any child who is enrolled in the States Childen with Special Health Care Needs Program administered by the Office of Maternal, Child, Family Health

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Complaints, Grievances, and Disenrollment Data
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-Disenrollment Survey
-State-developed Survey
-State-developed Survey of Children with Special Health Needs

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-Not Applicable

Validation - Methods:
-Comparison to benchmarks and norms (e.g. comparisons

to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Comprehensive Diabetes Care
-Controlling high blood pressure
-Frequency of on-going prenatal care
-Heart Attack care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Smoking prevention and cessation
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Call Answer Abandonment
-Call Timeliness
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Ambulatory Surgery/Procedures/1,000 members months
-Days/1000 an average length of stay of IP administration, ER visits, ambulatory surgery, maternity care, newborn care
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Maternity - Discharges/1,000 Member Months, Days/1,000 Member Months, and ALOS
-Medicine - Discharges/1,000 member months, Days/1,000 member months, and ALOS
-Number of OB/GYN visits per adult female beneficiary
-Observation Room Stays/1,000 membrer months
-Outpatient Visits/1,000 member months
-Surgery - Discharges/1,000 member months, Days/1,000 Member Months, and ALOS
-Total Inpatient-Discharge/1,000 member months, days/1,000 member months and ALOS

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
-Board Certification

WEST VIRGINIA
Mountain Health Trust

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for
women giving birth during the reporting period

Performance Measures - Others:
-Prevention and Screening

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own
choosing
-All MCOs participating in the managed care program are
required to conduct a common performance improvement
project(s) prescribed by State Medicaid agency

Clinical Topics:
-Asthma
-Childhood Immunization
-Childhood Obesity
-Emergency Room service utilization

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care
(QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Delmarva Foundation for Medical Care

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of
clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting
quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance
program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

WEST VIRGINIA
Mountain Health Trust

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Program Evaluation
-Provider Profiling

Consumer Self-Report Data:
None

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Average distance to primary care case manager

Use of Services/Utilization:
None

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

CONTACT INFORMATION

State Medicaid Contact:

Tom Betlach
AHCCCS
(602) 417-4483

State Website Address:

http://www.AZAHCCCS.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
July 13, 1982

Implementation Date:
October 01, 1982

Waiver Expiration Date:
September 30, 2016

Sections of Title XIX Waived:
-1902(a)(10) Non Covered Activities
-1902(a)(10)((A)(ii)(V) Eligibility based on Institutionalized Status
-1902(a)(10)(B) Amount, Duration & Scope
-1902(a)(13) DSH Requirement
-1902(a)(14) Cost Sharings
-1902(a)(18) Estate Recovery
-1902(a)(23)(A) Freedom of Choice
-1902(a)(34) Retroactive Coverage
-1902(a)(4) Proper & Efficient Administration
-1902(a)(54) Drug Utilization Review

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-1903(m)(2)(A) except 1903(m)(2)(A)(i), 1903(m)(2)(A)(vi), 1903(m)(2)(H)
-Expenditures Related to Administration Simplication and Delivery Systems
-Expenditures Related to Benefits
-Expenditures Related to Expansion of Existing Eligibility Groups base on Eligibility Simplification

Guaranteed Eligibility:
12 months guaranteed eligibility for deemed newborns, 6 months guaranteed eligibility for first-time AHCCCS enrollees

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

Included Services:

Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Maternity, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplantation of Organs and Tissue and Related Immunosuppresant Drugs, Transportation, Vision, X-Ray

Allowable PCPs:

-Family Practitioners
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Adoption Subsidy Children
-Adults Without Minor Children Title XIX Waivers
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Federal Poverty Level Children Under Age 19 (SOBRA)
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XIX Waiver Spend Down Population

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-None - managed care entity provides standard prescription drug coverage

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:

Case Management, Crisis, Detoxification, Emergency and Non-emergency Transportation, Individual Therapy and Counseling, Inpatient Mental Health, Inpatient Psychiatric, Inpatient Substance Use Disorders, Laboratory, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Use Disorders, Pharmacy, Residential Substance Use Disorders Treatment Programs, X-Ray

Allowable PCPs:

-Family Practitioners
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants

Contractor Types:

-Regional Authority Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Adoption Subsidy Children
-Adults Without Minor Children Title XIX Waiver, Frozen as of 7/8/2011
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Families with Dependent Children under age 18 (1931) and Continuing Coverage (TMA/CS)
-Federal Poverty Level Children Under Age 19 (SOBRA)
-Foster Care Children
-Medicare Dual Eligibles
-Pregnant Women (SOBRA)
-Section 1931 Families with Children and Related Populations
-Title XIX Waiver Spend Down, Terminated 9/30/11

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-None - managed care entity provides standard prescription drug coverage

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Acute uses health risk assessment form to identify members
-ALTCS considers all members special needs

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Maternal and Child Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AZ Physicians IPA (Family Planning Extension)

AZ Physicians IPA (HP)

Bridgeway (Family Planning Extension)

Bridgeway Health Solution (HP)

Bridgeway Health Solution (PC)

Care 1st Health Plan

Care 1st Health Plan (Family Planning Extension)

Cochise Co. Dept. of Health Services (PC)

Department of Economic Security/Childrens Medical and Dental Program (Family Planning Extension)

Department of Economic Security/Childrens Medical and Dental Program (HP)

Department of Economic Security/Division of Developmental Disabilities (PC)

Department of Health Services (Behavioral Health)

Evercare Select (PC)

Health Choice Arizona (Family Planning Extension)

Health Choice Arizona (HP)

Maricopa County Health Plan (Family Planning Extension)

Maricopa County Health Plan (HP)

Mercy Care Plan (Family Planning Extension)

Mercy Care Plan (HP)

Mercy Care Plan (PC)

Phoenix Health Plan (Family Planning Extension)

Phoenix Health Plan (HP)

Pima Health System (Family Planning Extension)

Pima Health System (HP)

Pima Health System (PC)

Pinal County Long Term Care (PC)

SCAN

University Family Care (Family Planning Extension)

University Family Care (HP)

Yavapai County Long Term Care (PC)

ADDITIONAL INFORMATION

12 months guaranteed eligibility for deemed newborns/born to mothers receiving Medicaid (Title XIX). Otherwise, 6 months eligibility guarantee for individuals enrolled with a health plan for the first time and become ineligible prior to 6 months of enrollment. This 6 month guarantee does not apply to members receiving Long Term Care services.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-EPSDT Annual Reports
-EPSDT Quarterly Reports
-Family Planning Annual Reports
-Focused Studies
-Maternity Annual Reports
-MCO Standards (see below for details)
-Member Survey
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Quality Improvement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

-Quality Management/Quality Improvement Annual Plans and Annual Evaluations

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NCPDP, ASC X12 837)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rates
-Advance Directives
-Annual Dental Visits among Children (ages 3 - 20)
-Asthma - appropriate use of medications
-Children's Access to Primary Care Providers
-Children's Access to Primary Care Providers - KidsCare Population
-Dental services
-Diabetes management

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

-Frequency of on-going prenatal care
-Health Screenings
-Immunizations for two year olds
-Influenza Immunizations and Pneumococcal Vaccination
Rates in the Elderly and Physically Disabled
-Initiation of prenatal care - timeliness of
-Lead Screening Rate
-Low Birth Weight Infants
-Population in Nursing Facilities and In Home Community
Based Setting (ALTCS indicator)
-Utilization of Family Planning Services
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries
-Utilization of Family Planning Services

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of home health visits per beneficiary
-Number of PCP visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Agency performance bond requirements
-Financial Viability Ratios (i.e., Current Ratio, Medical
Expense, Adminstrative, Equity/Member)
-Net income
-Total revenue

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Geographic
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Race / Ethnicity

Performance Measures - Others:
-Health Plan Stability/Financial

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are
required to conduct a common performance improvement
project(s) prescribed by State Medicaid agency
-Individual MCOs are required to conduct a project prescribed
by the State Medicaid agency

Clinical Topics:

-Childhood Immunization
-Diabetes management
-Medical problems of the elderly
-Pharmacy management & coordination of care
-Prevention of Influenza

Non-Clinical Topics:

-Advance Directives
-Availability of language interpretation services
-Provider education regarding cultural health care needs of
members

Standards/Accreditation

MCO Standards:
-CMS Meaningful Use (electronic medical records)
-CMS's Quality Improvement System for managed Care
(QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of

Accreditation Required for Participation:
None

Healthcare Organizations) Standards
-Managed Care Rules (BBA)
-NCQA (National Committee for Quality Assurance)
Standards
-State-Developed/Specified Standards
-URAC Standards

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group
-Healthcare Excel

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of some performance improvement projects
-Validation of some performance measures

EQRO Optional Activities:
-Ad hoc QM reviews
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Physician Survey
-PIHP Standards (see below for details)
-Provider Data
-Quality Management/Quality Improvement Annual Plans and Annual Evaluations

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-Member Survey
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across PIHPs
-PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Appropriateness of services
-Coordination of care with acute contractors/pcp's
-Member/Family involvement
-Percentage of beneficiaries who are satisfied with their

Health Status/Outcomes Quality:
-Coordination of Care
-Patient satisfaction with care
-Symptomatic and functional improvement
-Transition of Care

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

ability to obtain care

Access/Availability of Care:
-Access to care/ appointment availability
-Appointment Standards
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Agency performance bond requirements
-Financial Viability Ratios (i.e., Current Ratio, Medical Expense, Administrative, Equity/Member)
-Net income
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Geographic
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to PIHPs
-PIHP/PCP-specific disenrollment rate

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

-Access to Care
-Behavior health assessment - birth to 5 years of age
-Coordination of primary and behavioral health care
-Follow-up after hospitalization
-Informed consent for psychotropic medication prescription
-Pharmacy management
-Reducing the use of seclusion & restraint
-Transition of Care

Non-Clinical Topics:

-Availability of language interpretation services

Standards/Accreditation

PIHP Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards
-URAC Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Care Excel

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

ARKANSAS
Connectcare

CONTACT INFORMATION

State Medicaid Contact:

ANDREW ALLISON
State Medicaid Agency
(501) 682-8292

State Website Address:

http://www.medicaid.state.ar.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 03, 2006

Implementation Date:
October 01, 2006

Waiver Expiration Date:
September 30, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration & Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Cost Containment Strategy

SERVICE DELIVERY

PCCM Provider - Primary Care Case Management Fee

Service Delivery

Included Services:
Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Personal Care, Physical Therapy, Physician, Podiatry, Speech Therapy, X-Ray

Allowable PCPs:
-Area Health Education Centers (AHECs)
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-1115 Demonstration Waiver (AR Kids B
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

ARKANSAS
Connectcare

-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Eligiblity Period that is Retroactive
-family planning waiver
-Medically Needy "Spenddown" Categories
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Connect Care

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM

ARKANSAS
Connectcare

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Track Health Service provision

Consumer Self-Report Data:
-Satisfaction Survey

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Number of children with diagnosis of rubella(measles)/1,000 children
-Percentage of low birth weight infants

Access/Availability of Care:
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization:
-Inpatient admissions/1,000 beneficiaries

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

CALIFORNIA
Bridge to Reform Demonstration: COHS Model

CONTACT INFORMATION

State Medicaid Contact:

Margaret Tatar
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 01, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
October 31, 2015

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13) Payment to Providers
-1902(a)(23) Freedom of Choice
-1902(a)(30) Payment to Providers
-1902(a)(5) Single State Agency

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-None

SERVICE DELIVERY

HIO - Risk-based Capitation

Service Delivery

Included Services:
Acute ICF Visits, Comprehensive Case Management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education and Counseling, Health Risk Assessment (HRA), Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Long Term Care, Nurse Practitioner, Optometry, Outpatient Hemodialysis, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Rural Health Clinic (RHC), Skilled Nursing Facility, Subacute Care, Swing Bed, Transitional Inpatient Care, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Specialty Providers (MD)

CALIFORNIA
Bridge to Reform Demonstration: COHS Model

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Breast and Cervical Cancer Preventive Treatment
-Children with Accelerated Eligibility
-Foster Care Children
-Medi-Cal Eligibles with Share Cost
-Medically Needy
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP (non-State only Healthy Families)

Subpopulations Excluded from Otherwise Included Populations:
-CHIP Title XXI (State-only Healthy Families)
-Enrolled in another Medicaid Managed Care program
-Medicare Dual Eligibles

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups
-Utilization data (TARs, FFS)

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Caloptima-Orange	Central California Alliance For Health
Gold Coast Health Plan	Health Plan of San Mateo
Partnership Health Plan	Santa Barbara San luis Obispo Regional Health Authority

CALIFORNIA
Bridge to Reform Demonstration: COHS Model

ADDITIONAL INFORMATION

Operating authority under 1115 Demonstration Waiver. Authorizes a county operated managed health care program in 14 counties. Enrollment is mandatory for all covered aid codes. Health Plan of San Mateo is the only MCO that is under contract with the COHS model while the rest of the plans are HIOs.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Drug Rebate
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

CALIFORNIA
Bridge to Reform Demonstration: COHS Model

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Avoidance of antibiotic treatment in adults with acute Bronchitis
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Postpartum care
-Use of imaging studies for low back pain
-Weight assessment and counseling for nutrition and physical activity for children and adolescents
-Well-child care visit rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Average distance to PCP

Use of Services/Utilization:
-Ambulatory care - ambulatory surgery/procedures
-Ambulatory care - emergency department visits
-Ambulatory care - observation room stays
-Ambulatory care - outpatient visits
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Frequency of selected procedures
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement

Clinical Topics:
-Emergency Room service utilization
-Weight assessment and counseling for nutrition and physical activity for children and adolescents

project(s) prescribed by State Medicaid agency

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

CALIFORNIA
Bridge to Reform Demonstration: Geographic Managed Care Model

CONTACT INFORMATION

State Medicaid Contact:

Margaret Tatar
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Health Care Options/Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 01, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
October 31, 2015

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13) Payment to Providers
-1902(a)(23) Freedom of Choice
-1902(a)(30) Payment to Providers
-1902(a)(5)Single State Agency

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Acute ICF, Comprehensive Case Management, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, FQHCs, Health Education, Health Risk Assessment (HRA), Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Long Term Care Services for Month of Admission Plus one Additional Month, Nurse Practitioner, Optometry, Outpatient Hemodialysis, Outpatient Hospital, Outpatient Mental Health, Outpatient Rehab, Pharmacy, Physical Therapy, Physician, Subacute Care, Swing Bed, Transitional Outpatient, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)
-Specialty Providers (MDs)

CALIFORNIA
Bridge to Reform Demonstration: Geographic Managed Care Model

Enrollment

Populations Voluntarily Enrolled:
-Adoption Assist/Medically Indigent-Child
-American Indian/Alaska Native
-Foster Care Children
-Foster Care/Medically Indigent Child
-Medicare Dual Eligibles
-Pregnant/Medically Indigent-Adult

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Public Assistance-Family
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Program/Percent/Children

Subpopulations Excluded from Otherwise Included Populations:
-CHIP Title XXI Children(Healthy Families)
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - progam linkage and/or family contact
-Uses provider referrals to identify members of these groups
-Utilization data (TARs, FFS)

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Education Agency
-Home and Community Based Care
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Title V

CALIFORNIA
Bridge to Reform Demonstration: Geographic Managed Care Model

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem Blue Cross Partnership Plan - Sacramento

Community Health Group Partnership Plan-San Diego

Health Net Community Solutions, Inc.-San Diego

KP Cal, LLC-San Diego

Molina Healthcare of California Partner Plan, Inc. - San Diego

Care 1st Health Plan/San Diego

Health Net Community Solutions, Inc. - Sacramento

KP Cal, LLC - Sacramento

Molina Healthcare of California Partner Plan, Inc. - Sacramento

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries submission

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Avoidance of antibiotic treatment in adults with acute Bronchitis
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes Management/Care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Postpartum care
-Use of imaging studies for low back pain
-Weight assessment & counseling for nutrition & physical activity for children & adolescents
-Well-child care visit rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Ambulatory care - ambulatory surgery/procedures
-Ambulatory care - emergency department visits
-Ambulatory care - observation room stays
-Ambulatory care - outpatient visits
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Frequency of selected procedures
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

CALIFORNIA
Bridge to Reform Demonstration: Geographic Managed Care Model

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Cervical cancer screening among seniors and persons with disabilities
-Childhood obesity
-Emergency Room service utilization
-Hypertension management
-Postpartum care

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

Rewards Model:
Preferential auto-enrollment to reward MCOs

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)
Utilization of safety net providers by MCOs

Initial Year of Reward:
2005

Evaluation Component:
The State HAS NOT conducted an evaluation of the

effectiveness of its P4P program, but plans to conduct an evaluation in the future

Member Incentives:

Not Applicable

CALIFORNIA
Bridge to Reform Demonstration: LIHP Model

CONTACT INFORMATION

State Medicaid Contact:

Jalynne Callori
Low Income Health Program Division
(916) 324-0725

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
November 01, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
October 31, 2015

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13) Payment to Providers
-1902(a)(23) Freedom of Choice
-1902(a)(30) Payment to Providers
-1902(a)(5) Single State Agency

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-None

SERVICE DELIVERY

Medical-only PIHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Durable Medical Equipment, Emergency Care, Inpatient Hospital, Laboratory, Mental Health, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Prescription Drugs, Prosthetic and Orthotic Devices, Radiology, Transportation

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)
-Specialized Providers (MDs)

CALIFORNIA
Bridge to Reform Demonstration: LIHP Model

Enrollment

Populations Voluntarily Enrolled:
-HCCI: Individuals between 19-64 (not enrolled in Medicaid with incomes between above 133% up to 200%
-MCE: Individuals between 19-64(not enrolled in Medicaid with incomes at or below 133% FPL)

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Enhanced Alternative Coverage

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Coverage Enrollment Program	Contra Costa Health Plan
Health Way LA	HealthyPAC
Kern Medical Center Health Plan	Medical Services Initiative
San Diego LIHP	San Mateo Access & Care
SF Path	Valley Care

ADDITIONAL INFORMATION

"Low Income Health Programs (LIHPs) are county-based elective programs to serve the Medicaid Expansion populations. They consist of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The services listed above are the minimum benefits that must be provided to the MCE population. HCCI minimum benefits exclude mental health, transportation, and prescription drugs. While LIHPs must provide the minimum benefit packages many also offer additional services, which vary by county."

QUALITY ACTIVITIES FOR PIHP

CALIFORNIA
Bridge to Reform Demonstration: LIHP Model

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Plan Reimbursement
-Program Evaluation

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Plans submit encounter data quarterly

Collection: Standardized Forms:
-UCLA Electronic Specifications Identifies

Validation - Methods:
-Basic logic test
-Rates of utilization are validated between counties and against previous data

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Timely access

Use of Services/Utilization:
-Rate of service utlization for required services

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Standards/Accreditation

CALIFORNIA
Bridge to Reform Demonstration: LIHP Model

PIHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-NA (Exempt)

EQRO Organization:
-NA (Exempt)

EQRO Mandatory Activities:
-NA (Exempt)

EQRO Optional Activities
-NA (Exempt)

CALIFORNIA
Bridge to Reform Demonstration: Sacramento Dental PAHP

CONTACT INFORMATION

State Medicaid Contact:

Jon Chin
Medi-Cal Dental Services Division
(916) 464-3888

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
November 01, 2010

Operating Authority:
1115(a) - Demonstration Waiver Program

Implementation Date:
November 01, 2010

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
October 31, 2015

Enrollment Broker:
Health Care Options/Maximus

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13) Payment to Providers
-1902(a)(23) Freedom of Choice
-1902(a)(30) Payment to Providers
-1902(a)(5) Single State Agency

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-None

Guaranteed Eligibility:
None

SERVICE DELIVERY

Dental PAHP - Risk-based Capitation

Service Delivery

Included Services:
Dental, EPSDT, Health Education, Prevention, Screening

Allowable PCPs:
-Dentists

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care/Medically Indigent-Child
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Public Assistance-Family
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Program/Percent/Children

CALIFORNIA
Bridge to Reform Demonstration: Sacramento Dental PAHP

-Pregnant/Medically Indigent-Adult

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Less Than 3 Months
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan-Sacramento

Community Dental Services/Sacramento

Health Net of CA-Dental-Sacramento

Liberty Dental Plan of CA/Sacramento

Western Dental Services-Sacramento

ADDITIONAL INFORMATION

This waiver allows mandatory enrollment into dental managed care under Sacramento GMC. This program also includes EPSDT, screening, preventive, and health education services relating to dental services.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-PAHP Standards (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Track Health Service provision

CALIFORNIA
Bridge to Reform Demonstration: Sacramento Dental PAHP

-Performance Measures (see below for details)

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing

Collection: Standardized Forms:
None

Validation - Methods:
-Verify Provider ID with States Provider Master File

PAHP conducts data accuracy check(s) on specified data elements:
None
-Provider ID

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
-Number of procedures provided and monthly and yearly unduplicated users

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

CALIFORNIA
Bridge to Reform Demonstration: Two-Plan Model

CONTACT INFORMATION

State Medicaid Contact:

Margaret Tatar
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Health Care Options/Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 01, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
October 31, 2015

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13)Payment to Providers
-1902(a)(23) Freedom of Choice
-1902(a)(30)Payment to Providers
-1902(a)(5) Single State Agency

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Acute ICF, Case Management, Cultural/Linguistic, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, FQHC, Health Education, Health Risk Assessment (HRA), Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Long Term Care for Month of Admission Plus 1 Additional Month, Nurse Practitioner, Occupational Therapy, Optometry, Outpatient Hemodialysis, Outpatient Hospital, Outpatient Rehab, Pharmacy, Physical Therapy, Physician, Preventive Health Screening, Specialist, Subacute Care, Swing Bed, Transitional Outpatient, Transportation, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)
-Specialty Care Providers (MDs)

CALIFORNIA
Bridge to Reform Demonstration: Two-Plan Model

Enrollment

Populations Voluntarily Enrolled:
-Adoption Assistance/Medically Indigent Children
-American Indian/Alasaka Native
-Foster Care Children
-Medicare Dual Eligibles
-Pregnant/Medically Indigent Adults

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Public Assistance - Family
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Program/Percent/Children
-Title XXI CHIP (non-State only Healthy Families)

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Title XXI CHIP (State only Healthy Families)

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses other means to identify members of these groups -

Agencies with which Medicaid Coordinates the Operation of the Program:
-California Childrens Services
-Department of Managed Health Care
-Developmental Disabilities Agency
-Early Periodic Screening Diagnosis and Treatment Program
-Education Agency
-Mental Health Agency

CALIFORNIA
Bridge to Reform Demonstration: Two-Plan Model

program linkage and/or family contact
-Uses provider referrals to identify members of these groups
-Utilization data (TAR, FFS, AC)

-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Alameda Alliance for Health	Anthem Blue Cross Partnership Plan-TPMP
CalViva Health	Contra Costa Health Plan
Health Net Community Solutions, Inc.-TPMP	Health Plan of San Joaquin
Inland Empire Health Plan	Kern Family Health Care
LA Care Health Plan	Molina Healthcare of California Partner Plan, Inc.-TPMP
San Francisco Health Plan	Santa Clara Family Health Plan

ADDITIONAL INFORMATION

Eligibles may choose to join either a local initiative plan or a commercial plan selected by the State. Transportation services are included when medically necessary. This program operates under the 1115 Demonstration Waiver.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Ombudsman
-On-site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

CALIFORNIA
Bridge to Reform Demonstration: Two-Plan Model

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes Management/Care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Postpartum Care
-Use of imaging studies for low back pain
-Weight assessment & counseling for nutrition & physical activity for children & adolescents
-Well-child care visit rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Ambulatory care - ambulatory surgery/procedures
-Ambulatory care - emergency department visits
-Ambulatory care - observation room stays
-Ambulatory care - outpatient visits
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Frequency of selected procedures
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)
-Provider turnover

-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:	**Performance Measures - Others:**
-Beneficiary need for interpreter	None
-Information of beneficiary ethnicity/race	
-Information on primary languages spoken by beneficiaries	
-MCO/PCP-specific disenrollment rate	
-Percentage of beneficiaries who are auto-assigned to MCO	

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent obesity
-Asthma management
-Attention deficit hyperactivity disorder management
-Cervical cancer screening among seniors and persons with disabilities
-Childhood obesity
-Comprehensive diabetic quality improvement
-Diabetic testing & retinal exam screening
-Emergency Room service utilization
-Hypertension management
-Improving postpartum care rates

Non-Clinical Topics:

-Improving the patient experience

Standards/Accreditation

MCO Standards:

-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of

Rewards Model:
Preferential auto-enrollment to reward MCOs

CALIFORNIA
Bridge to Reform Demonstration: Two-Plan Model

Eligibility

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)
Utilization of safety net providers by MCOs

Initial Year of Reward:
2005

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

Member Incentives:
Not Applicable

DELAWARE
DIAMOND STATE HEALTH PLAN

CONTACT INFORMATION

State Medicaid Contact:

Glyne Williams
Division of Medicaid and Medical Services
(302) 255-9628

State Website Address:

http://www.dmap.state.de.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
HP Enterprise Services, LLC

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 17, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(34)
-1902(a)(43)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1902(a)(43)
-Budget Neutrality
-Eligibility Expansion
-Family Planning Expenditures

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Mental Health, Inpatient Substance Use Disorders, Integrated Services, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Podiatry, Private Duty Nursing, Skilled Nursing Facility, Speech Therapy, Vision, X-Ray

Allowable PCPs:
-Addictionologists
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Psychiatrists
-Psychologists
-Rural Health Clinics (RHCs)

DELAWARE
DIAMOND STATE HEALTH PLAN

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Adults, nonhead of household at or below 100% FPL
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Tricare/CHAMPUS

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

DELAWARE
DIAMOND STATE HEALTH PLAN

Fee for Service Model - Risk-based Capitation

Service Delivery

Included Services:

Dental, Durable Medical Equipment, EPSDT, Family
Planning, Hearing, Home Health, Hospice, Immunization,
Inpatient Hospital, Inpatient Mental Health, Inpatient
Substance Use Disorders, Laboratory, Occupational Therapy,
Outpatient Hospital, Outpatient Mental Health, Outpatient
Substance Use Disorders, Pharmacy, Physical Therapy,
Physician, Private Duty Nursing, Skilled Nursing Facility,
Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:

-Addictionologists
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Psychiatrists
-Psychologists
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Expanded Adults at or below 100 % FPL
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

**Subpopulations Excluded from Otherwise
Included Populations:**

-CHAMPUS
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid
Managed Care Contracts:**

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

DELAWARE
DIAMOND STATE HEALTH PLAN

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Delaware Physicians Care, Inc

Diamond State Partners

UnitedHealthcare Community Plan

ADDITIONAL INFORMATION

The Diamond State Health Plan (DSHP) is a state-wide mandatory managed care program. Approximately 80% of the Delaware Medicaid population is included in this program with the exception of member in other community-based waivers and Medicare dual eligibles. The DSHP includes an expansion population of adults with incomes below 100% of FPL.

Unison Health Plan of Delaware, Inc. is now rebranded UnitedHealthcare Community Plan

Under the MCO managed care entity, Special Needs Children (State-defined): All children below 21, no income or resource limit that meet the SSN Functional Disability Requirements. Vision and hearing services are provided to children under 21.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation

Consumer Self-Report Data:

-CAHPS
   Adult Medicaid AFDC Questionnaire
   Child Medicaid AFDC Questionnaire
   Child with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups
-State-developed Survey

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

DELAWARE
DIAMOND STATE HEALTH PLAN

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Antidepressant medication management
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Cholesterol screening and management
-Controlling high blood pressure
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Blood tests results for diabetes
-Obesity rates for adolescents
-Patient satisfaction with care
-Percentage of low birth weight infants
-Provider surveys

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

DELAWARE
DIAMOND STATE HEALTH PLAN

-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Diabetes management
-Emergency Room service utilization
-Low birth-weight baby
-Pharmacy management
-Pre-natal care

Non-Clinical Topics:

-Availability of language interpretation services
-Health information technology (e.g. state implementation of immunization and other registries, telemedicine initiatives, etc…)
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Mercer Government Human Services

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

DELAWARE
DIAMOND STATE HEALTH PLAN

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO, but plans to implement one in the future

Program Payers:
Medicaid has collaborated with a private sector entity to support the P4P program

Population Categories Included:
A subset of MCO members, defined by disease and medical condition

Rewards Model:
To be determined

Clinical Conditions:
Possible clinical conditions not yet identified

Measurement of Improved Performance:
To be determined

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

DISTRICT OF COLUMBIA
Childless Adults 1115 Demonstration

CONTACT INFORMATION

State Medicaid Contact:

Lisa Truitt
Department of Health Care Finance
(202) 422-9109

State Website Address:

http://www.dchealth.dc.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Policy Studies, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 28, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(3)
-1902(a)(34) Retroactive Eligibility
-1902(a)(8)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Expenditures not otherwise specified under 1903
-Uncompensated Care Expenditures

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Addiction Professionals (i.e. Substance Use Disorder counselors, alcohol and drug counselors,
-Pediatricians
-Physician Assistants
-Psychiatrists
-Psychologists

DISTRICT OF COLUMBIA
Childless Adults 1115 Demonstration

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Childless adults (21-64) between 133 and 200 FPL

Subpopulations Excluded from Otherwise Included Populations:
-Eligible only for TB-related Services
-Enrolled in CDC BCCT Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman (SOBRA)
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

DC Chartered Health Plan, Incorporated

United Healthcare Community Plan

ADDITIONAL INFORMATION

The Childless Adult 1115 Demonstration provides eligibility to childless adults (age 21-64) between 133-200 FPL. Enrollees select one of two managed care organizations, and are enrolled via enrollment broker. They receive the same comprehensive Medicaid benefits package that all Medicaid managed care enrollees receive, and there are no exceptions or limits in place for this population. It was implemented in concert with a state plan amendment (under ACA authority) providing coverage to childless adults up to 133% FPL.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Plan Reimbursement

DISTRICT OF COLUMBIA
Childless Adults 1115 Demonstration

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-Not Applicable

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Mortality rates
-Patient satisfaction with care

Access/Availability of Care:
None

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Standards/Accreditation

DISTRICT OF COLUMBIA
Childless Adults 1115 Demonstration

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Delmarva Foundation for Medical Care

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
Withholds as an incentive

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing the timely submission of complete and accurate electronic encounter/claims data
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2010

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

FLORIDA
Florida Medicaid Reform

CONTACT INFORMATION

State Medicaid Contact:

Linda Macdonald
Florida Agency for Health Care Administration
(850) 412-4031

State Website Address:

http://ahca.myflorida.com/Medicaid/medicaid_reform

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
October 19, 2005

Operating Authority:
1115(a) - Demonstration Waiver Program

Implementation Date:
July 01, 2006

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
June 30, 2014

Enrollment Broker:
Automated Health Systems, Inc.

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(A) Eligibility
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(c)(i) Income and Resource Test
-1902(a)(14) Cost Sharing insofar as it incorporate
-1902(a)(23) Freedom of Choice
-1902(a)(27) Provider Agreements
-1902(a)(34) Retroactive Eligibility
-1902(a)(37)(B) Payment Review

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-1903(m)(2)(H) Automoatic Re-enrollemnt Expenditures
-Expenditures for employee costs of insurance for individuals who have opted out of Medicaid
-Expenditures for enhanced benefit accounts
-Expenditures for health care services provided under the Low Income Pool

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Community Mental Health, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mental Health Targeted Case Management, Occupational Therapy,

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists

FLORIDA
Florida Medicaid Reform

Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Respiratory Therapy, Speech Therapy, Transportation, Vision, X-Ray

-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-Family Planning Waiver Eligibles
-Medically Needy
-MediKids
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Women with Breast or Cervical Cancer

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-None - managed care entity provides standard prescription drug coverage

FLORIDA
Florida Medicaid Reform

Medical-only PIHP (risk or non-risk, non-comprehensive) - FFS w/ Some Risk Capitation

Service Delivery

Included Services:

Case Management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women

Populations Mandatorily Enrolled:

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Family Planning Waiver Eligibles
-Medically Needy
-MediKids
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Women with Breast or Cervical Cancer

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

FLORIDA
Florida Medicaid Reform

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AHF MCO of Florida, Inc.(Reform) d/b/a Positive Healthcare Florida (Reform)

Better Health, LLC (Reform)

Children's Medical Services (Reform)

First Coast Advantage (Reform)

Freedom Health Plan, Inc. (Reform)

Humana Medical Plan, Inc. (Reform)

Medica Health Plans of Florida, Inc. (Reform)

Molina Healthcare of Florida, Inc. (Reform)

Preferred Care Partners, Inc. d/b/a Care Florida (Reform)

South Florida Community Care Network (Reform)

Sunshine State Health Plan, Inc. (Reform)

United Healthcare of Florida, Inc. (Reform)

Universal Health Care, Inc. (Reform)

ADDITIONAL INFORMATION

The Provider Service Networks are reimbursed on a fee-for-service basis for all Florida state plan covered services. Under Reform, the fee-for-service PSN must cover transportation, which is done on a capitated basis.

The Childrens Medical Services Network is classified as a Provider Service Network and a speciality plan under Medicaid Reform. This plan was developed to serve children with special health care needs as defined by Florida statutes on a voluntary basis.

AIDS Healthcare Foundation of Florida (AHF MCO), d/b/a Positive Health Care, is a specialty plan (HMO) for beneficiaries living with HIV/AIDS.

Those children whose serious or chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting

FLORIDA
Florida Medicaid Reform

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionaire (Modified)
    Adult Medicaid SSI Questionaire (Modified)
    Children Medicaid AFDC Questionaire (Modified)
    Children Medicaid SSI Questionaire (Modified)
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Adults Access to Preventive/Ambulatory Health Services
-Ambulatory care
-Annual dental visits
-Antidepressant medication management
-Appropriate Testing for Pharyngitis
-BMI Assessment
-Breast Cancer screening rate
-Cervical cancer screening rate
-Childhood Immunization Status-Combo 2 and 3
-Chlamydia Screening for Women
-Controlling high blood pressure

Health Status/Outcomes Quality:
-Comprehensive Diabetes Care
-Controlling high blood pressure

FLORIDA
Florida Medicaid Reform

-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Follow-up Care for Children Prescribed ADHD Medication
-Frequency of HIV Disease Monitoring Lab Tests
-Highly Active Anti-Retroviral Treatment
-HIV-Related Medical Visits
-Immunizations for Adolescents
-Lead Screening in Children (LSC)
-Lipid Profile Annually
-Mental Health Readmission Rate
-Prenatal and postpartum care
-Prenatal Care Frequency
-Transportation Availability
-Transportation Timeliness
-Use of Angiotensin-Converting Enzyme
Inhibitors/Angiotensin Receptor Blockers Therapy
-Use of Appropriate Medications for People with Asthma
(ASM)
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Annual dental visit

Use of Services/Utilization:
-Adolecent wellcare visits
-Ambulatory care
-Well child visit in the 3rd, 4th, 5th, and 6th years of life
-Well child visit in the first 15 months of life

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own
choosing

Clinical Topics:
-Adolescent Well Care/EPSDT
-Asthma management
-Child Health Checkups
-Childhood Immunization
-CLAS - Well-Child Visits in the Third, Fourth, Fifth, and Sixth
Years of Life
-Clinical Health Care Disparities - Blood Lead Screening in
African American Children
-Clinical Health Care Disparities: Oral Health (Annual Dental Visit)
-Coordination of care for persons with physical disabilities
-Depression management
-Follow-up After Discharge From Mental Health Acute Care
Facility
-Improving Ambulatory Follow-up Appointments After Discharge
From Inpatient Mental Health Treatment
-Improving Annual Dental Visits
-Inpatient maternity care and discharge planning
-Lead toxicity
-Sexually transmitted disease treatment
-Use of Appropriate Asthma Drug Therapy
-Well Child Care/EPSDT
-Well-Child Visits in the First 15 Months of LIfe - Six or More Visits

Non-Clinical Topics:
-Adolescent Child Health Check-up Participation Rates within
and Across Ratial Groups

FLORIDA
Florida Medicaid Reform

-Behavioral Health Discharge Planning
-Disparity in Well-Checkup Visits between Younger and Older
Children
-Improving Member Satisfaction With Customer Service
-Language and Culturally Appropriate Access to Preventive
Health Care Services
-Member Service Call Answer Timeliness and Call
Abandonment Rate
-Quality Assessment and Performance Improvement (QAIP)

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care
(QISMC) Standards for Medicaid and Medicare
-Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for Participation:
-AAAHC (Accreditation Association for Ambulatory Health Care)
-NCQA (National Committee for Quality Assurance)
-URAC

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Systems Advisory Group (HSAG)

EQRO Organization:
-Health Systems Advisory Group (HSAG)
-Private accreditation organization

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Assessment of MCO information systems
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of
clinical or non-clinical services
-Technical Assistance
-Technical assistance to MCOs to assist them in conducting
quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance
program with the MCO, but plans to implement one in the
future

Program Payers:
Unknown at this time

Population Categories Included:
Unknown at this time

Rewards Model:
Unknown at this time

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Unknown at this time

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PIHP

FLORIDA
Florida Medicaid Reform

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement

Consumer Self-Report Data:
-CAHPS
   Adult Medicaid SSI Questionaire (Modified)
   Adult Medicaid TANF Questionaire (Modified)
   Children Medicaid SSI Questionaire (Modified)
   Children Medicaid TANF Questionaire (Modified)

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-State uses/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Ambulatory Care
-Annual Dental Visit
-Cervical cancer screening rate
-Controlling high blood pressure
-Diabetes medication management
-Follow-up After Hospitalization for Mental Illness
-Follow-up after hospitalization for mental illness
-Mental Health Readmission Rate
-Mental Health Utilization
-Prenatal and Postpartum Care
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Comprehensive Diabetes Care
-Controlling high blood pressure

Access/Availability of Care:
-Annual Dental Visit
-Prenatal and Postpartum Care

Use of Services/Utilization:
-Adolocent Wellcare Visit
-Ambulatory Care
-Number of enrollees admitted to state mental hospitals
-Use of beta agonist
-Wellchild visit in the 3rd, 4th, 5th, and 6th years of life
-Wellchild visit in the first 15 months of life

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own

Clinical Topics:
-Adolescent Immunization

choosing

-Adolescent Well Care/EPSDT
-Asthma management
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Follow-up within Seven Days After Acute Discharge for a Mental Health Diagnosis
-HIV/AIDS Prevention and/or Management
-Well Child Care/EPSDT

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Decreasing the Time from Claims Receipt to Claims Payment
-FARS/CFARS Submission Rates
-Improvement of Documentation Related to Coordination of Care between Mental Health Providers and PCPs within a Prepaid Mental Health Plan
-Improving Assessment to Care by Reducing Abandoned Call Rate

Standards/Accreditation

PIHP Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for Participation:
-PIHPs not required to be accredited at this time, as they are fee-for-service

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Systems Advisory Group (HSAG)

EQRO Organization:
-Private accreditation organization

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

HAWAII
Hawaii QUEST Expanded (QEx)

CONTACT INFORMATION

State Medicaid Contact:

Kenneth Fink
Hawaii Department of Human Services, Med-QUEST Division
(808) 692-8134

State Website Address:

http://www.med-quest.us/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
ACS

For All Areas Phased-In:
No

Initial Waiver Approval Date:
July 16, 1993

Implementation Date:
August 01, 1994

Waiver Expiration Date:
June 30, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(C)
-1902(a)(17)
-1902(a)(17)(D)
-1902(a)(23) Freedom of Choice
-1902(a)(34)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-HCBS
-MCO Definition 1903(m)(1)(A)
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)
-MCO Payments in non-rural areas to the extent necessary if a plan exceeds its enrollment cap 1903(m)(2)(A)(xii)

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Cornea and Kidney Transplants and Bone Grafts, Dental, Dietary, Durable Medical Equipment, EPSDT, HCBS, Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Intermediate Care Facility, Laboratory, Language/Interpreter, Long Term Care, Maternity, Occupational Therapy, Optometry, Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Preventive, Skilled Nursing Facility, Speech Therapy, Sterilization/Hysterectomies,

Allowable PCPs:
-Advanced Practice Registered Nurse
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Licensed Physician Assistant
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

HAWAII
Hawaii QUEST Expanded (QEx)

Subacute Care (when cost appropriate), Transportation, X-Ray

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Breast and Cervical Cancer Treatment Group
-Childless Adults who meet Medicaid asset limits
-Foster Care Children
-Medically Needy AFDC-related Adults and Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-None - managed care entity provides standard prescription drug coverage

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Education Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HAWAII
Hawaii QUEST Expanded (QEx)

Aloha Care   Evercare
HMSA-Medical   Kaiser Permanente
Ohana

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries
-Use of state proprietary forms

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

HAWAII
Hawaii QUEST Expanded (QEx)

-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-State contracted with HSAG on encounter validation project

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Annual monitoring for patients on persistent medication
-Antidepressant medication management
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Avoidance of antibiotic treatment in adults with acute bronchitis
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Childhood immunizations
-Chlamdyia screening in women
-Cholesterol management for patients with cardiovascular conditions
-Comprehensive diabetes care
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Flu shots for older adults
-Follow-up after hospitalization for mental illness
-Follow-up of care for children prescribed ADHD medication
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Medication reconciliation post-discharge
-Osteoporosis testing in older women
-Persistence of B blocker treatment after a heart attack
-Pneumonia vaccination status for older adults
-Smoking prevention and cessation
-Use of appropriate medications for people with asthma
-Use of high-risk medications in the elderly
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Blood pressure control
-Cholesterol control (LDL)
-Diabetes care (ALC)
-Emergency room visits
-Inpatient admissions
-Patient satisfaction with care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average wait time for an appointment with PCP
-CAHPS survey - getting care quickly/getting needed care

Use of Services/Utilization:
-Ambulatory care
-Drug Utilization
-Emergency room visits/1,000 beneficiary

HAWAII
Hawaii QUEST Expanded (QEx)

-Children's access to primary care practitioners
-Initiation and engagement of alcohol and other drug dependence treatment
-Prenatal and postpartum care
-Ratio of PCPs to beneficiaries

-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Inpatient utilization - general hospital/acute care
-Mental health utilization - percentage of members receiving inpatient, day/night care and ambulatory services
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of PCP visits per beneficiary
-Rate of preventable hospital admissions
-Re-admission rates of MH/SUD
-Well-child visits in first 15 months of life
-Well-child visits in the third, fourth, fifth and sixth year of life

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Net worth
-Relative resource use for people with asthma
-Relative resource use for people with diabetes
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Adolescent Well Care/EPSDT
-Asthma management
-Childhood Immunization
-Childhood obesity
-Diabetes management
-Emergency Room service utilization
-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-URAC Standards

Accreditation Required for Participation:
-AAAHC (Accreditation Association for Ambulatory Care)
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-URAC

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Organization:
-Private accreditation organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

HAWAII
Hawaii QUEST Expanded (QEx)

-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
Quest MCOs (Non-ABD) have imnplemented P4P. QExA Plans (ABD) have not implemented P4P, but plan to in the future.

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by disease and medical condition

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
5 conditions are measued each year, they change annually
Asthma
Childhood immunizations
Chlamydia Screening
Controlling high blood pressure
Diabetes
Prenatal Care
Well-child visits

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2010

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

INDIANA
Healthy Indiana Plan

CONTACT INFORMATION

State Medicaid Contact:

Sarah Jagger
Office of Medicaid Policy & Planning
(317) 234-5545

State Website Address:

http://www.in.gov/fssa/2408.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

Initial Waiver Approval Date:
December 14, 2007

Implementation Date:
January 01, 2008

Waiver Expiration Date:
December 31, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness/Uniformity
-1902(a)(10)(6)(i) Income and Resource Test
-1902(a)(10)(A) Eligibility Section
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13)(A) Disproportionate Share Hospital (DSH)
-1902(a)(23) Freedom of Choice
-1902(a)(3)/1902(a)(8) Reasonable Promptness
-1902(a)(34) Retroactive Eligibility
-1902(a)(37)(B) Prepayment Review
-1902(a)(4) Methods of Adminstration: Transportation
-1902(a)(43) Dental and Vision Coverage for Certain HIP
Caretakers and HIP Adults
-1916(a)(1) Premiums

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Eligibility Expansion

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Durable Medical Equipment, Emergency, EPSDT, Family
Planning, FQHC, Home Health, Immunization, Inpatient
Hospital, Inpatient Mental Health, Inpatient Substance Use
Disorders, Laboratory, Occupational Therapy, Out-of-state
Medical, Outpatient Hospital, Outpatient Mental Health,
Outpatient Substance Use Disorders, Pharmacy, Physical
Therapy, Physician, Podiatry, Respiratory Therapy, RHC,

Allowable PCPs:
-Members are not required to select a primary care provider

INDIANA
Healthy Indiana Plan

Smoking Cessation, Speech Therapy, X-Ray

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Uninsured Adults Under 200% FPL

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Primary Health Insurance
-Participate in HCBS Waiver
-Persons above 200% FPL
-Persons with employer sponsored insurance
-Persons with insurance during the past six months
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Claims Analysis
-Surveys medical needs of enrollee to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Eligibility Agency
-Enrollment Broker
-Health Plans
-PBM
-State Actuary

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem-Healthy Indiana Plan

Enhanced Services Plan (ESP)-Healthy Indiana Plan

Managed Health Services-Healthy Indiana Plan

MDwise-Healthy Indiana Plan

INDIANA
Healthy Indiana Plan

ADDITIONAL INFORMATION

The HIP Enhanced Services Plan (ESP) is designated for certain individuals with health care conditions that require additional support. These conditions include internal cancers, HIV/AIDS, hemophilia, aplastic anemia and organ transplants. ESP is delivered fee for service and it offers the same benefit package as the MCO under this program except for the disease and case management services particular to their health condition. ESP is administered by contract with vendors that administer the Indiana Comprehensive Health Insurance Association (ICHIA). The ESP plan includes a wide selection of providers throughout the State, as every Medicaid or Indiana Health Coverage Program provider is included in the network. Additionally, all ESP members will receive disease and case management services particular to their health condition. The ESP plan has experience with providing health care to persons with significant and serious health conditions. The State reimburses the ESP plan update to the Medicaid allowable. In addition ESP is paid a per member per month fee for administering the health plan.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

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Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCO
-Specification/source code review, such as a programming

electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Annual Preventive Services

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Number of PCP visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Provider turnover

Beneficiary Characteristics:
-MCO/PCP-specific disenrollment rate

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Annual Preventive Services

Non-Clinical Topics:
-Encounter Data

Standards/Accreditation

INDIANA
Healthy Indiana Plan

MCO Standards:
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-URAC Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Burns & Associates, Inc.

EQRO Organization:
-Independent Consultant

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-An Independent Annual Report which documents accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstrations.
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

INDIANA
Hoosier Healthwise (1115)

CONTACT INFORMATION

State Medicaid Contact:

Sarah Jagger
Office of Medicaid Policy & Planning
(317) 234-5545

State Website Address:

http://www.in.gov/fssa/2408.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 14, 2007

Implementation Date:
January 01, 2008

Waiver Expiration Date:
December 31, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness/Uniformity
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13)(A) DSH Payments
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Eligibility Expansion

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Food Supplements, FQHC, Hearing, Home Health, Immunization, Infant Formulas, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nutritional Supplements, Occupational Therapy, Organ Transplants, Out-of-state Medical, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Respiratory Therapy, RHC, Smoking Cessation, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians

Enrollment

INDIANA
Hoosier Healthwise (1115)

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Hospice
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses Health Needs Screening

Agencies with which Medicaid Coordinates the Operation of the Program:
-Eligibility Agency
-Enrollment Broker
-Health Plans
-PBM
-State Actuary

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem-Hoosier Healthwise
MDwise-Hoosier Healthwise

Managed Health Services (MHS)-Hoosier Healthwise

ADDITIONAL INFORMATION

Hoosier Healthwise is authorized by both an 1115(a) Demonstration and a 1915(b) Waiver. The MCHIP and Presumptively Eligible Pregnant Women populations are the only populations still on the 1915(b). The 1115(a) demonstration was established for the Healthy Indiana Plan. The remainder of the Hoosier Healthwise population was placed onto that 1115(a) demonstration for budget neutrality purposes.

State defined special needs children are children who have or at increase risk for a chronic physical, developmental, behavioral, or

emotional condition.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCO
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment

State conducts general data completeness assessments:
Yes

INDIANA
Hoosier Healthwise (1115)

-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Annual Monitoring for Persistant Medications
-Antidepressant medication management
-Appropriate Testing and Treatment for COPD
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Depression management/care
-Diabetes Management
-Follow-up after hospitalization for mental illness
-Follow-Up for Children Prescribed ADHD Medications
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Initiation of Prenatal Care
-Lead screening rate
-Use of Imaging Studies for Low Back Pain
-Utilization for Ambulatory, Inpatient, and Mental Health Treatment
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Administrative Cost Ratio
-Claims Payable per Member
-Cost per Member
-Days cash on hand
-Days in Claims Receivable
-Days in unpaid claims/claims outstanding
-Equity per Member
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income

Health Plan/ Provider Characteristics:
-Grievance and Appeal Timeliness
-Languages Spoken (other than English)
-Provider Complaints
-Provider turnover

INDIANA
Hoosier Healthwise (1115)

-Net worth
-Ratio Assets to Liabilities
-Revenue per Member
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-ADHD Medication Follow-Up: Initiation Phase
-Adolescent Well-Care Visits
-Behavioral Health Seven Day Follow-Up
-Breast Cancer Screening
-Cervical Cancer Screening
-Diabetes-LDL-C, HbA1c and Eye Exam
-Lead Screening
-Timely Prenatal Visits

Non-Clinical Topics:
-Program Integrity
-Provider Network Services

Standards/Accreditation

MCO Standards:
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards
-URAC Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Burns & Associates, Inc.

EQRO Organization:
-Independent Consultant

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Provider Survey

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

INDIANA
Hoosier Healthwise (1115)

Population Categories Included:
A subset of MCO members, defined by beneficiary age
A subset of MCO members, defined by disease and medical condition

Clinical Conditions:
Cervical Cancer Screening
Comprehensive Diabetes Care-LDL-C Screening
Follow Up Care for Children Prescribed ADHD Medication
Follow-Up after inpatient mental health hospitalization-Seven Day
Frequency of Ongoing Prenatal Care
Timeliness of Post Partum Visit
Timeliness of Prenatal Care
Well Child Visit in the Third-Sixth Years of Life, One or More Visits
Well-Child Visits, First 15 Months, Six or More Visits

Initial Year of Reward:
2008

Member Incentives:
Not Applicable

Rewards Model:
Payment incentives/differentials to reward MCOs
Withholds as an incentive

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

KENTUCKY
Kentucky Health Care Partnership Program

CONTACT INFORMATION

State Medicaid Contact:

April Lowery
Kentucky Department for Medicaid Services
(502) 564-8196

State Website Address:

http://www.chfs.ky.gov/dms

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
October 06, 1995

Implementation Date:
November 01, 1997

Waiver Expiration Date:
December 31, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(A) Coverage of Services for FQHCs and RHCs
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(15) Payment for FQHCs and RHCs
-1902(a)(17) Financial Eligibility Standard
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive eligibility
-1902(e)(2) Eligibility

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Expenditures for capitation payments made to MCO not in compliance with section 1903(2)(A)(vi)
-MCO Definition 1903(m)(1)(A)
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)
-MCO Payments to FQHC/RHC 1903(m)(A)(ix)

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Alternative Birth Center, Ambulatory Surgical Centers, Case Management, Chiropractic, Dental, Durable Medical Equipment, End Stage Renal Dialysis, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Independent Laboratory, Inpatient Hospital, Laboratory, Medical Detoxification, Outpatient Hospital, Pharmacy, Physician, Podiatry, Preventive Health, Therapeutic Evaluation & Treatment, Transportation, Urgent Emergency

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians

KENTUCKY
Kentucky Health Care Partnership Program

Care, Vision, X-Ray

-Physician Assistants
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility for Spend down
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Psychiatric Residential Treatment Facility PRTF
-Reside in Nursing Facility or ICF/MR
-Residents of Institutions for Mental Disease

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-None - managed care entity provides standard prescription drug coverage

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Uses claims data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-KY Commission for Children with Special Health Care Needs
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

KENTUCKY
Kentucky Health Care Partnership Program

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Passport Health Plan

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Comparison to claims payment data

KENTUCKY
Kentucky Health Care Partnership Program

-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Adolescent Well Care/EPSDT
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment
-Pre-natal care
-Sickle cell anemia management
-Smoking prevention and cessation, "Yes You Can"
-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

KENTUCKY
Kentucky Health Care Partnership Program

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-Standards for Medicaid and Medicare

Accreditation Required for Participation:
-Plan required to obtain MCO accreditation by NCQA or other accrediting body

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization (IPRO)

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects (PIPs)
-Validatioon of performance measures reported by MCO

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of high cost services and procedures
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as clams and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

LOUISIANA
Greater New Orleans Community Health Connection (GNOCHC)

CONTACT INFORMATION

State Medicaid Contact:

Marisa Naquin
LA Dept of Health & Hospitals
(504) 568-8280

State Website Address:

www.dhh.louisiana.gov

PROGRAM DATA

Program Service Area:
Parish

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
September 22, 2010

Implementation Date:
October 01, 2010

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(B) and 1902(a)(17) Comparability
-1902(a)(17) Eligibility Standards
-1902(a)(2)State Financial Share
-1902(a)(23) Freedom of Choice
-1902(a)(3) and 1902(a)(8) Reasonable Promptness
-1902(a)(34) Retroactive Eligibility
-1902(a)(4),insofar as it incorporates 42CFR 431.53
-1902(a)(43)Early and Periodic Screening, Diagnostic, and
Treatment Services

**Sections of Title XIX Costs Not Otherwise Matchable
Granted:**

-Department of Health & Hospitals

SERVICE DELIVERY

All-Inclusive Encounter-Based Rates - Other

Service Delivery

Included Services:
Basic behavioral care services include mental hearlth and or
substance abuse screening, assessment,, Care Coordination,
Immunization, Laboratory, Physician, Preventive, Primary
Care, Specialty Care- with referral from and by discretion of
Primary Care, X-Ray

Allowable PCPs:
-Behavioral health care licensed practitioners
-Clinical Nurse Specialist
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Pediatricians

LOUISIANA
Greater New Orleans Community Health Connection (GNOCHC)

-Physician Assistants
-Practitioners authorized to provide services directly or under supervision according to Medicaid Men
-Psychiatrists
-Psychologists

Enrollment

Populations Voluntarily Enrolled:

-American Indian/Alaskan Native
-Are between 19 and 64 years old
-Are non-pregnant
-Have a family income up to 200 of the federal poverty level
-Resident of Greater New Orleans Region
-Uninsured for at least 6 months

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Enrolled in CDC BCCT Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman (SOBRA)
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Greater New Orleans Community Health Connection (GNOCHC)

Non-Applicable

ADDITIONAL INFORMATION

The array of services described below is provided under the Greater New Orleans Community Health Connection (GNOCHC) Waiver and must be delivered on an outpatient basis. Requests for pre-admission certification for inpatient hospitalization and inpatient hospital

services are not covered.

GNOCHC services fall into two broad categories: core services and specialty services. Core services are medically necessary services coverable under section 1905(a) of the Social Security Act which each GNOCHC provider is expected to provide or purchase on behalf of recipients. Core services include both primary care and behavioral health care services. Specialty services are medically necessary services which each GNOCHC primary care provider is expected to provide to recipients directly or by referral from the primary care provider.

There is no annual visit limit; however, only one primary care visit and/or one behavior health care visit is allowed for the same date of service.

MARYLAND
HealthChoice

CONTACT INFORMATION

State Medicaid Contact:

Nadine Smith
Department of Health and Mental Hygiene
(410) 767-1483

State Website Address:

http://www.dhmh.state.md.us/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
(PSI) Policy Studies, Inc

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 30, 1996

Implementation Date:
June 02, 1997

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility
-1902(a)(47) Presumptive Eligibility
-1902(a)(8) - 6-month period of uninsurance for XIX children
-1902(bb) FQHC Payments

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Not Applicable

SERVICE DELIVERY

Medical-only PAHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Durable Medical Equipment, Family Planning, Hospital ER facility charges only, Laboratory, Pharmacy, Physician, Substance Abuse, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

MARYLAND
HealthChoice

None

-Individuals ages 19 and over with incomes < 116% of FPL

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

MARYLAND
HealthChoice

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Case Management, Chiropractic, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Gynecologists
-Internists
-Nurse Practitioners
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency

MARYLAND
HealthChoice

-Uses enrollment forms to identify members of these
groups
-Uses provider referrals to identify members of these
groups

-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMERIGROUP - PAC	AMERIGROUP Maryland Inc.
JAI Medical System	JAI Medical Systems - PAC
Maryland Physicians Care	Maryland Physicians Care - PAC
Medstar Family Choice	Priority Partners - PAC
Priority Partners MCO	The Diamond Plan
United Health Care	United HealthCare - PAC

ADDITIONAL INFORMATION

An eligible HealthChoice enrollee may be permitted to disenroll "for cause" from an MCO and enroll in another MCO outside of his/her annual right to change period if he/she is not hospitalized. The Department is responsible for purchase, examination, or fitting of hearing aids and supplies, tinnitus maskers, dental services provided for enrollees under 21 years old and pregnant women of any age, OT, PT, and ST for children under 21. There are additional optional services that some MCOs provide for their enrollees such as dental services for adults. Pregnant women in the Maryland Childrens Health Program are guaranteed eligibility for the duration of the pregnancy and 2 months postpartum. PAC enrollees with diabetes receive DME, podiatry and vision services.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Report Card

Use of Collected Data:
-Beneficiary Plan Selection
-Consumer Report Card
-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
   Medicaid Adult/ Version 4.0
   Medicaid Children/Version 3.0
   Special Needs Children with Chronic Conditions

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837,

-Standards to ensure complete, accurate, timely encounter data submission

ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Ambulatory Care for SSI Children and Adults
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Diabetes Management
-Frequency of on-going prenatal care
-HEDIS-Prenatal and Postpartum Care
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Lead screening rate
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Call Abandonment
-Call Answer Timeliness
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income

Health Plan/ Provider Characteristics:
None

-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to MCO

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Cervical cancer screening (Pap Test)
-Initiation and Engagement of Alcohol and Other Drug Services

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Delmarva Foundation for Medical Care

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by disease and medical condition

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Adolescent Well Care
Ambulatory Care for SSI Adults
Ambulatory Care for SSI Children
Asthma
Cervical Cancer Screening
Childhood immunizations
Diabetes Eye Exam

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

MARYLAND
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Lead Screening
Postpartum Care
Well-child visits

Initial Year of Reward:
2002

Evaluation Component:
The State has conducted an evaluation of the
effectiveness of its P4P program

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-Network Data
-PAHP Standards (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Beneficiary Plan Selection
-Fraud and Abuse
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for
Medicaid
-The State DOES NOT generate from encounter data any of the
HEDIS measure listed for Medicaid
-State use/requires PAHPs to follow NCQA specifications for all
of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may
have been clarified or revised over time)
-Requirements for PAHPs to collect and maintain encounter
data
-Specifications for the submission of encounter data to the
Medicaid agency
-Standards to ensure complete, accurate, timely encounter
data submission

Collections - Submission Specifications:
-Data submission requirements including documentation
describing set of encounter data elements, definitions, sets
of acceptable values, standards for data processing and
editing
-Encounters to be submitted based upon national
standardized forms (e.g. UB-04, NCPDP, ASC X12 837,
ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting
health care claims data

Validation - Methods:
-Automated edits of key fields used for calculation (e.g.
codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons
to State FFS utilization rates, comparisons to PAHP
commercial utilization rates, comparisons to national
norms, comparisons to submitted bills or cost-ratios)
-Medical record validation

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility

State conducts general data completeness assessments:
Yes

MARYLAND
HealthChoice

-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Performance Measures

Process Quality:
-Access to Preventative Ambulatory Care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes medication management

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Expenditures by medical category of service (ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PAHPs

Performance Measures - Others:
None

Standards/Accreditation

PAHP Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

MASSACHUSETTS
Mass Health

CONTACT INFORMATION

State Medicaid Contact:

Robin Callahan
Office of Medicaid
(617) 573-1745

State Website Address:

http://www.mass.gov/masshealth

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

Initial Waiver Approval Date:
April 24, 1995

Implementation Date:
July 01, 1997

Waiver Expiration Date:
June 30, 2014

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(A) Eligibility Procedures and Standards
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(C)(i-iii)
-1902(a)(13) insofar as 1923 DSH Requirements
-1902(a)(17) Eligibility Procedures and Standards
-1902(a)(23) Freedom of Choice
-1902(a)(32) Direct Provider Reimbursements
-1902(a)(34) Retroactive Eligibility
-1902(a)(52) Extended Eligibility

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-BCCTP
-Diversionary Behavioral Health
-Early Intervention for Autism
-ELE
-Peds Asthma Project
-Population Expansion
-Premium Assistance
-SNCPs

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Abortion, Adult Day Health Services, Adult Foster Care Services, Ambulance Services, Ambulatory Surgery,

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)

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Mass Health

Audiology Services, Chapter 766: home assessments and participation in team meetings, Chiropractic, Chronic Disease and Rehab Inpatient Services, Community Health Center, Day Habitation Services, Dental, Diabetes Self-Management Training, Durable Medical Equipment, Early Intervention, EPSDT, Family Planning, Hearing, Hearing Aid, Home Health, Immunization Administration, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medical Nutrition Therapy, Medical/Surgical Supplies, Nurse Midwife, Nurse Practitioner, Nursing Facility Services, OB/GYN and Prenatal, Occupational Therapy, Orthotic, Outpatient Hospital, Outpatient Mental Health and Substance Use Disorder services, Oxygen and Respiratory Therapy services and equipment, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Primary Care and Specialty Care Visits, Private Duty Nursing Services, Prosthetics, Radiology and diagnostic services, Rehabilitation services, Renal Dialysis Services, Speech Therapy, Tobacco Cessation, Transportation, Vision, X-Ray

-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Over 65 years old
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

MASSACHUSETTS
Mass Health

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, Detoxification, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Intermediate or Day/Night and Substance Use Disorder Treatment, Mental Health Intermediate or Day/Night, Mental Health Outpatient, Opioid Treatment Programs, Outpatient Substance Use Disorders, Substance Use Disorders Support

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Contractor Types:
-Managed Behavioral Health Organization (Private)

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Special Needs Children (BBA defined)

Populations Mandatorily Enrolled:
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Over 65
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only (children under age 21)
QMB (children under age 21)
SLMB, QI, and QDWI (children under age 21)

Medicare Dual Eligibles Excluded:
QMB Plus, SLMB Plus, and Medicaid only (age 21 and over)
QMB (age 21 and over)
SLMB, QI, and QDWI (age 21 and over)

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

MASSACHUSETTS
Mass Health

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Abortion, Audiologist, Case Management, Chiropractic, Dental - Emergency Related Dental in and Ambulatory Surgery/Outpatient Hospital Care, Diabetes Self-Management Training, Dialysis, Disease Management, Durable Medical Equipment, Early Intervention, Emergency, Emergency Services Program (ESP), EPSDT, Family Planning, Flouride Varnish, Hearing Aids, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional Care - for all Levels of Care Provided at either a Nursing Facility, Chronic, Laboratory, Medical Nutrition Therapy, Mental Health Diversionary, Orthotics, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Oxygen and Respiratory Therapy Equipment, Pharmacy, Physician, Podiatry, Prosthetics, Radiology and Diagnostic Tests - Magnetic Resonance Imagery and other Radiological and Diagnostic, Tobacco Cessation, Transportation (Emergent) - Ambulance (Air and Land) Including Specialty Care Transport, Transportation (Non-Emergent, to Out-of-State Location); Located Outside a 50-Mile Radius of Massach, Vision Care (Medical Component),

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:

-American Indian/Alaska Native
-Foster Care Children

Populations Mandatorily Enrolled:

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Over 65 years old
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

HIV/AIDS Dual Eligibles
Severely Physically Disabled Dual Eligibles

Medicare Dual Eligibles Excluded:

All categories of Medicare Dual Eligilbes other that "grandfathered HIV/AIDS Dual Eligibles and Severely Physically Disabled dual Eligibles"

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

MASSACHUSETTS
Mass Health

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Barbituates
-Benzodiazepines
-Nonprescription drugs

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Department of Mental Retardation
-Department of Youth Services
-Developmental Disabilities Agency
-Education Agency
-Housing Agencies
-Massachusetts Rehabilitation Commision
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Boston Medical Center HealthNet Plan

Health New England

Neighborhood Health Plan

Primary Care Clinician Plan

Fallon Community Health Plan

MA Behavioral Health Partnership

Network Health

ADDITIONAL INFORMATION

PCCM:
The PCC Plan Reimbursement arrangement is fee-for-service with enhanced office visit claim - no case management fee paid for each member each month.

PIHP:
Mass Health has a behavioral carve-out for PCCM enrollees and for children in the care or custody of the Commonwealth and other members under 21 with other insurance who are eligible for CBHI services. Regarding the MH/SUD PIHP included services, there is no long-term care in mental health residential or residential substance abuse treatment programs. The Outpatient Day programs are defined as full or part-time substance abuse or mental health services provided in an ambulatory setting.

Massachusetts Behavioral Health Partnership, the MH SUD PIHP is financed using actuarially sound capitation payments to fund the delivery and provision of behavioral health covered services. The aggregate capitation payments are assessed against actual BH service expenditures by the PIHP. Actual spending is then applied to the established risk-sharing corridors/the financial parameters which limited the extent to which the PIHP may experience earnings or losses. After those parameters are accounted for the State conducts a final financial reconciliation to address "surplus funding" recovery from the PIHP or to cover the cost of excess expenditures. CBHI capitated services are excluded from the risk arrangement.

MASSACHUSETTS
Mass Health

Childrens Behavioral Health Initiative (CBHI) is an interagency undertaking by the Massachusetts Executive Office of Health and Human Services (EOHHS) and MassHealth whose mission is to strengthen, expand and integrate behavioral health services for MassHealth Members under the age of 21 into a community-based, culturally competent care.

Under the PIHP: Excluded Populations data element: Persons with other insurance with the exception for youth and adolescents under 21 receiving or eligible for CBHI services are excluded.

MCO Programs - Skilled Nursing Facility services are provided in the Institutional Care benefit (which also includes chronic or rehabilitation hospital) for up to 100 days per enrollee per calendar year.

As of 07/01/2010, Neighborhood Health Plan's (NHP) previous years' two special programs for HIV/AIDS members and severely disabled dual eligible members were transitioned and grandfathered into MassHealth's managed care disabled categories. These grandfathered dual members have the option to enroll in any of the five contracted MCOs. Most of these members continue to be enrolled in NHP. These dual members get their pharmacy benefit from Medicare Part D Drug Plan which includes OTCs, Barbiturates and Benzodiazepines and legislatively mandated drugs. As of 7/01/2011 NHP served approximately 148 dually eligibles.

Effective 1/01/2011, Neighborhood Health Plan (NHP) was awarded the MassHealth Contract for the Special Kids/Special Care (SK/SC) Program, formerly a pilot program. This program serves children with special health care needs that are in the custody of Department of Children and Families (DCF) and living in a foster home at the time of enrollment. NHP provides and arranges for the full range of medical and behavioral health services. The clinical criteria consists of: complex medical management and direct administration of skilled nursing care requiring complex nursing procedures; or skilled assessment and/or monitoring related to an unstable medical condition on a regular basis over a prolonged period of time. This program is offered state-wide and as of 7/01/2011, NHP served approximately 125 children in SK/SC program.

The MCO Program's previous P4P Program was not extended for this reporting period. It will be evaluated for possible Implementation in the future.

APS, the current EQRO Vendor's contract was extended and MassHealth is in the process of rebidding this contract.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-ANOVA (Analysis of Variance)
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-State Medicaid Managed Care Quality Strategy
-Track Health Service provision

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and

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encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCO
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Controlling high blood pressure
-Dental services
-Depression management/care
-Diabetes medication management
-Follow up care for children prescribed ADHD medication
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Identification of Substance Use Disorders
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Initiation of prenatal care - timeliness of
-Pediatric behavioral health screening
-Percentage of beneficiaries with at least one dental visit

Health Status/Outcomes Quality:
-Mortality rates
-Patient satisfaction with care
-Pediatric behavioral health (BH) screens with potential BH need identified
-Pediatric behavioral health (BH) screens with potential BH need identified ad follow-up received
-Percentage of beneficiaries who are satisfied with their ability to obtain care

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-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Audited Financial Statements
-Cost/Utilization
-Days in unpaid claims/claims outstanding
-Debt ratio
-Division of Insurance (DOI) statutory financial reports
-Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, vision, etc.)
-Liquidity ratios (current ratio and acid test ratio)
-Medical loss ratio
-Net income
-Net worth
-Rate of return on assets
-Statutory minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries auto-assigned to a PCP
-Percentage of beneficiaries who are auto-assigned to a PCCM

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Coordination of Primary and Behavioral Health care
-Depression management
-Diabetes management
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment
-Hospital Discharge Planning
-Inpatient maternity care and discharge planning
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Prescription drug abuse
-Primary Care Medical Home Initiative; Motivational Interviewing
-Substance Use Disorders treatment after detoxification service

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-Well Child Care/EPSDT

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners
-Reducing health care disparities via health literacy,
education campaigns, or other initiatives

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance)
Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-APS Healthcare

EQRO Organization:
-QIO-like entity

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
None

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance
program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PIHP

**State Quality Assessment and Improvement
Activities:**
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Network Data
-On-Site Reviews

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal

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-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

-Regulatory Compliance/Federal Reporting
-State Managed Care Medicaid Quality Strategy
-Track Health Service provision

Consumer Self-Report Data:
-MHQP Member Exp. Pilot Survey
-PIHP developed survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data ALL of the HEDIS measures listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
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-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

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Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across PIHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

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Process Quality:
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Timely access to MH/SUD services after hospitalization for MH/SUD condition.

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Continuing Care Rate
-Identification of Alcohol and other Drug Services
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD
-Timeliness of Post discharge after care

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by Behavioral Health category of covered service
-Net income
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PIHPs
-PIHP/PCP-specific disenrollment rate

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

-Coordination of primary and behavioral health care
-Depression management
-Emergency room service utilization for MH/SUD conditions
-ETOH and other substance abuse screening and treatment
-Hospital Discharge Planning for MH/SUD condtions
-Substance Use Disorders treatment after detoxification service

Non-Clinical Topics:

-Member Access to Behavioral Health Services
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

Standards/Accreditation

PIHP Standards:
-Timely availability and access to Behavioral Health services following BH hospitalizations

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-APS Healthcare

EQRO Organization:
-QIO-like entity

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State

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-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Assessment of PIHP Information System
-Calculation of performance measures
-Conduct of performance improvement projects
-Technical assistance to PIHPs to assist them in conducting quality activities

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Network Data
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-State Medicaid Managed Care Quality Strategy

Consumer Self-Report Data:
-Member Satisfaction collected biennial by PCC Plan

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Behavioral Health screening in children
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia screening in women
-Controlling high blood pressure
-Depression medication management
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Percentage of children with Behavioral Health (BH) screen with BH need identified
-Percentage of children with Behavioral Health need identified who received follow up.

Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Percentage of beneficiaries with at least one dental visit

Provider Characteristics:
None

Beneficiary Characteristics:
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries auto-assigned to PCP
-Percentage of beneficiaries who are auto-assigned to PCCM

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Performance Measures - Others:
None

Performance Improvement Projects

Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Coordination of primary and behavioral health care
-Depression management
-Diabetes management
-Emergency Room service utilization
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Prescription drug abuse
-Well Child Care/EPSDT

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Health information technology

MINNESOTA
Minnesota Prepaid Medical Assistance Project Plus-1115(a)

CONTACT INFORMATION

State Medicaid Contact:

Gretchen Ulbee
Minnesota Department of Human Services
(651) 431-2192

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
July 27, 1995

Operating Authority:
1115(a) - Demonstration Waiver Program

Implementation Date:
July 01, 1995

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
December 31, 2013

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(A)(i)(IV) Coverage/Benefits for Pregnant Women
-1902(a)(10)(B) - Amount, Duration & Scope
-1902(a)(17) Comparability of Eligibility Standards
-1902(a)(23)(A) Freedom of Choice

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Eligibility Expansion
-Graduate Medical Education

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Durable Medical Equipment, Emergency Room, EPSDT, Family Planning, Hearing, Home Health, Hospice, ICF/MR, Community-Based, IEP, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Preventive Visits, Respiratory Therapy, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

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Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-American Indians as defined in 25 U.S.C. 1603(c)
-Children under age 19 who are in state subsidized foster care or other out of home placement
-Children under age 19 who are receiving adoption assistance under Title IV-E
-Children under age 19 who are receiving foster care under Title IV-E
-Children under age 19 with special health care needs who are receiving services under a care system
-Disabled children under age 19 who are eligible for SSI under Title XVI who are not using a disabled
-MA One year olds
-Medicare Dual Eligibles
-MinnesotaCare Caretaker Adults
-MinnesotaCare Children < 21
-MinnesotaCare Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-Blind and disabled recipients under age 65
-Enrolled in Another Managed Care Program
-Had other health insurance during preceding 4 months (not including Medical Assistance, GAMC, TricCare/CHAMPUS)
-Individuals with household income above 150% of poverty with other health insurance
-Medicare Dual Eligibles
-Non-documented alien recipients who receive only emergency MA under Minn. Stat. 256B.06(4)
-Non-institutionalized recipients eligible on spend down basis
-Pregnant Women Up to 275 of FPG With Other Insurance
-Recipients residing in state institutions
-Recipients with private coverage through a MCO not participating in Medicaid
-Recipients with terminal or communicable diseases at time of enrollment
-Refugee Assistance Program recipients

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
Under 65 and not using a disabled basis of eligibility

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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Minnesota Prepaid Medical Assistance Project Plus-1115(a)

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus

Itasca Medical Care

Metropolitan Health Plan

South Country Health Alliance

Health Partners

Medica

PrimeWest Health System

UCARE

ADDITIONAL INFORMATION

PCP provider types are designated by MCO, not the State. County staff perform enrollment function.

Included Population- SED/SPMI- Severe Emotional Disturbance/Serious and Persistent Mental Illness

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:

-Assess Program Results
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Access and Utilization

Consumer Self-Report Data:

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
    Child with Special Needs Questionnaire
-Disenrollment Survey

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

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Minnesota Prepaid Medical Assistance Project Plus-1115(a)

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-None

MCO/HIO conducts data accuracy check(s) on specified data elements:
-None

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Adult Preventive Visits
-Antidepressant medication management
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Colorectal Cancer Screening
-Dental services
-Diabetes Screening
-Immunizations for two year olds
-Mental Health Discharges
-Osteoporosis Care After Fracture
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
-CD Initiating and Treatment
-Mental Health Discharges
-Postpartum Visits
-Primary Care Visitis- 3 - 6 Year Olds
-Well-Care Visits-Adolescents
-Well-child visits in first 15 months of life

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Aspirin Therapy
-Asthma management
-Asthma-Reduction of Emergency Department Visits
-Breast cancer screening (Mammography)
-Calcium and Vitamin D
-Cholesterol screening and management

-Colon Cancer Screening
-Depression management
-Diabetes management
-Diabetic Statin Use 40 to 75 Year Olds
-Human Papillomavirus
-Hypertension management
-Lead toxicity
-Mental Health/Chemical Dependency Dual Diagnoses
-Obesity
-Pneumococcal Vaccine
-Sexually transmitted disease screening

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-MetaStar (QIO)
-Michigan Performance Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
MCOs
Medicaid has collaborated with a public sector entity to support the P4P program

Population Categories Included:
A subset of MCO members, defined by disease and medical condition

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Cardiac Care
Diabetes

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
1999

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

NEW MEXICO
New Mexico State Coverage Insurance Section 1115 Demonstration

CONTACT INFORMATION

State Medicaid Contact:

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NM HSD/Medical Assistance Division
(505) 827-6234

State Website Address:

http://www.insurenewmexico.state.nm.us/scihome.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility

Initial Waiver Approval Date:
December 30, 2009

Implementation Date:
January 01, 2010

Waiver Expiration Date:
September 30, 2014

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(17) Financial Eligibility Standards
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility
-1902(a)(4) Proper and Efficient Administration of the State
Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Eligibility Expansion
-MCO Choice {1932(a)(3)}
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Diagnostics, Disease Management, Durable Medical
Equipment, Emergency, Home Health, Inpatient Hospital,
Inpatient Mental Health, Inpatient Substance Use Disorders,
Maternity, Occupational Therapy, Outpatient Hospital,
Outpatient Mental Health, Outpatient Substance Use
Disorders, Pharmacy, Physical Therapy, Physician, Pre/Post
Natal Care, Preventive, Speech Therapy, Urgent Care

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other providers who meet the MCO credentialling
requirements for PCP.
-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants
-Primary care teams at teaching faciltties.
-Rural Health Clinics (RHCs)

NEW MEXICO
New Mexico State Coverage Insurance Section 1115 Demonstration

Enrollment

Populations Voluntarily Enrolled:
-Non-pregnant childless adults age 19-64 with incomes < 200% FPL

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Eligible only for TB-related Services
-Enrolled in Another Managed Care Program
-May not be eligible for regular Medicaid.
-May not have voluntarily dropped private health insurance within the last six months.
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Lovelace Community Health Plan

Molina Healthcare of New Mexico

Presbyterian Health Plan

ADDITIONAL INFORMATION

Each beneficiary is limited to $100,000 maximum per benefit year. The SCI program requires co-payments for services and prescriptions, and monthly premiums to be paid by the beneficiary and the employer. When Medicare eligibility is verfiied, SCI members are disenrolled from the SCI program prospectively and provided with adverse action. SCI enrollment may coexist when only Medicare Part A coverage is issued retroactively to SCI members in order to maintain coverage for services other than hospitalization that were provided through the SCI program. An adjusted capitation payment is provided to the managed care organization in such instances.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes

State conducts general data completeness assessments:
Yes

-Procedure Codes
-Revenue Codes

Performance Measures

Process Quality:
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes medication management
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Provider turnover

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Asthma management
-Diabetes management
-Emergency Room service utilization

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-HealthInsight dba New Mexico Medical Review Association

NEW MEXICO
New Mexico State Coverage Insurance Section 1115 Demonstration

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by disease and medical condition

Rewards Model:
Payment incentives/differentials to reward MCOs
Public reporting to reward MCOs
Withholds as an incentive

Clinical Conditions:
Diabetes

Measurement of Improved Performance:
Assessing levels of technology adoption
Assessing the adoption of systematic quality improvement processes
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2010

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

NEW YORK
F-SHRP - Medicaid Advantage

CONTACT INFORMATION

State Medicaid Contact:

Jennfer Dean
Division of Health Plan Contracting & Oversight
(518) 473-1134

State Website Address:

http://www.nyhealth.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
Yes

Initial Waiver Approval Date:
September 30, 2006

Implementation Date:
October 01, 2006

Waiver Expiration Date:
March 31, 2014

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(25) Third Party Liability
-1902(a)(3) Access to State Fair Hearing
-1902(a)(4)(a) MEQC

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Designated State Health Programs
-Dual-Eligibles Appeals
-Exemption from MEQC disallowances {1903(u)}
-Facilitated Enrollment Services
-Institute For Mental Disease Expenditures
-Twelve Month Continuous Eligibility

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Ambulance, Bone Mass Measurement, Chiropractic, Colorectal Screening, Dental, Diabetes Monitoring, Durable Medical Equipment, Emergency Room, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mammograms, Non-covered Medicare visits, Occupational Therapy, Outpatient Mental Health, Outpatient Substance Use Disorders, Outpatient Surgery, Pap Smear and Pelvic Exams, PCP visits, Pharmacy, Physical Therapy, Podiatry, Private Duty Nursing, Prostate Cancer Screening, Prosthetics, Radiation therapy, Routine Physical Exam - 1

Allowable PCPs:
-Not Applicable

NEW YORK
F-SHRP - Medicaid Advantage

year, Skilled Nursing Facility, Specialty Office Visits, Speech
Therapy, Transportation, Urgent Care, Vision, X-Ray

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

**Subpopulations Excluded from Otherwise
Included Populations:**

Lock-In Provision:
No lock-in

-Eligible for Family Planning services only
-Eligible for TB related services only
-Eligible for the Medicaid buy-in for the working disabled
program who pay a premium
-Eligible less than 6 months
-Elilgible for treatment for breast or cervical cancer only
-Enrolled in hospice at the time of enrollment
-In the LTHHCP, except for the DD
-In the Restricted Recipient Program
-Individuals enrolled in a long term care demonstration
-Medicare Dual Eligibles
-Other Insurance
-Persons with ESRD at the time of enrollment, unless meet the
Medicare exception
-Placed in a State OMH family care home
-Residents of Residential Health Facility at enrollment whose
stay is classified as premanent
-Residents of State operated Psych facilites or residents of
State certified treatment facilities for children and youth
-Spend downs

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
QMB

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid
Managed Care Contracts:**

-Analgesic and Antipyretic
-Antacid
-Anti-diarrheal
-Antihistamine
-Anti-vertigo
-Artificial tears and occular/oral lubricants
-Chronic renal disease
-Cough and cold
-Dermatological
-Family Planning
-Fecal softener and laxative
-Hematinic
-Insulin
-Insulin Biosynthetic Human
-Pediculocide
-Smoking cessation agents

NEW YORK
F-SHRP - Medicaid Advantage

-Vitamin/Mineral

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Requires MCOs to identify through assessments

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Mental Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity/Medicaid Advantage

GHI/Medicaid Advantage

Liberty Health Advantage/Medicaid Advantage

MetroPlus/Medicaid Advantage

Senior Whole Health/ Medicaid Advantage

United Health Plan/Medicaid Advantage

ElderPlan/Medicaid Advantage

HIP Health Plan/Medicaid Advantage

Managed Health Inc/Medicaid Advantage

NYS Catholic Health Plan/Fidelis/Medicaid Advantage

Touchstone/Prestige/Medicaid Advantage

ADDITIONAL INFORMATION

The Medicaid Advantage program strictly serves dual eligibles. Transportation and dental services are optional outside of NYC. Within NYC, these services are required.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-MCOs must comply with Medicare requirements for quality in 42 CFR 422

Use of Collected Data:
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

data submission

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
No

Standards/Accreditation

MCO Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities:
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

NEW YORK
F-SHRP - Medicaid Managed Care

CONTACT INFORMATION

State Medicaid Contact:

Jennifer Dean
Division of Health Plan Contracting & Oversight
(518) 473-1134

State Website Address:

http://www.nyhealth.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
No

Initial Waiver Approval Date:
September 29, 2006

Implementation Date:
October 01, 2006

Waiver Expiration Date:
September 30, 2011

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(25) Third Party Liability
-1902(a)(4)(a) MEQC

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Designated State Health Programs
-Dual-Eligible Appeals
-Exemption from MEQC disallowances {1903(u)}
-Facilitated Enrollment Services
-Institute For Mental Disease Expenditures
-Twelve Months Continuous Coverage

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Qualified Obstetricians/Gynecologists

NEW YORK
F-SHRP - Medicaid Managed Care

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Admitted to hospice at the time of enrollment
-Eligible less than 6 Months
-Eligible only for TB related services
-Enrolled in Another Managed Care Program
-Enrolled in the Restricted Recipient Program
-Foster children in direct care
-Infants weighing less than 1200 grams or infants who meet SSI criteria
-Medicare Dual Eligibles
-Other Insurance
-Partcipation in LTC Demonstration Program
-Reside in Nursing Facility or ICF/MR
-Reside in residential treatment facility for children and youth
-Reside in State Operated Psychiatric facility
-Special Needs Children (State defined)
-Spend downs

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

NEW YORK
F-SHRP - Medicaid Managed Care

PCCM Provider - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Qualified Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Admitted to hospice at the time of enrollment
-Eligible Less Than 6 Months
-Eligible only for TB-related Services
-Enrolled in Another Managed Care Program
-Enrolled in the Restricted Recipient Program
-Foster Care Children in direct care
-Medicare Dual Eligibles
-Other Insurance
-Participation in LTC Demonstration
-Reside in Nursing Facility or ICF/MR
-Reside in Residential Treatment Facility for children and youth
-Reside in State Operated Psychiatric Facility
-Special Needs Children (State defined)
-Spend downs

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

NEW YORK
F-SHRP - Medicaid Managed Care

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity Health Plan	Amerigroup
AmidaCare Special Needs	Capital District Physicians Health Plan
Excellus	Health First
Health Now	HealthPlus
Hudson Health Plan	MetroPlus Health Plan
MetroPlus Health Plan Special Needs	MVP Health Plan
Neighborhood Health Providers	NYPS Select Health Special Needs
NYS Catholic Health Plan 1199	NYS Catholic Health Plan/Fidelis
Physician Case Management Program	SCHC TotalCare
Southern Tier Pediatrics	Southern Tier Priority
United Healthcare	Univera Community Health
Wellcare	

ADDITIONAL INFORMATION

This program enrolls ABD populations statewide & AFDC populations in specific counties into mandatory managed care. MCO Optional Services: Dental, Family Planning, and Transportation are included at the option of the MCO.

PCCMs are capitated for primary care services, only.

Enrollment in a PCCM is voluntary. There is no auto-assignment to PCCMs in mandatory counties.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

NEW YORK
F-SHRP - Medicaid Managed Care

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Adult BMI Assessment
-Annual monitoring of patients on persistent medications
-Antidepressant medication management
-Appropriate testing for pharyngitis
-Appropriate use of antibiotics for URI
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia testing
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Drug therapy for rheumatoid arthritis
-Follow up ADHD medication - new prescription
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

NEW YORK
F-SHRP - Medicaid Managed Care

-HIV/AIDS care
-Imaging studies for low back pain
-Immunizations for two year olds
-Influenza immunization for adults (50 - 64 years)
-Initiation of prenatal care - timeliness of
-Lead Screening rate
-Medical assistance with tobacco use cessation
-Pharmacotherapy for COPD exacerbation
-Spirometry in COPD assessment
-Weight, nutrition, physical activity for children & adolescents
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Frequency of selected procedures/1,000 beneficiaries
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics:
-Eliminating disparities in asthma care
-Reducing potentially preventable readmissions

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization

NEW YORK
F-SHRP - Medicaid Managed Care

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

Rewards Model:
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs
Public reporting to reward MCOs

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2000

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-On-Site Reviews
-Performance Measures (see below for details)

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
None

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
-Number of primary care case manager visits per beneficiary

NEW YORK
F-SHRP - Medicaid Managed Care

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

NEW YORK
Partnership Plan - Family Health Plus

CONTACT INFORMATION

State Medicaid Contact:

Kathleen Johnson
Division of Coverage & Enrollment
(518) 474-8887

State Website Address:

http://www.nyhealth.gpv

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
June 29, 2001

Implementation Date:
September 04, 2001

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(14) Cost-Sharing Requirements
-1902(a)(23) Freedom of Choice
-1902(a)(25) Third Party Liability
-1902(a)(34) Retroactive Eligibility
-1902(a)(4)(a) MEQC
-1902(a)(43) EPSDT

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-12 Months Continuos Coverage
-Eligibility Expansion
-Exemption from MEQC disallowances {1903(u)}
-Facilitated Enrollment Services
-Family Planning Expenditures
-Guaranteed Eligibility Expenditures
-HCBS
-Institute For Mental Disease Expenditures

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chemical Dependence, Dental, Diabetic supplies and equipment, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medically

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis

NEW YORK
Partnership Plan - Family Health Plus

Managed Detox - Inpatient, Medically Supervised Withdrawal Inpatient/Outpatient, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Radiation Therapy, Chemotherapy, Hemodialysis, Smoking cessation products, Transportation, Vision, X-Ray

-Pediatricians
-Qualified Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
-Adults 19-64 no children up to 100% FPL
-Adults 19-64 with children up to 150% FPL

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Equivalent Insurance
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:
None

Populations Mandatorily Enrolled:
None

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity Health Plan	Amerigroup
Capital District Physicians Health Plan	Excellus
Health First	Health Now
HealthPlus	HIP Combined
Hudson Health Plan	Independent Health/Hudson Valley&WNY
MetroPlus Health Plan	MVP Health Plan
Neighborhood Health Providers	NYS Catholic Health Plan 1199
NYS Catholic Health Plan/Fidelis	SCHC TotalCare
United Healthcare	Univera Community Health
Wellcare	

ADDITIONAL INFORMATION

Benefit Limitations (per calendar year): Home Health is limited to 40 visits; Outpatient Substance Use Disorders and Outpatient Mental Health are limited to 60 visits combined. Inpatient Mental Health and Inpatient Chemical Dependence stays are limited to 30 days per year combined.

NEW YORK
Partnership Plan - Family Health Plus

Effective April 1, 2008, implemented Family Health Plus Premium Assistance Program. Persons with access to qualified cost-effective Employer Sponsored Health Insurance (ESHI) must enroll in the ESHI. The State subsidizes the premiums and reimburses any deductibles and co-pays, to the extent that the co-pays exceed the amount of the enrollees co-payment obligations under FHPlus. The State also pays for any FHPlus benefits not covered by the ESHI when the service is obtained from a Medicaid fee-for-service provider.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service

State conducts general data completeness assessments:
Yes

-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Performance Measures

Process Quality:
-Adult BMI assessment
-Asthma care - medication use
-Avoidance of antibiotics for bronchitis
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia screening
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Depression management/care
-Diabetes medication management
-Drug therapy for rheumatoid arthritis
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Imaging studies for low back pain
-Influenza immunization for adults (50-64 years)
-Initiation of prenatal care - timeliness of
-Medical assistance with tobacco use cessation
-Monitoring of patients on persistent medications
-Pharmacotherapy for COPD exacerbation
-Spirometry in COPD assessment

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient,
ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

Performance Measures - Others:
None

NEW YORK
Partnership Plan - Family Health Plus

Performance Improvement Projects

Project Requirements:
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics:
-Eliminating disparities in asthma care
-Reducing potentially preventable readmissions

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

Rewards Model:
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2000

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

NEW YORK
Partnership Plan Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

Jennifer Dean
Division of Health Plan Contracting & Oversight
(518) 473-1134

State Website Address:

http://www.nyhealth.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
No

Initial Waiver Approval Date:
July 15, 1997

Implementation Date:
October 01, 1997

Waiver Expiration Date:
July 31, 2011

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(25) Third Party Liability
-1902(a)(4)(a) MEQC

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-12 Months Continuous Coverage
-Eligibility Expansion
-Enrollment Assistance Service {1903(b)(4)}
-Exemption from MEQC disallowances {1903(u)}
-Family Planning Expenditures
-Guaranteed Eligibility Expenditures
-HCBS
-Institute For Mental Disease Expenditures

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Qualified Obstetricians/Gynecologists

NEW YORK
Partnership Plan Medicaid Managed Care Program

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-Safety Net Adults
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Admitted to hospice at the time of enrollment
-Eligible less than 6 Months
-Eligible only for TB related services
-Enrolled in Another Managed Care Program
-Enrolled in the Restricted Recipient Program
-Foster children in direct care
-Infants weighing less than 1200 grams or infants who meet SSI criteria
-Medicare Dual Eligibles
-Other Insurance
-Partcipation in LTC Demonstration Program
-Reside in Nursing Facility or ICF/MR
-Reside in residential treatment facility for children and youth
-Reside in State Operated Psychiatric facility
-Special Needs Children (State defined)
-Spend downs

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

NEW YORK
Partnership Plan Medicaid Managed Care Program

PCCM Provider - Risk-based Capitation

Service Delivery

Included Services:

Case Management, Dental, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray

Allowable PCPs:

-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Qualified Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:

-Foster Care Children

Populations Mandatorily Enrolled:

-Safety Net Adults
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Admitted to hospice at the time of enrollment
-Eligible less than 6 Months
-Eligible only for TB related services
-Enrolled in Another Managed Care Program
-Enrolled in the Restricted Recipient Program
-Foster care children in direct care
-Medicare Dual Eligibles
-Other Insurance
-Participation in a LTC Demonstration Program
-Reside in Nursing Facility or ICF/MR
-Reside in Residential Treatment Facility for children and youth
-Reside in State Operated Psychiatric Facility
-Special Needs Children (State defined)
-Spend downs

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

NEW YORK
Partnership Plan Medicaid Managed Care Program

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity Health Plan	Amerigroup
AmidaCare Special Needs	Capital District Physicians Health Plan
Excellus	Health First
Health Now	HealthPlus
Hudson Health Plan	Independent Health/Hudson Valley&WNY
MetroPlus Health Plan	MetroPlus Health Plan Special Needs
MVP Health Plan	Neighborhood Health Providers
NYPS Select Health Special Needs	NYS Catholic Health Plan 1199
NYS Catholic Health Plan/Fidelis	Physician Case Management Program
SCHC TotalCare	Southern Tier Pediatrics
Southern Tier Priority	United Healthcare
Univera Community Health	Wellcare

ADDITIONAL INFORMATION

Monthly premium for primary care services and medical care coordination.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

NEW YORK
Partnership Plan Medicaid Managed Care Program

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent preventive care
-Adult BMI assessment
-Antidepressant medication management
-Appropriate testing for pharyngitis
-Appropriate use of antibiotics for URI
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia testing
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Drug therapy for rheumatoid arthritis
-Follow-up ADHD medication - new prescription
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Imaging studies for low back pain
-Immunizations for two year olds
-Influenza immunization for adults (50-64 years)
-Initiation of prenatal care - timeliness of

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

NEW YORK
Partnership Plan Medicaid Managed Care Program

-Lead screening rate
-Medical assistance with tobacco use cessation
-Monitoring patients on persistent medications
-Pharmacotherapy for COPD exacerbation
-Spirometry in COPD assessment
-Weight, nutrition, physical activity for children & adolescents
-Well care visits for ages 12-21
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Adults access to preventive & ambulatory care
-Children's access to primary care
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics:

-Eliminating disparities in asthma care
-Reducing potentially preventable readmissions

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance improvement projects

NEW YORK
Partnership Plan Medicaid Managed Care Program

-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

Rewards Model:
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs
Public reporting to reward MCOs

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2000

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-On-Site Reviews
-Performance Measures (see below for details)

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
None

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
-Number of primary care case manager visits per beneficiary

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:

None

OKLAHOMA
SoonerCare

CONTACT INFORMATION

State Medicaid Contact:

Rebecca Pasternik-Ikard
Oklahoma Health Care Authority
(405) 522-7208

State Website Address:

http://www.okhca.org

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
LifeCare

For All Areas Phased-In:
No

Initial Waiver Approval Date:
October 12, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(17) Counting Income and Comparability of
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-Eligibility Expansion
-Expenditures for otherwise non-covered costs related to our Health Management Program
-Expenditures for per member per month payments made to our Health Access Networks
-Expenditures for reimbursing out-of-pocket costs in excess of 5 percent of annual gross income for individuals enrolled in the Insure Oklahoma Program

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants

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-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaska Native

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Children in custody (option for voluntary enrollment in managed care)
-Covered by an HMO
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Soon-To-Be-Sooners (STBS)
-Title XXI stand alone Insure Oklahoma dependents

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

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American Indian PCCM - Fee-for-Service

Service Delivery

Included Services:

Case Management, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:

-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:

-American Indian/Alaska Native

Populations Mandatorily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-Children in custody (option for volunary enrollment in managed care)
-Covered by an HMO
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility os ICF/MR
-Soon-To-Be-Sooners (STBS)
-Title XXI stand alone Insure Oklahoma dependents

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency

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groups
-Surveys medical needs of enrollee to identify members
of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these
groups

-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

SoonerCare American Indian PCCM

SoonerCare PCCM

ADDITIONAL INFORMATION

The Primary Care Provider/Case Manager is capitated for case management for each enrollee.

American Indians have an option of enrolling in the PCCM or American Indian PCCM under the SoonerCare program.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
None

Use of Collected Data:
None

Consumer Self-Report Data:
None

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CONTACT INFORMATION

State Medicaid Contact:

Jon Pelkey
Division of Medical Assistance Programs
(503) 947-2315

State Website Address:

http://www.oregon.gov/DHS/healthplan/index.shtml

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
March 19, 1993

Implementation Date:
February 01, 1994

Waiver Expiration Date:
October 31, 2013

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(A) Eligibility Procedures
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13)(A) DSH
-1902(a)(17) Eligibility Standards
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Coverage
-1902(a)(4) Proper and Efficient Administration of the State
Plan
-1902(a)(43)(c) EPSDT
-1902(a)(8) Reasonable Promptness
-2103 Benefits
-2103(e) Cost-Sharing

For All Areas Phased-In:
No

**Sections of Title XIX Costs Not Otherwise Matchable
Granted:**

-1903(f)
-Chemical Dependency Treatment 1905(a)(13)
-Eligibility Expansion
-Employer Sponsored Insurance
-Guaranteed Eligibility Expenditures
-MCO Definition 1903(m)(1)(A)
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services: **Allowable PCPs:**

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Crisis, IMD, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Opioid Treatment Programs, Outpatient Substance Use Disorders, Screening, Identification, and Brief

-Not applicable, contractors not required to identify PCPs

Contractor Types:
-Regional Authority Operated Entity (Public)
-County Operated Entity (Public)
-Behavioral Health MCO (Private)
-CMHC Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaska Native
-Foster Care Children

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Other Insurance

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

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PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Physician

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

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Dental PAHP - Risk-based Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Does not apply

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Other Insurance
-QMB and MN Spenddown

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

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MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Other Insurance
-QMB and MN Spenddown

Lock-In Provision:

6 month lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

Yes

Provides Part D Benefits:

No

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Barbituates
-Benzodiazepines

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Health Plans use multiple means to identify such members
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Employment Agencies
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan	Accountable Behavioral Health
Advantage Dental Services	Capitol Dental Care, Inc.
CareOregon	Cascade Comprehensive Care
Clackamas County Mental Health	Doctors of the Oregon Coast South
Douglas County IPA	Family Dental Care
FamilyCare (Mental Health)	FamilyCare Health Plans
Greater Oregon Behavioral Health, Inc.	InterCommunity Health Network
Jefferson Behavioral Health	Kaiser Permanente Oregon Plus
Lane Care MHO	Lane Individual Practice Association
Managed Dental Care of Oregon	Marion Polk Community Health Plan
Mid Rogue Independent Physician Association	Mid Valley Behavioral Care Network
MultiCare Dental	ODS Community Health (Dental)
ODS Community Health Inc.	Oregon Health Management Services
PacificSource Community Solutions	PacificSource Community Solutions (Mental Health)
PCCM	Providence Health Assurance
Tuality Health Alliance	Verity MHO
Washington County Health (Mental Health)	Willamette Dental

ADDITIONAL INFORMATION

A $6.00 Case Management Fee is paid on a per member/per month basis. This fee is not a capitation payment. The Oregon PCCM program is fee-for-service.

Under age one is guaranteed 12 months continuous eligibility.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On Site Reviews as needed
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Child Medicaid AFDC Questionnaire
    Child Medicaid SSI Questionnaire
    Child with Special Needs Questionnaire
-Disenrollment Survey
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-CMS 1500
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well care visits
-Adult access to preventive/ambulatory care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Children and Adolescents access to primary care practitioners
-Chlamydia screening
-Colon Rectal Cancer Screening Rate

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with obtaining care

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-Dental Preventive Services (all ages)
-Follow-up after hospitalization for mental illness
-Immunizations for two year olds
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of child beneficiaries with at least one dental visit
-Percentage of ED visits with a follow up outpatient visit within 30 days
-Percentage of hospital visits with a follow up outpatient visit with in 30 days
-Percentage of members with persistent asthma
-Percentage of members with persistent asthma who had a hospital visit for asthma
-Percentage of members with persistent asthma who had an ED visit for asthma
-Percentage of members with persistent asthma who had an outpatient visit for asthma
-Percentage of members with persistent asthma who overused rescue medicine
-Percentage of members with persistent asthma who received an influenza immunization
-Percentage of members with persistent asthma who received at least one maintenance medicine dispensing
-Percentage of members with persistent asthma who received at least one rescue medicine dispensing
-Percentage of members with persistent asthma with a satisfactory asthma medicine ratio
-Percentage of members with persistent asthma with good asthma medicine ratio
-Smoking prevention and cessation
-Well child visits in 3rd, 4th, 5th and 6th years of life
-Well child visits in first 15 months of life

Access/Availability of Care:
-Average wait time for an appointment with PCP
-Prevention Quality Indicator - Ambulatory Care Sensitive Conditions Hospitalizations

Use of Services/Utilization:
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percentage of child beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Asthma management
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment
-Pre-natal care
-Smoking prevention and cessation

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Non-Clinical Topics:

-Physical Health and Behavioral Health Integration

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Accumentra

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Rapid Cycle Review
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PIHP Standards
-On Site Reviews as needed
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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Consumer Self-Report Data:
-Consumer/Beneficiary Focus Groups
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Ambulatory Care ED and Outpatient
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)

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-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Coordination of primary and behavioral health care
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Accumentra

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-Disenrollment Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS

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measures listed for Medicaid
-State use/requires PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Dental services

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Ratio of dental providers to beneficiaries

Use of Services/Utilization:
-Percentage of beneficiaries that have at least one preventive service
-Percentage of child beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Expenditures by medical category of service (ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

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Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-PAHP/PCP-specific disenrollment rate

Performance Measures - Others:
None

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman

Use of Collected Data:
-Health Services Research
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    - "Cores" Adult/Child Survey with elected Medicaid and Special
Needs Questions

RHODE ISLAND
Connect Care Choice

CONTACT INFORMATION

State Medicaid Contact:

Ellen Mauro

RI Medicaid, EOHHS Medical Services, Office of Institutional/

(401) 462-0140

State Website Address:

http://www.ohhs.ri.gov

PROGRAM DATA

Program Service Area:

Statewide

Operating Authority:

1115(a) - Demonstration Waiver Program

Statutes Utilized:

Not Applicable

Enrollment Broker:

No

For All Areas Phased-In:

No

Guaranteed Eligibility:

No guaranteed eligibility

Initial Waiver Approval Date:

January 16, 2009

Implementation Date:

January 16, 2009

Waiver Expiration Date:

December 31, 2013

Sections of Title XIX Waived:

-1092(a)(32) Payment for Self-Directed Care

-1092(a)(8) Reasonable Promptness

-1902(a)(10)(B) Amount, Duration and Scope

-1902(a)(14) Cost-Sharing Requirements

-1902(a)(17) Comparability of Eligibility Standards

-1902(a)(23) Freedom of Choice

-1902(a)(34) Retroactive Eligibility

-1902(a)(37)(B) Payment Review

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-Other

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:

Case Management, Clinical Case Management, Disease Management, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Smoking Cessation, Speech Therapy, State Plan Benefits, Transportation, Vision, X-Ray

Allowable PCPs:

-Family Practitioners

-Federally Qualified Health Centers (FQHCs)

-General Practitioners

-Internists

RHODE ISLAND
Connect Care Choice

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Other Health Insurance

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Connect Care Choice

ADDITIONAL INFORMATION

Connect Care Choice is a primary care case management program for adults with Medicaid coverage who are 21 years old or older. The goal is to provide improved access to a persons primary care doctor and nurse case manager so they can better manage chronic illnesses and conditions. Emphasis is placed on preventive and primary care and teaching self-management skills to optimize wellness and reduce illness and hospitalizations.

RHODE ISLAND
Connect Care Choice

To be able to enroll, individuals must not have other comprehensive health insurance coverage and must live in the community: at home, in assisted living, or in a group home.

Under Data Element: Section of Title XIX Waived: 1902(a)(14) Cost Sharing Requirements in so far as it incorporates 1916

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation

Consumer Self-Report Data:
None

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-SF-36 Survey

Access/Availability of Care:
None

Use of Services/Utilization:
-Drug Utilization

Provider Characteristics:
None

Beneficiary Characteristics:
-Katz Index of ADL
-PHQ-9 Patient Health Questionnaire
-SF-36 Survey

Performance Measures - Others:
None

Performance Improvement Projects

Clinical Topics:
-Beta Blocker treatment after a heart attack
-Depression management
-Diabetes management
-Hypertension management
-Smoking prevention and cessation

Non-Clinical Topics:
None

RHODE ISLAND
Rhody Health Partners

CONTACT INFORMATION

State Medicaid Contact:

Deborah J. Florio
Center for Child and Family Health
(401) 462-0140

State Website Address:

http://www.ohhs.ri.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
January 16, 2009

Implementation Date:
January 16, 2009

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1092(a)(32) Payment for Self-Directed Care
-1092(a)(8) Reasonable Promptness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(14) Cost-Sharing Requirements
-1902(a)(17) Comparability of Eligibility Standards
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility
-1902(a)(37)(B) Payment Review

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Benefit Expansion
-HCBS

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter, Laboratory, Nutrition, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Smoking Cessation, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants
-Rural Health Centers (RHCs)

RHODE ISLAND
Rhody Health Partners

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Access to Cost Effective, Comprehensive, Employer-Sponsored Coverage
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Neighborhood Health Plan of Rhode Island   United HealthCare of New England

ADDITIONAL INFORMATION

RHODE ISLAND
Rhody Health Partners

Rhody Health Partners is a mandatory managed care program for adults on Medical Assistance. Eligible clients are enrolled on a monthly basis, and can choose between 2 health plans (Neighborhood Health Plan of RI or United Healthcare of New England) or Connect Care Choice. Connect Care Choice is a primary care physician practice model, that offers on-site nurse care management. Rhody Health Partners is a traditional MCO model.

Under Data Element: Section of Title XIX Waived: 1902(a)(14) Cost Sharing Requirements in so far as it incorporates 1916

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Grievances and Appeals
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
-Consumer Advisory Committee

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison of State data with plan-specifc data
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Monitoring submision processes from providers to health plans to assure complete and timely submissions
-Per member per month analysis and comparisons across

RHODE ISLAND
Rhody Health Partners

MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adult BMI Assessment
-Antidepressant medication management
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Complaint Resolution Statistics
-Patient/Member Satisfaction with Access to Care

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Inpatient days per 1,000
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Prescriptions per 1,000 population by category (name brand, generic, OTC)
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCO

Performance Measures - Others:
None

RHODE ISLAND
Rhody Health Partners

-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
-None

EQRO Name:
-IPRO, Inc.

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by disease and medical condition
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Adult preventive care
Cervical Cancer screening
Depression
Diabetes
Obesity
Smoking and Tobacco Use

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing patient satisfaction measures

Initial Year of Reward:
2010

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

RHODE ISLAND
Rite Care

CONTACT INFORMATION

State Medicaid Contact:

Deborah J. Florio
Center for Child & Family Health
(401) 462-0140

State Website Address:

http://www.ohhs.ri.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 16, 2009

Implementation Date:
January 16, 2009

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(14) Cost-Sharing Requirements
-1902(a)(17) Comparability of Eligibility Standards
-1902(a)(23) Freedom of Choice
-1902(a)(32) Payment for Self-Directed Care
-1902(a)(34) Retroactive Eligibility
-1902(a)(37)(B) Payment Review
-1902(a)(8) Reasonable Promptness

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Benefit Expansion
-Expenditures for core and preventive services for at-risk youth
-Family Planning Services
-FQHC payments
-HCBS
-Population Expansion
-Premium Assistance
-Substitute Care Provision for behavioral health

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter, Laboratory, Nutrition, Occupational Therapy, Outpatient Hospital,

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists

RHODE ISLAND
Rite Care

Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Smoking Cessation, Speech Therapy, State Plan Benefits, Transportation, Vision, X-Ray

-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)
-School-based health clinics

Enrollment

Populations Voluntarily Enrolled:

-Foster Care Children

Populations Mandatorily Enrolled:

-Poverty-Level Pregnant Women
-Pregnant Women above Poverty Level
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Access to Cost Effective, Comprehensive, Employer-Sponsored Coverage
-Exclusion of individuals with TPL except pregnant women b/w 185-250 with TPL can enroll
-Medicare Dual Eligibles
-Other Insurance
-Special Needs Children with Other Insurance Coverage

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Child Welfare Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency

RHODE ISLAND
Rite Care

-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Neighborhood Health Plan of Rhode Island   United HealthCare of New England

ADDITIONAL INFORMATION

Since September 2003, Children with Special Health Care Needs are offered enrollment in RIte Care unless they have comprehensive medical insurance from another source -- these children include SSI recipients, children eligible through Katie Beckett provisions, and children in subsidized adoption settings. Managed care enrollment is mandatory for these groups, but is not offered if children are covered by comprehensive third-party insurance. Coordination with other agencies in the care of Children with Special Health Care Needs takes place through the CEDARR program, available to children in managed care as well as to those in fee-for-service Medicaid -- this program combines evaluation, diagnosis, referral, reevaluation and a range of other services for families of Children with Special Needs. Definition of Special Needs Children (State defined): SSI/State Supplement-eligible child; Child eligible under Katie Beckett provisions; Child in subsidized adoption setting. RIte Care was first implemented in August 1994 under a distinct 1115 Demonstration waiver. Effective January 16, 2009 it was incorporated into the RI Global Consumer Choice Compact 1115(a) Demonstration, which encompasses almost the entire RI Medicaid Program. Enrollment became mandatory in October 2008.

Global Consumer Choice Compact program includes Connect Care Choice, Rhody Health Partners, Rite Care and Rite Smiles.

Under Data Element: Section of Title XIX Waived: 1902(a)(14) Cost Sharing Requirements in so far as it incorporates 1916

Children who have or at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-EQRO
-Focused Studies
-Grievances and Appeals
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
-Consumer Advisory Committee
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

RHODE ISLAND
Rite Care

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data elements for all services on UB-04 and CMS-1500
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison of State data with plan-specifc data
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Monitoring submision processes from providers to health plans to assure complete and timely submissions
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Adult BMI Assessment
-Antidepressant medication management
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Comprehensive Diabetes Care
-Follow-up after hospitalization for mental illness
-Follow-up for Children Prescribed ADHD Medication
-Frequency of on-going prenatal care
-Immunizations for Adolescents
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

RHODE ISLAND
Rite Care

-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking Cessation
-Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care:
-Adolescents' Access to PCPs
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Complaint Resolution Statistics
-Patient/Member Satisfaction with Access to Care

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Discharges from Neonatal Intensive Care Unit per 1,000 live births
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Inpatient days per 1,000
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Prescriptions per 1,000 population by category (name brand, generic and OTC)
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Antidepressant Medication Management
-ED Visits for Ambulatory Care Sensitive Conditions
-Follow-up for Children Prescribed ADHD Medications
-Notification of TPL

Non-Clinical Topics:
-Notifying the State of TPL Data within Five Days
-Work Distribution in the Grievance and Appeals Unit

Standards/Accreditation

MCO Standards:
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance)

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

RHODE ISLAND
Rite Care

Standards

Non-Duplication Based on Accreditation:
-None

EQRO Name:
-IPRO, Inc.

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Detailed technical report for each MCO
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by disease and medical condition
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
ADHD
Adolescent Immunizations
Adult preventive care
Cervical Cancer Screening
Childhood immunizations
Chlamydia Screening
Depression
Diabetes
Lead Screening
Obesity
Perinatal Care
Smoking Cessation
Well-child visits

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, etc.)

Initial Year of Reward:
1999

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

RHODE ISLAND
RIte Smiles

CONTACT INFORMATION

State Medicaid Contact:

Deborah J. Florio
Center for Child and Family Health
(401) 462-0140

State Website Address:

http://www.ohhs.ri.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 16, 2009

Implementation Date:
January 16, 2009

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1092(a)(8) Reasonable Promptness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(14) Cost-Sharing Requirements
-1902(a)(17) Comparability of Eligibility Standards
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility
-1902(a)(37)(B) Payment Review

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-None

SERVICE DELIVERY

Dental PAHP - Risk-based Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Children and Related Populations

RHODE ISLAND
RIte Smiles

-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Children born before 5/1/2000
-Children residing out of state
-Other Dental Insurance
-Reside in Nursing Facility or ICF/MR

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

United HealthCare Dental - RIte Smiles

ADDITIONAL INFORMATION

RIte Smiles is a children's dental program only covering those born on or after May 1, 2000. It was originally implemented on May 1, 2006 under 1915(b) authority and was subsumed into the Rhode Island Global Consumer Choice Compact 1115(a) Demonstration, as of 1/16/2009.

Under Data Element: Section of Title XIX Waived: 1902(a)(14) Cost Sharing Requirements in so far as it incorporates 1916

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)

Use of Collected Data:
-Contract Standard Compliance

RHODE ISLAND
RIte Smiles

-Encounter Data (see below for details)
-Network Data
-PAHP Standards (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per Member per month analysis
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Percentage of beneficiaries having at least one dental prophy visit per year
-Percentage of beneficiaries having at least one dental sealant per year

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Average Speed to Answer

Use of Services/Utilization:
-Annual Dental Visit by age

RHODE ISLAND
RIte Smiles

-Call Abandonment Rate
-Complaint Resolution Statistics
-Ratio of dental providers to beneficiaries

-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Risk Share Reporting

Health Plan/ Provider Characteristics:
-Provider Specialty Types

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-Individual PAHPs are required to conduct a project
prescribed by the State Medicaid agency

Clinical Topics:

-Annual Dental Visit for 2-3, 4-6 and 7-10 year olds
-Postcard Outreach to Parents of Non-Utilizing Children

Non-Clinical Topics:

Not Applicable - PAHPs are not required to conduct common
project(s)

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

TENNESSEE
TennCare II

CONTACT INFORMATION

State Medicaid Contact:

Darin J. Gordon
TennCare
(615) 507-6443

State Website Address:

http://www.tn.gov/tenncare

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Initial Waiver Approval Date:
May 30, 2002

Implementation Date:
July 01, 2002

Waiver Expiration Date:
June 30, 2013

Sections of Title XIX Waived:
-1902(a)(1) Statewideness/Uniformity
-1902(a)(10) Access to FQHCs and RHCs
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(17) Comparability and Amount, Duration, and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility
-1902(a)(4)(A) Proper and Efficient Administration
-1902(a)(54) Payment for Outpatient Drugs
-1902(a)(8) Reasonable Promptness

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-CHIP-Related Medicaid Expansion Demonstration Population Children
-Continuing Receipt of Home and Community-Based Services
-Continuing Receipt of Nursing Facility Care
-Expenditures for Expanded Benefits and Coverage of Cost-Effective Alternative Services
-Expenditures for Pool Payments
-Expenditures Related to Eligibility Expansion
-Expenditures Related to Expansion of Existing Eligibility Groups
-Expenditures related to MCO Enrollment and Disenrollment
-HCBS Services for SSI-Eligibles
-Indirect Payment of Graduate Medical Education
-LTC Partnership
-Payments for Non-Risk Contractor
-The 217-Like HCBS Group

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

TENNESSEE
TennCare II

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Bariatric Surgery, Case Management, Chiropractic, Community Health Services, Crisis, Detoxification, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Medical Supplies, Mental Health Rehabilitation, Mental Health Residential, Methadone Clinic Services Under Age 21 Only, Occupational Therapy, Organ & TissueTransplant Services and Donor Organ/Tissue Procurement Services, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Physician Inpatient Services, Physician Outpatient Services/Community Health Clinics/Other Clinical Services, Podiatry, Private Duty Nursing, Psychiatric Inpatient Facility Services, Psychiatric Rehabilitation Services, Psychiatric Residential Treatment Services, Reconstructive Breast Surgery, Renal Dialysis Clinic Services, Residential Substance Use Disorders Treatment Programs, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Institutionalized adults
-Institutionalized children
-Medically Needy (Pregnant Women and Children)
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-SSI eligible children
-Uninsurable children (Title XIX)
-Uninsured children (Title XXI)

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

TENNESSEE
TennCare II

Prepaid Inpatient Health Plan (partial risk, comprehensive) - Partial Capitation

Service Delivery

Included Services:

Bariatric Surgery, Case Management, Chiropractic, Community Health Services, Crisis, Detoxification, Disease Management, Donor Organ/Tissue Procurement Services, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Medical Supplies, Mental Health Rehabilitation, Mental Health Residential, Methadone Clinic Services (under age 21 only), Occupational Therapy, Organ and Tissue Transplant Services, Outpatient Hospital, Outpatient Substance Use Disorders, Physical Therapy, Physicial Outpatient Services, Physician, Physician Inpatient Services, Podiatry, Private Duty Nursing, Psychiatric Inpatient Facility Services, Psychiatric Rehabilitation Services, Psychiatric Residential Treatment Services, Reconstructive Breast Surgery, Renal Dialysis Clinic Services, Residential Substance Use Disorders Treatment Programs, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:

-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Children and Adults in HCBS
-Children in Nursing Facility or ICF/MR
-Foster Care Children
-Medicare Dual Eligibles
-SSI Eligible Children

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only (under age 21)

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

TENNESSEE
TennCare II

Pharmacy Benefit Manager PAHP - Administrative Services Fee

Service Delivery

Included Services:
Pharmacy

Allowable PCPs:
-Not applicable, contractors are not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Institutionalized Adults
-Institutionalized Children
-Medically Needy (Pregnant Women and Children)
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-SSI Eligible Children
-Uninsurable Children (Title XIX)
-Uninsured Children (Title XXI)

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only (under age 21)

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB
QMB Plus, SLMB Plus, and Medicaid only (age 21 and older)

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

TENNESSEE
TennCare II

Dental Benefit Manager PAHP - Administrative Services Fee

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-All TENNCARE Standard and TENNCARE Medicaid under age 21
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only (under age 21)

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI
QMB Plus, SLMB Plus, and Medicaid only (age 21 and older)

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Social Services Agencies
-Substance Abuse Agency

TENNESSEE
TennCare II

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice - East TN

AmeriChoice - West TN

DentaQuest

Volunteer State Health Plan (Bluecare) - East

Volunteer State Health Plan (TennCare Select)

AmeriChoice - Middle TN

AmeriGroup Community Care

SXC Health Solutions Corporation

Volunteer State Health Plan (Bluecare) - West

ADDITIONAL INFORMATION

1. Phased-In: As of July 1, 2010, the CHOICES program in TennCare was NOT fully phased in. On July 1, 2010, Nursing Facility (NF) services and Home and Community Based Services (HCBS) for persons considered to be institutionalized were provided through the MCOs and the PIHP (TennCare Select) in Middle Tennessee. NF services and HCBS in East and West Tennessee continued to be provided on a fee-for-service basis until August 1, 2010, when the CHOICES program was implemented statewide.

2. Guaranteed Eligibility is offered to Pregnant Women only - 60 days post delivery. The total period of eligibility will vary depending on the number of months the enrollees was pregnant at the time eligibility was granted.

3. Not all categories included in TennCare are mandatory Medicaid categories.

4. MCO /PIHP included Services: Chiropractic, Hearing, and Methadone Clinic Services are covered as medically necessary for under 21. Private Duty Nursing services are subject to specific limitations and medical necessity. Emergency Air and Ground Transportation is covered. Non-Emergency Transportation including Ambulance services is covered.

5. PIHP: TennCare Select is a prepaid inpatient health plan (PIHP) (as defined in 42 CFR 438.2) which operates in all areas of the State and covers the same services as the MCOs for the individuals described in paragraph 7 below. The State's TennCare Select contractor is reimbursed on a partial risk basis for services rendered to covered populations, and in addition receives fees from the State to offset administrative costs. TennCare Select is at risk for meeting EPSDT Screening Rate targets as reported annually on the CMS 416 report. TennCare Select is also at risk for medical and mental health services.

6. Lock-in: MCOs: Enrollees have 45 days after initial enrollment to change plans, after which they must stay in their plan until the annual re-determination unless there is a good cause reason.

7. Lock-in: PIHP: Children eligible for SSI, children receiving care in a NF or Intermediate Care Facility for Persons with Mental Retardation, and children and adults in a Home and Community Based Services 1915(c) Waiver for individuals with mental retardation are not locked into TennCare Select and may enroll in an MCO if one is available. Children in State custody and children leaving State custody for six months post-custody who remain eligible and enrollees living in areas where there is insufficient capacity to serve them are locked into TennCare Select.

8. MCO/PIHP: Full Benefit Medicare Dual Eligibles are enrolled in managed care programs. QMB only, SLMB only, QI and QDWI are not enrolled in managed care.

9. The Dental Benefits Manager (DBM) and Pharmacy Benefits Manager (PBM) are PAHPs and are paid an Administrative Services Fee. The managers handle claims administrative and are reimbursed for the claims amount(s). The DBM and PBM are currently non-risk but may be renegotiated as at risk. Provider rates are established in accordance with the State plan.

10. In both the DBM and the PBM, full benefit dual eligibles under age 21 are included. Partial benefit dual eligibles of any age and full benefit dual eligibles age 21 and older are excluded.

11. Some of our managed care entities have separate Medicare Advantage Plans, but these are independent of the Medicaid Program. The Bureau of TennCare does not have separate contracts with these plans for passive enrollment of dual eligibles into their Medicare Advantage Plans.

QUALITY ACTIVITIES FOR MCO/PIHP

TENNESSEE
TennCare II

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Development of Quality Strategy for Tennessee
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO/PIHP Standards
-Monitoring of MCO/PIHP Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
-CAHPS
    Health Plan Survey Adult Version (CPA)
    Health Plan Survey Child Version: Children with Chronic Conditions (CCC)
    Health Plan Survey Child Version: General Population (CPC)
      Medicaid Adult Questionnaire
      Medicaid Child Questionnaire

Use of Collected Data:
-ANOVA (Analysis of Variance)
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs/PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO/PIHP
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment

State conducts general data completeness assessments:
Yes

-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Breast Cancer and Cervical Cancer rates
-Infant Mortality
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Children's and adolescents access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Prenatal and Postpartum Care
-Ratio of dental providers to beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of home health visits per beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Annual Financial Statements
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Quarterly Financial Statements
-State minimum reserve requirements
-Total revenue
-Weekly Claims Inventory Reports

Health Plan/ Provider Characteristics:
-Board Certification
-Provider turnover

Beneficiary Characteristics:
-Beneficiary need for interpreter

Performance Measures - Others:
None

TENNESSEE
TennCare II

-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCO/PIHP
-Weeks of pregnancy at time of enrollment in MCO/PIHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements:

-MCOs/PIHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:

-Cholesterol screening and management
-Diabetes management
-Emergency Room service utilization
-Inpatient maternity care and discharge planning
-Low birth-weight baby
-Post-natal Care
-Pre-natal care

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Q-Source

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO/PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Assessment of MCO/PIHP information systems
-Calculation of performance measures
-Technical assistance to MCOs/PIHPs to assist them in conducting quality activities

Pay for Performance (P4P) for MCO

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
Payment incentives/differentials to reward MCOs
Withholds as an incentive

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness

of MCO response to grievances, improving customer
service, etc.)
Using clinically-based outcome measures (e.g., HEDIS,
NQF, etc.)

Initial Year of Reward:
2006

Evaluation Component:
The State HAS NOT conducted an evaluation of the
effectiveness of its P4P program, but plans to conduct
an evaluation in the future

Member Incentives:
Not Applicable

Quality Activities for Dental Benefit Manager PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-Network Data
-On-Site Reviews
-PAHP Standards (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the
HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may
have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely
encounter data submission
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter
data
-Specifications for the submission of encounter data to the
Medicaid agency
-Standards to ensure complete, accurate, timely encounter
data submission

Collections - Submission Specifications:
-Data submission requirements including documentation
describing set of encounter data elements, definitions, sets
of acceptable values, standards for data processing and
editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national
standardized forms (e.g. UB-04, NCPDP, ASC X12 837,
ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting
health care claims data
-NCPDP - National Council for Prescription Drug Programs
pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved
electronic flat file format for transmitting institutional billing
data between trading partners, such as hospitals, long term
care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help
determine to data completeness (e.g. frequency
distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g.
codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons
to State FFS utilization rates, comparisons to PAHP
commercial utilization rates, comparisons to national
norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Specification/source code review, such as a programming
language used to create an encounter data file for
submission

TENNESSEE
TennCare II

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Amount of Payment

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Dental services

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries satisfied with their ability to obtain care

Access/Availability of Care:
-Dental Screening ratio (observed/expected)
-Ratio of dental providers to beneficiaries

Use of Services/Utilization:
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Prompt Pay Review

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-PAHPs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Child/Adolescent Dental Screening and Services

Non-Clinical Topics:
Not Applicable - PAHPs are not required to conduct common project(s)

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

TENNESSEE
TennCare II

QUALITY ACTIVITIES FOR PHARMACY BENEFIT MANAGER PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PAHP Standards
-Network Data
-On-Site Reviews
-PAHP Standards (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID

State conducts general data completeness assessments:
Yes

TENNESSEE
TennCare II

-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Amount of Payment

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
-Drug Utilization

Health Plan Stability/ Financial/Cost of Care:
-Net Worth
-Total Revenue

Health Plan/ Provider Characteristics:
-Pharmacy Taxonomy (retail vs. specialty vs. LTC, etc)
-Valid Pharmacy License

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-PAHPs are required to conduct a project(s) of their own choosing

Clinical Topics:
None

Non-Clinical Topics:

-Network Access
-Trends in Pharmacy Appeals

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

UTAH
Primary Care Network (PCN)

CONTACT INFORMATION

State Medicaid Contact:

Emma Chacon
Utah State Department of Health
(801) 538-6577

State Website Address:

http://www.health.utah.gov/medicaid

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 08, 2002

Implementation Date:
July 01, 2002

Waiver Expiration Date:
June 30, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(14) Enrollment Fee
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Eligibility Expansion
-Restrictions on Coverage

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Crisis, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-American Indian/Alaska Native
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

Lock-In Provision:

UTAH
Primary Care Network (PCN)

-Medicare Dual Eligibles
-Other Insurance

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

UTAH
Primary Care Network (PCN)

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Case Management, Dental, Diabetes self-management, Durable Medical Equipment, Emergency Room, ESRD, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Medical Detoxification, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Primary Care, Speech Therapy, Vision, X-Ray

Allowable PCPs:

-Family Practitioners
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-American Indian/Alaska Native
-Medically Needy (not aged, blind, or disabled) Adults
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Resident of the State Developmental Center (DD/MR facility)
-Resident of the Utah State Hospital (IMD)

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

UTAH
Primary Care Network (PCN)

Medical-only PAHP (risk or non-risk, non-comprehensive) - Non-risk Capitation

Service Delivery

Included Services:

Case Management, Diabetes self-management, Durable Medical Equipment, ESRD, Family Planning, Hearing, HIV Prevention, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient medical detoxification, Laboratory, Medical Supples, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Speech Therapy, Vision, X-Ray

Allowable PCPs:

-Family Practitioners
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-American Indian/Alaska Native
-Medically Needy (not aged, blind, or disabled) Adults
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Demonstration Population I, under the Waiver III, IV, V, VI
-During Retroactive Eligibility Period
-Eligibility Less Than 3 Months
-Eligible only for TB-related Services
-If approved as exempt from mandatory enrollment
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

UTAH
Primary Care Network (PCN)

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Education Agency
-Mental Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy U

Select Access

Molina Healthcare of Utah (Molina)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCO

UTAH
Primary Care Network (PCN)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Possible duplication of encounter.

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Cholesterol screening and management
-Colorectal Cancer Screening
-Diabetes medication management
-Immunizations for two year olds
-Influenza vaccination rate

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services

Use of Services/Utilization:
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Diabetes management

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-HCE Quality Quest

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Primary Care Network (PCN)

EQRO Organization:
-QIO-like entity

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
None

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Performance Improvement Projects (see below for details)

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Performance Improvement Projects

Project Requirements:
-PAHPs are required to conduct a project(s) of their own choosing

Clinical Topics:
None

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

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Primary Care Network (PCN)

Non-Duplication Based on Accreditation:
None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance

Consumer Self-Report Data:
-State-developed Survey

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Average wait time for an appointment with primary care case manager

Use of Services/Utilization:
None

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Clinical Topics:
None

Non-Clinical Topics:
None

VERMONT
Global Commitment to Health

CONTACT INFORMATION

State Medicaid Contact:

Mark Larson
Department of Vermont Health Access
(802) 879-5900

State Website Address:

http://dvha.vermont.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
September 27, 2005

Implementation Date:
October 01, 2005

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(c)(i)(III)
-1902(a)(13)
-1902(a)(14)
-1902(a)(17)
-1902(a)(17)(D)
-1902(a)(19)
-1902(a)(23) Freedom of Choice
-1902(a)(3)
-1902(a)(30)
-1902(a)(32)
-1902(a)(34)
-1902(a)(4)
-1902(a)(8)

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-Expenditures related to additional services
-Expenditures related to defining the uninsured
-Expenditures related to Eligibility Expansion Demo Populations 3-10
-Expendiures related to MCO cap payment
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)
-Populations 3-10

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

VERMONT
Global Commitment to Health

Included Services:

Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nursing Home Health, Occupational Therapy, Outpatient Addiction, Outpatient Hospital, Outpatient Mental Health, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-CHIP XXI
-Individuals covered under Choices for Care 1115 Waiver except those Community Rehabilitation and Treatment Program
-Unqualified Aliens, Documented and Undocumented

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

Yes

Provides Part D Benefits:

Yes

Scope of Part D Coverage:

Standard Prescription Drug

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Agents when used for anorexia, weight loss, weight gain
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

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Global Commitment to Health

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Department for Children and Families (DCF)
-Department of Disability, Aging and Independent Dept. of Disability, Aging and Independent Living (D
-Department of Education (DOE)
-Department of Mental Health (DMH)
-Vermont Department of Health (VDH)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Global Committment to Health

ADDITIONAL INFORMATION

Under Vermont's Global Commitment to Health 1115 Demonstration, the single State agency (Agency of Human Services (AHS)) has entered into an agreement with the Division of Vermont Health Access (DVHA)). DVHA is a public agency. The AHS pays DVHA on a capitated basis (fixed rate multiplied by member months).

For the purposes of mental health: Children with severe emotional distrubance having a DSM diagnosis, a GAF score less than or equal to 60 and are ages 6-17.

Globally the state provides financial assistance and cost sharing in support of CSHN, but there is no set administratively defined roll.

The federal definition defines the scope of a subpopulation for the purposes of public health.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Grievances and Appeals
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Ombudsman
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter

Collections: Submission Specifications:
None

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Global Commitment to Health

data

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Comprehensive Diabetes Care, Antidepressant Medicaition Management, Use of Appropriate Medications with Asthma
-Effectiveness of care, Access/Availability of Care Process
-Medical record validation
-Per member per month analysis and comparisons across MCO
-Specification/source code review, such as a programming language used to create an encounter data file for submission
-Use of Services/Utilization

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Adult Access to Preventative /Ambulatory Health Services
-Asthma care - medication use
-Children and Adolescent access to Primary Care Practicioners
-Dental services
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
-Adolescent well-care visits utilization
-Drug Utilization
-Inpatient admissions/1,000 beneficiary
-Well-child visits in first 15 months of life
-Well-child visits in the 3,4,5 and 6 years of life

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

VERMONT
Global Commitment to Health

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Increasing adherence to Evidence Based Guidelines in Members with Congestive Heart failure

Non-Clinical Topics:
-Fostering Healthy Families

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities:
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

WASHINGTON
Bridge to Reform: Medical Care Services

CONTACT INFORMATION

State Medicaid Contact:

Mary Anne Lindeblad
Washington Health Care Authority
(360) 725-1040

State Website Address:

http://hrsa.dshs.wa.gov/programsandservices.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 2011

Implementation Date:
January 01, 2011

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility
-1902(a)(43); 1902(a)(13)(A); 1902(a)(3) from date of
approval until 07/01/2011
-1902(a)(8)
-1902(a)18 and 1902(a)(25)(i) as well as 1902(a45) and (60)
insofar as they incorporate Section 1917

**Sections of Title XIX Costs Not Otherwise Matchable
Granted:**

-1903(m)(2)(A)(xii) but only insofar as it requires compliance
with section 1932(a)(4)
-MCO Limits Disenrollment Rights {1903(m)(2)(A)(vi)}

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Disease Management, Family Planning,
Hearing, Home Health, Immunization, Laboratory,
Occupational Therapy, Outpatient Mental Health, Pharmacy,
Physical Therapy, Physician, Speech Therapy,
Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants
-Rural Health Clinics (RHCs)

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Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-American Indian/Alaskan Native
-Non-pregnant individuals ages 19 to 64 with incomes up to and including 133% of FPL who have not been determined to be eligible for Medicaid or CHIP, and who are currently enrolled, or become newly enrolled in Medical Care Services

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Poverty Level Pregnant Woman (SOBRA)
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Economic Services Administration which does eligibility determinations
-Housing Agencies
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Health
Plan

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ADDITIONAL INFORMATION

Population consists of adults ages 19 through 64 and who are not otherwise eligible for Medicaid; are physically or mental incapacitated and expected to be unable to work for at least 90 days. Eligible enrollees are automatically enrolled in managed care organization through state enrollment and payment system at the first of every month and then remained enrolled while eligibility lasts.

Medical Care Services used to be known as Disability Lifeline.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-State Medicaid Managed care Quality Strategy
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Not Applicable

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MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Diabetes medication management

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Not Applicable

Non-Clinical Topics:
-Not Applicable

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Accumentra

EQRO Organization:
-EQRO

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

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EQRO Optional Activities:
-Assessment of MCO information systems
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

WASHINGTON
Bridge to Reform: The Basic Health Plan

CONTACT INFORMATION

State Medicaid Contact:

Mary Anne Lindeblad
Washington Health Care Authority
(360) 725-1040

State Website Address:

http://www.hca.wa.gov/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
January 01, 2011

Implementation Date:
January 01, 2011

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(b)(i) Waiting Period for Pre-existing Conditions
-1902(a)(13)(A) Public Process for Hospital Payments
-1902(a)(14) Cost-Sharing Requirements
-1902(a)(17)(D) Comparability for Eligibility Standards
-1902(a)(18) and 1902(a)(25)(i) as well as 1902(a)(45) and
(60) insofar as they incorporate section 1917 Liens,
Adjustments and recoveries collection of sufficient information
-1902(a)(23) Freedom of Choice
-1902(a)(3) Fair Hearings (Restricted Period)
-1902(a)(34) Retroactive Eligibility
-1902(a)(43) EPSDT
-1902(a)(8) Reasonable Promptness

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-1903(m)(2)(A)(xii), but only insofar as it requires compliance
with section 1932(a)(3)(A)
-MCO Limits Disenrollment Rights {1903(m)(2)(A)(vi)}

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Disease Management,
Family Planning, Home Health, Hospice, Immunization,
Inpatient Hospital, Inpatient Mental Health, Inpatient
Substance Use Disorders, Institutional, Laboratory,
Occupational Therapy, Outpatient Hospital, Outpatient Mental

Allowable PCPs:
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers

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Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Skilled Nursing Facility, X-Ray

-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Psychiatrists
-Psychologists
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Must be age 19 to 64, U.S. citizen or qualified non U.S. citizen, not eligible or enrolled in free or purchased Medicare, not eligible or enrolled in Medicaid, not enrolled in Washington Health Program and not living in the U.S. on student visa

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-Eligibility Less Than 3 Months
-Eligible only for TB-related Services
-Enrolled in Another Managed Care Program
-Enrolled in CDC BCCT Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman (SOBRA)
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Mental Health Agency
-Private Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Columbia United Providers

Community Health Plan

Group Health Cooperative

Molina Healthcare

ADDITIONAL INFORMATION

Enrollees may terminate their enrollment at any time, however, depending on the reason for the termination, an enrollee may not be allowed to reenroll for a period of at least 12 months and may first have to have their name added to the established wait list before they may reapply.

Basic Health is intended for low-income Washington residents who are not eligible for other state-purchased health programs. It has historically been fully state funded, but is now partially funded through federal funds under the Transitional Bridge waiver. Federal approval of the waiver required some eligibility changes, which led to changes in state law regarding program eligibility. For example, today an enrollee must be a U.S. citizen or qualified noncitizen and the program no longer covers children, who are by definition eligible for other state programs. The program also includes enrollee cost sharing in the form of premiums based on the family's gross income in addition to point of service co-pays, deductibles, and coinsurance. Enrollee cost sharing is limited to a yearly per-person maximum based on the deductible and coinsurance

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-Use the most recent HEDIS version of the commercial adult questionnaire or as
instructed by NCQA for 2011 CAHPS™ surveys
Use the most recent HEDIS version of the commercial adult questionnaire or as
instructed by NCQA for 2011 CAHPS™ surveys

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

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Bridge to Reform: The Basic Health Plan

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Performance Measures

Process Quality:
-Antidepressant medication management
-Cholesterol screening and management
-Controlling high blood pressure
-Diabetes medication management
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Percent of PCPs with open or closed patient assignment panels
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Reinsurance Premium Paid
-Reinsurance Recoveries
-State minimum reserve requirements
-Third-Party Liability (TPL) Recoveries
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Whether the provider is accepting new BH enrollees as patients

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Percentage of beneficiaries who are auto-assigned to PCP

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-The contractor should conduct at least one Clinical Performance Improvement Topic as specified in the CMS protocol at http://www.cms.gov/medicaidchipqualprac/07_tools_tips_and_prot
o
cols.asp

Non-Clinical Topics:
-The contractor should conduct at least one Non-clinical Performance Improvement Topic as specified in the CMS protocol at http://www.cms.gov/medicaidchipqualprac/07_tools_tips_and_
proto
cols.asp

Standards/Accreditation

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Bridge to Reform: The Basic Health Plan

MCO Standards:
-JCAHO (Joint Commission on Accreditation of
Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance)
Standards
-State-Developed/Specified Standards
-URAC Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
-JCAHO (Joint Commission on Accreditation of
Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-URAC

EQRO Name:
-Accumentra

EQRO Organization:
-EQRO

EQRO Mandatory Activities:
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-HCA reserves the right to include additional optional activities
described in 42 CFR 438.358 if additional funding becomes
available and as mutually negotiated between HCA and the
Contractor

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance
program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

COLORADO
Accountable Care Collaborative (ACC) Program

CONTACT INFORMATION

State Medicaid Contact:

Jerry Smallwood
Department of Health Care Policy and Financing
303-866-5947

State Website Address:

http://www.colorado.gov/hcpf

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS , INC.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 01, 2011

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, EPSDT, Hearing, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Pharmacy, Physician, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaskan Native
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

COLORADO
Accountable Care Collaborative (ACC) Program

-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Accountable Care Collaborative Program

ADDITIONAL INFORMATION

Program is a PCCM that closely resembles a ACO organization and pays benefits on a FFS basis and also pays a pmpm for medical home, case management, care coordination.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-On-Site Reviews
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Program Evaluation
-Program Modification, Expansion, or Renewal

COLORADO
Accountable Care Collaborative (ACC) Program

Consumer Self-Report Data:
-State-developed Survey

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
None

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiaries
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Use of high cost imaging

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

COLORADO
Primary Care Physician Program

CONTACT INFORMATION

State Medicaid Contact:

Valerie baker-Easley
Department of Health Care Policy and Financing
303-866-3830

State Website Address:

http://www.colorado.gov/hcpf

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus, INC.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
June 30, 2003

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
EPSDT, Hearing, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Pharmacy, Physician, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

COLORADO
Primary Care Physician Program

-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

ePCCM - Fee-for-Service

Service Delivery

Included Services:
Case Management

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

COLORADO
Primary Care Physician Program

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ePCCM   Primary Care Physician Program

ADDITIONAL INFORMATION

This program provides beneficiaries the option of a fee-for-service physician who acts as a gatekeeper and refers for specialty care. In addition to the gatekeeper "Primary Care Case Management Program" called the "Primary Care Physician Program", Colorado offers an enhanced Primary Care Case Management (ePCCM) program with two levels of enhanced services. All three versions share the common elements: Reimbursement for medical services is fee-for-service, Enrollment is voluntary (a "passive" or default enrollment mechanism is available), There is a 12 month lock-in period (until the Enrollees next birthday), and Most medical services provided by someone other than the chosen Primary Care Provider need a referral.

The two enhanced version of the program have these additional characteristics: Per Member per Month (PMPM) case management payments depending upon the level of "enhancements" provided and the kinds of clients enrolled, and Ability to earn bonus incentive payments attributable to a reduction in utilization or costs after recovery of PMPM expenditures.

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

Lisa Truitt
Department of Health Care Finance
(202) 442-9109

State Website Address:

http://www.dchealth.dc.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Policy Studies, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Addictionologists
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Psychiatrists
-Psychologists

Enrollment

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

Populations Voluntarily Enrolled:
-Children receiving adoption assistance
-Immigrant Children (State only)
-Special Needs Children (State defined)

Populations Mandatorily Enrolled:
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-TANF HIV Patients: Pregnant > 26 weeks
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify
members of these groups
-Surveys medical needs of enrollee to identify members
of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these
groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

DC Chartered Health Plan, Incorporated

United Healthcare Community
Plan

ADDITIONAL INFORMATION

Adult Day Treatment applies to Mental Health Retardation. TANF HIV patients can opt out of managed care, pregnant women do not have opt out provision unless they are HIV positive or have AIDS.

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

Children with Special Health Care Needs: Those children who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond those required by children generally. This definition includes children who receive Supplemental Security Income (SSI), children whose disabilities meet the SSI definition, children who are or have been in foster care, and children who meet the standard of limited English proficiency.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Number of children with diagnosis of rubella(measles)/1,000 children
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

Clinical Topics:

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Adult hearing and vision screening
-Asthma management
-Beta Blocker treatment after a heart attack
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Depression management
-Diabetes management/care
-Low birth-weight baby
-Newborn screening for heritable diseases
-Post-natal Care
-Pre-natal care
-Primary and behavioral health care coordination
-Well Child Care/EPSDT

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
-AAAHC (Accreditation Association for Ambulatory Health Care)
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-MCO must be accredited by appropriate body
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Delmarva Foundation for Medical Care

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Assessing patient satisfaction measures
Ratio of Encounter to Financial Data

Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2006

Member Incentives:
Not Applicable

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

GEORGIA
Georgia Better Health Care

CONTACT INFORMATION

State Medicaid Contact:

Juanita Hines
Director, GBHC
(404) 657-0623

State Website Address:

http://www.dch.ga.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 1993

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Physician

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

GEORGIA
Georgia Better Health Care

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Georgia Better Health Care

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM

GEORGIA
Georgia Better Health Care

Quality Oversight Activities:
-Enrollee Hotlines
-Performance Measures (see below for details)

Use of Collected Data:
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
None

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 member months
-Inpatient admissions/1,000 member months
-Number of primary care case manager visits per beneficiary

Provider Characteristics:
None

Beneficiary Characteristics:
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Measures - Others:
None

GEORGIA
Georgia Families

CONTACT INFORMATION

State Medicaid Contact:

Jerry Dubberly
GA Department of Community Health
(404) 651-8681

State Website Address:

http://www.dch.ga.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
June 01, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Ambulatory Surgical, Audiology, Case Management, Childbirth Education, Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, FQHC, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Nurse Midwife, Nurse Practitioner, Obstetrical, Occupational Therapy, Oral Surgery, Orthotic, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Pregnancy Related, Private Duty Nursing, Prosthetic, Radiology, RHC, Skilled Nursing Facility, Speech Therapy, Swing Bed, Targeted Case Management, Transplants, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Public Health Department
-Rural Health Clinics (RHCs)

Enrollment

GEORGIA
Georgia Families

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Low-income Medicaid
-Poverty-Level Pregnant Women
-Refugees
-Right from State Medicaid
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Women with Breast or Cervical Cancer

Subpopulations Excluded from Otherwise Included Populations:
-Aged, Blind, and Disabled
-Foster Care Children
-Long Term Care (includes Hospice)
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-SSI and Members of Federally Recognized Indian Tribes

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Community Care
WellCare

Peach State Health Plan

ADDITIONAL INFORMATION

None

GEORGIA
Georgia Families

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-Network Data
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-CMS1500
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-A monthly reconciliation of submitted encounters
-Periodic audit of encounter transaction to source document

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Age-appropriate diagnosis/procedure
-A unique TCN
-All required CMS1500 and UB04 codes
-CMO Paid Amount

State conducts general data completeness assessments:
Yes

GEORGIA
Georgia Families

-Date of Birth
-Diagnosis Primary and Secondary
-Facility Code
-NPI Number
-Patient Name
-Place of Service
-Tax Identification Number
-Treating Provider
-Units of Service

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Comprehensive Diabetes Management
-Dental services
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Emergency room visits/1,000 member months
-Inpatient admissions/1,000 member months
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCO

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Adult Access
-Blood Lead Screening
-Dental
-Emergency Room Service Utilization
-Immunization
-Obesity
-Well Child Care/EPSDT

GEORGIA
Georgia Families

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance)
Standards
-URAC Standards

Accreditation Required for Participation:
-AAAHC (Accreditation Association for Ambulatory Health Care)
-JCAHO (Joint Commission on Accreditation of Healthcare
Organizations)
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-Health Services Advisory Group (HSAG)

EQRO Organization:
-Private accreditation organization
-QIO-like entity
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of health plan compliance with State and Federal
Medicaid Managed Care Regulations
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Conduct studies on quality that focus on a particular aspect of
clinical or non-clinical services

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance
program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Assessing improvements in, or reaching established
standards in, administrative processes (e.g., timeliness
of MCO response to grievances, improving customer
service, etc.)

Initial Year of Reward:
2009

Evaluation Component:
The State HAS NOT conducted an evaluation of the
effectiveness of its P4P program, but plans to conduct
an evaluation in the future

Member Incentives:
Not Applicable

ILLINOIS
Illinois Health Connect Primary Care Case Management

CONTACT INFORMATION

State Medicaid Contact:

Michelle Maher
Illinois Department of Healthcare and Family Services
(217) 524-7478

State Website Address:

http://www.hfs.illinois.gov/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health Systems

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Assisted/Augmentative Communication Devices, Audiology, Blood and Blood Components, Case Management, Chiropractic, Clinic, Dental, Diagnosis and treatment of medical conditions of the eye, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Psychiatric Care, Inpatient Substance Use Disorders, Laboratory, Non-Durable Medical Equipment and Supplies, Nurse Midwives, Occupational Therapy, Orthotic/Prosthetic Devices, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Psychiatric Care, Skilled Nursing Facility, Speech Therapy, Transplants, Transportation, Vision, X-Ray

Allowable PCPs:
-Certified Local Health Departments
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)
-School-Based/Linked Clinics

Enrollment

ILLINOIS
Illinois Health Connect Primary Care Case Management

Populations Voluntarily Enrolled:
-American Indian/Alaska Native

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP
-Veterans Care Population

Subpopulations Excluded from Otherwise Included Populations:
-All Kids Rebate and Family Care Rebate Program
-Blind Disabled Children and Related Populations
-Emergency Medical Only
-Individuals enrolled for treatment in the health benefit for persons with Breast or Cervical Cancer Program
-Individuals enrolled in programs with limited benefits
-Individuals in Presumptive Eligible Programs
-Medicare Dual Eligibles
-Non-citizens only receiving emergency services
-Other Insurance (High Level)
-PACE Participants
-Refugees
-Reside in Nursing Facility or ICF/MR
-Some people who receive Home and Community Based services
-Special Needs Children (BBA defined)
-Spendown Eligibles
-Transitional Assistance, Age 19 and Older

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses claims data to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-All local agencies under administrative oversight of State agencies
-Employment Agencies
-Housing Agencies
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

ILLINOIS
Illinois Health Connect Primary Care Case Management

-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Illinois Health Connect

ADDITIONAL INFORMATION

Enrollment in Illinois Health Connect is mandatory for all included populations except; American Indian/Alaskan Native may choose to enroll in the Illinois Health Connect health plan and in areas with voluntary managed care plans available most clients have the option to choose a primary care provider in Illinois Health Connect or a managed care organization.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Network Data
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service Provision and Health Outcomes

Consumer Self-Report Data:
-Enrollee Survey
-Health Needs Assessment

Performance Measures

Process Quality:
-Access to Preventive/Ambulatory Health Services
-Ace Inhibitor/ARB Therapy
-Adolescent well-care visits rates
-Ambulatory Care Sensitive Hospital Visits for CHF, Angina, Diabetes, Cellulitis, Asthma, COPD, Bacte
-Annual Urine Microalbuminuria Testing
-ASA, other antiplatelet or anticoagulant
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Blood Pressure Control
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol Screening
-Chronic Obstructive Pulmonary Disease - Care and Management
-Depression medication management
-Developmental Screening age 12 - 24 months
-Developmental Screening before age 12 months
-Diabetes management/care
-Diuretic - Heart Failure
-Foot Exams
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care - timeliness of
-Lead screening rate

Health Status/Outcomes Quality:
-Comparison to statewide averages and HEDIS 50th percentile benchmarks to measure performance
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

-Pneumonia vaccination
-Prenatal and Postpartum Care
-Prenatal and Postpartum Screening for Depression
-Retinal Exam
-Statin Therapy
-Vision Services for 3, 4, 5, and 6 year olds
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Children's access to primary care practitioners
-Enrollee Helpline to locate providers for services
-Percent of PCPs with open or closed patient assignment panels
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiaries
-Hospitalizations for ambulatory sensitive conditions/1,000 beneficiaries
-Increase in Well Child Visits/3,4,5 and 6 yrs
-Increase in Well Child Visits/first 15 months

Provider Characteristics:
-Gender
-Languages spoken (other than English)
-Office hours
-Panel Availability
-Specialties

Beneficiary Characteristics:
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Measures - Others:
None

ILLINOIS
Integrated Care Program

CONTACT INFORMATION

State Medicaid Contact:

Michelle Maher
Healthcare and Family Services
(217) 524-7478

State Website Address:

http://www.hfs.illinois.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health Systems

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 2011

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Advanced Practice Nurse, Ambulatory Surgical Treatment Center, Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Federally Qualified Health Centers, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Nursing Care for Medically Fragile Technology Dependant children not in the Home and Community Based, Nursing Services for the purpose of transitioning children (under age 21) from a hospital to home pl, Occupational Therapy, Other Encounter Rate Clinics, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Post-Stabilization Services, Practice Visits for Enrollees with special needs, Renal Dialysis services, Rural Health Centers, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Certified Local Health Departments
-Community Mental Health Centers
-Cook County Bureau of Health Clinics
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Clinics including Specified Hospitals
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)
-School Based/Linked Clinics

ILLINOIS
Integrated Care Program

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations (Age 19 and older)

Subpopulations Excluded from Otherwise Included Populations:
-Children under 19 years of age
-Enrolled in CDC BCCT Program
-Medicaid beneficiaries in programs with presumptive eligibility
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Other Insurance
-Poverty Level Pregnant Woman (SOBRA)

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses Medicaid claims data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Employment Agencies
-Housing Agencies
-Mental Health Agency
-Other Local Agencies under administrative oversight of State Agencies
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna Better Health   IlliniCare Health Plan, Inc.

ILLINOIS
Integrated Care Program

ADDITIONAL INFORMATION

Serves Aged, Blind and Disabled Medicaid clients age 19 and older, including those enrolled in Home and Community Based Waivers.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Access to Care Standards monitoring
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Enrollee Satisfaction Survey
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO
-Specification/source code review, such as a programming language used to create an encounter data file for submission

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ILLINOIS
Integrated Care Program

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Ace Inhibitor/ARB Therapy
-Adult BMI assessment
-Ambualtory Care Follow-up after inpatient discharge
-Antidepressant medication management
-Appropriate Follow-up with any provider following first behavioral health diagnosis
-Behavioral Health risk assessment and follow-up
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Cholesterol screening and management
-Chronic Objective Pulmonary Disease
-Colorectal Cancer Screening
-Coronary Artery Disease
-Dental services
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Follow-up visit within 14 days of every inpatient discharge
-Heart Failure care
-Influenza vaccination rate
-Medication reviews
-Percentage of beneficiaries with at least one dental visit

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Access to Substance Abuse Treatment
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-ED reduction with primary diagnosis dental
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)
-Provider NPI number
-Provider Specialty

Beneficiary Characteristics:
None

Performance Measures - Others:
None

ILLINOIS
Integrated Care Program

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Ambulatory Care Follow-up
-Care Coordination
-Inpatient Hospital Readmissions

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Service Advisory Group

EQRO Organization:
-External Quality Review Orgnization

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Assessment of MCO information systems
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
Bonus
Withholds as an incentive

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

ILLINOIS
Integrated Care Program

Initial Year of Reward:

2012

Evaluation Component:

The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

Member Incentives:

Not Applicable

INDIANA
Care Select

CONTACT INFORMATION

State Medicaid Contact:

Sarah Jagger
Office of Medicaid Policy & Planning
(317) 234-5545

State Website Address:

http://www.in.gov/fssa/2408.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 25, 2011

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Food Supplements, FQHC, Hearing, Home Health, Immunization, Infant Formulas, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Long-Term Care Acute Hospitalization, Nutritional Supplements, Occupational Therapy, Organ Transplants, Out-of-state Medical, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Respiratory Therapy, RHC, Smoking Cessation, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

INDIANA
Care Select

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

None

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Enrolled with Spend Down
-HCBS Waiver Participants
-Hospice
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Claims Data
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Eligibility Agency
-Health Plan
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Advantage Health Solutions-Care Select

MDwise-Care Select

ADDITIONAL INFORMATION

None

INDIANA
Care Select

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-State-developed Survey

Performance Measures

Process Quality:
-Adolescent well care visits, ages 12-21, one or more visits
-Annual dental visit for ages 21-64
-Annual dental visits for ages 3-20
-Annual medical attention for Nephropathy for those with diabetes
-Annual monitoring for members on ACE inhibitors or ARB
-Asthma Medications, use of appropriate medications
-Breast Cancer Screening for ages 52-69
-Comprehensive diabetes care, LDL-C screening
-ER bounce back measure
-Follow-Up after mental health hospitalization, 7 days
-Inpatient bounce back measure
-Well child visits in the 3rd through 6th years of life, one or more visits

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult access to preventive/ambulatory health services

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Percentage of beneficiaries with at least one dental visit

Provider Characteristics:
-Languages spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Measures - Others:
None

Performance Improvement Projects

Clinical Topics:
-Adolescent Well Care Visits
-Annual dental visits, for ages 21-64
-Annual dental visits, for ages 3-20
-Asthma management
-Behavioral Health Seven Day Follow-Up
-Breast cancer screening, ages 21-64
-Diabetes: LDL-C Screening
-ER bounce back measure
-Inpatient bounce back measure

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

-Well child visits, ages 7 througjh 11, one or more vistis
-Well child visitss in the 3rd through 6th years of life, one or
more visits

INDIANA
Hoosier Healthwise (1932)

CONTACT INFORMATION

State Medicaid Contact:

Sarah Jagger
Office of Medicaid Policy & Planning
(317) 234-5545

State Website Address:

http://www.in.gov/fssa/2408.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 25, 2011

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Food Supplements, FQHC, Hearing, Home Health, Immunization, Infant Formulas, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nutritional Supplements, Occupational Therapy, Organ Transplants, Out-of-state Medical, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Respiratory Therapy, RHC, Smoking Cessation, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Presumptively Eligible Pregnant Women

INDIANA
Hoosier Healthwise (1932)

-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Hospice
-Medicare Dual Eligibles
-Members receiving services in a HCBS waiver
-Reside in Nursing Facility or ICF/MR/SOF/PRTF

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses Health Needs Assessment

Agencies with which Medicaid Coordinates the Operation of the Program:

-Eligibility Agency
-Enrollment Broker
-Health Plans
-PBM
-State Actuary

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem-Hoosier Healthwise
MDwise-Hoosier Healthwise

Managed Health Services (MHS)-Hoosier Healthwise

ADDITIONAL INFORMATION

Hoosier Healthwise is authorized by both an 1115(a) Demonstration and a 1932(a) SPA effective March 25, 2011. The 1115(a) demonstration was established for the Healthy Indiana Plan. The remainder of the Hoosier Healthwise population was placed onto that 1115(a) demonstration for budget neutrality purposes.

QUALITY ACTIVITIES FOR MCO/HIO

INDIANA
Hoosier Healthwise (1932)

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCO
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

INDIANA
Hoosier Healthwise (1932)

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Annual Monitoring for Persistant Medications
-Antidepressant medication management
-Appropriate Testing and Treatment for COPD
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Depression management/care
-Diabetes Management
-Follow-up after hospitalization for mental illness
-Follow-Up for Children Prescribed ADHD Medication
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Initiation of Prenatal Care
-Lead screening rate
-Use of Imaging Studies for Low Back Pain
-Utilization for Ambulatory, Inpatient, and Mental Health Treatment
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Administrative Cost Ratio
-Claims Payable per Member
-Cost per Member
-Days cash on hand
-Days in Claims Receivable
-Days in unpaid claims/claims outstanding
-Equity per member
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Ratio Assets to Liabilities
-Revenue per Member
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Grievance and Appeal Timeliness
-Languages Spoken (other than English)
-Provider Complaints
-Provider turnover

INDIANA
Hoosier Healthwise (1932)

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-ADHD Medication Follow-Up: Initiation Phase
-Adolescent Well-Care Visits
-Behavioral Health Seven Day Follow-Up
-Cervical Cancer Screening
-Diabetes-LDL-C, HbA1c, and Eye Exam
-Frequency of ongoing prental care
-Generic dispensing rate
-Medication utlilization rate
-Post-natal Care
-Pre-natal care
-Well child visits in the 3rd through 6th years of life, one or more visits
-Well child visits in the first 15 months of life, six or more visits

Non-Clinical Topics:
-Program Integrity
-Provider Network Services

Standards/Accreditation

MCO Standards:
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards
-URAC Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Burns & Associates, Inc.

EQRO Organization:
-Independent Consultant

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Provider Survey

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

INDIANA
Hoosier Healthwise (1932)

Population Categories Included:
A subset of MCO members, defined by beneficiary age
A subset of MCO members, defined by disease and medical condition

Clinical Conditions:
Annual dental visits ages 21-64 (state)
Annual dental visits ages 3-20 (state)
Appropriate use of asthma medications ages 5-56 (HEDIS)
Breast cancer screening (mammogram) for women ages 52-69 (HEDIS)
Comprehensive diabetes care - LDL-C screening
ER bounce back-percentage of ER visits that result in a second ER visit within 30 days (state)
Follow-up after hospitalization to mental health illness within 7 days
Inpatient bounce back-percentage of inpatient stays that result in a second stay within 30 days (state)
Well-Child Visits (3-6 years) - one or more visits
Well-Child Visits for children 7-11 years old (state)

Initial Year of Reward:
2008

Member Incentives:
Not Applicable

Rewards Model:
Payment incentives/differentials to reward MCOs
Public reporting to reward MCOs
Withholds as an incentive

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

IOWA
Iowa Medicaid Managed Health Care

CONTACT INFORMATION

State Medicaid Contact:

Dennis Janssen
Department of Human Services
(515) 256-4643

State Website Address:

http://www.dhs.state.ia.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
December 01, 1986

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

IOWA
Iowa Medicaid Managed Health Care

Subpopulations Excluded from Otherwise Included Populations:

-Aged (over 65)
-American Indian/Alaskan Native
-Medically Needy
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Recipients placed into the "lock-in" program by the Department
-Recipients who have an eligibility period that is only retroactive
-Recipients who have commecial insurance paid under the Health Insurance Payment Program
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medipass

ADDITIONAL INFORMATION

Selected Medicaid member categories are required to select (or accept) a primary care provider (PCP) who will provide services or make a referral for services not offered at the PCP practice location.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Performance Measures (see below for details)

Use of Collected Data:
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Performance Measures

IOWA
Iowa Medicaid Managed Health Care

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiaries

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

KANSAS
HealthConnect Kansas

CONTACT INFORMATION

State Medicaid Contact:

Tracy Conklin
Division of Health Care Finance
(785) 296-7788

State Website Address:

http://www.kdheks.gov/hcf/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
HP

For All Areas Phased-In:
No

Guaranteed Eligibility:
Continuous eligibility for children under age 19

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1984

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Obstetrical, Occupational Therapy, Outpatient Hospital, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Local Health Departments (LHDs)
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Osteopaths
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

Enrollment

KANSAS
HealthConnect Kansas

Populations Voluntarily Enrolled:
-American Indian/Alaska Native
-Blind/Disabled Children and Related Populations
-Special Needs Children (BBA-defined)

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Aliens who are eligible for Medicaid for emergency conditions only
-Clients participating in the Refugee Resettlement Program
-Clients residing out of State
-Clients with an eligibility period that is only retroactive
-Enrolled in Another Managed Care Program
-Foster Care Children
-Medically Needy-eligible
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Receive Adoption Support
-Reside in Juvenile Justice Facility
-Reside in Nursing Facility or ICF/MR
-Reside in State Institution
-Retroactive Eligibility
-Spenddown Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses information from Title V agency to identify members
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

KANSAS
HealthConnect Kansas

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HealthConnect Kansas

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-CAHPS
   Adult Medicaid AFDC Questionnaire
   Adult Medicaid SSI Questionnaire
   Child Medicaid AFDC Questionnaire
   Child Medicaid SSI Questionnaire
   Child with Special Needs Questionnaire

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization:
-Drug Utilization

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

KANSAS
HealthWave 19

CONTACT INFORMATION

State Medicaid Contact:

Tracy Conklin
Division of Health Care Finance
(785) 296-7788

State Website Address:

http://www.kdheks.gov/hcf/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
HP

For All Areas Phased-In:
No

Guaranteed Eligibility:
Continuous eligibility for children under age 19

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
December 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Newborn, Nutrition, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Prenatal Health Promotion, Speech Therapy, Transfusions, Transplants (limited to Kidney and Cornea), Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

KANSAS
HealthWave 19

-American Indian/Alaska Native
-Special Needs Children (BBA-defined)

-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Aliens eligible for Medicaid for emergency conditions only
-Blind/Disabled Adults
-Blind/Disabled Children
-Clients participating in Refugee Resettlement program
-Clients participating in the subsidized adoption program
-Clients residing in State Institutions
-Clients under the custody of Juvenile Justice Authority
-Clients who are residing out of state
-Clients whose eligibility is only retro-active
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Reside in State Hospitals
-Retroactive Eligibility
-Spenddown
-Title XXI CHIP

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses information from the Title V agency to identify members
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Children's Mercy's Family Health Partners

UniCare Health Plan of Kansas, Inc.

KANSAS
HealthWave 19

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

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Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes

State conducts general data completeness assessments:
Yes

KANSAS
HealthWave 19

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Asthma treatment outcomes
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Panel size
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Diabetes management
-Pre-natal care

Non-Clinical Topics:
-Telephonic Improvement of Customer Care

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Kansas Foundation for Medical Care

KANSAS
HealthWave 19

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Assessment of MCO information systems
-Calculation of performance measures
-Focused Studies
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

KENTUCKY
Kentucky Patient Access and Care (KENPAC) Program

CONTACT INFORMATION

State Medicaid Contact:

Lee Barnard
Division of Medical Management
(502) 564-9444

State Website Address:

http://www.chfs.ky.gov/dms

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 2000

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

KENTUCKY
Kentucky Patient Access and Care (KENPAC) Program

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Spenddown

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Kentucky Patient Access and Care
(KenPAC)

ADDITIONAL INFORMATION

For the following Included services- EPDST, Mental Health, and Maternity Care including prenatal care delivery and post partum beneficiary may go to any participating providers for these services without a referral.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Enrollee Hotlines
-Ombudsman

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance

KENTUCKY
Kentucky Patient Access and Care (KENPAC) Program

-Provider Data

-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

None

LOUISIANA
CommunityCARE Program

CONTACT INFORMATION

State Medicaid Contact:

Veronica Dent
Department of Health and Hospitals
(225) 342-0327

State Website Address:

http://www.dhh.louisiana.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health Systems (AHS)

For All Areas Phased-In:
No

Guaranteed Eligibility:
Children under 19 have 12 months guaranteed eligibility
months guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

LOUISIANA
CommunityCARE Program

-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-CHAMP pregnant women
-Eligibility Less Than 3 Months
-Enrollees in the PACE Program
-Foster children, or children receiving adoption assistance
-Medically high-risk on a case-by-case basis
-Medicare Dual Eligibles
-Office of Youth Development recipients
-Prseumptive Eligible (PE) recipients
-Recipients in SURS lock-in (except "pharmacy-only" lock in)
-Recipients in the Family Planning Waiver Program
-Recipients in the Hospice Program
-Recipients in the LaChip Affordable Plan
-Recipients under the age of 19 in the NOW and Childrens Choice Waiver Programs
-Recipients under the age of 19 in the Supports Waiver and Supports SSI Programs
-Recipients who are 65 and older
-Recipients who have other primary insurance that includes physician benefits
-Reside in Nursing Facility or ICF/MR
-Residents of Psychiatric facilities
-Retroactive Eligibility
-SSI recipients under the age of 19

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Behavioral Health Agency
-Department of Children and Family Services
-Education Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

CommunityCARE

LOUISIANA
CommunityCARE Program

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Enrollee Hotlines
-Performance Measures (see below for details)

Use of Collected Data:
-Fraud and Abuse
-Program Improvements

Consumer Self-Report Data:
None

Performance Measures

Process Quality:
-Adolescent well-care visits rates
-Adult well care visits
-Breast Cancer screening rate
-Cervical cancer screening rate
-Childhood Immunization Status
-Cholesterol Management for People w/cardiovascular conditions
-Cholesterol screening and management
-Lead screening rate
-Use of Appropriate Medications for People with Asthma
-Well child visits 7-11 years of life
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Adolescent access to primary care practitioners
-Adult access to preventive/ambulatory health services
-Annual dental visits
-Children's access to primary care practitioners

Use of Services/Utilization:
None

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

MAINE
MaineCare Primary Care Case Management

CONTACT INFORMATION

State Medicaid Contact:

Loretta Dutill
MaineCare Services
(207) 624-6929

State Website Address:

http://www.maine.gov/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Public Consulting Group, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:

Ambulatory Surgical Center, Certain Family Planning, Chiropractic, Clinic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatric, Speech/Language Pathology, Vision, X-Ray

Allowable PCPs:

-Ambulatory Care Clinic or Hospital Based Outpatient Clinic
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Alaska Natives and Native Americans

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations

MAINE
MaineCare Primary Care Case Management

-American Indian/Alaska Native

-Blind/Disabled Children and Related Populations
-Children Receiving Adoption Assistance
-Non Categorical Adults
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Title XXI CHIP
-Women with Breast or Cervical Cancer

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Period Less Than 3 Months
-Foster Care Children placed in state without TANF
-Individuals eligible for SSI
-Individuals on Medicaid recipient restriction program
-Katie Beckett Eligibles
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

MaineCare Primary Care Case Management

MAINE
MaineCare Primary Care Case Management

ADDITIONAL INFORMATION

Included Services: Certain family planning services and family planning are different in the sense that all family planning services are exempt when provided in a family clinic. Certain family planning services generally refers to services in other setting such as a physicians office. Clinic services may include FQHCs and RHCs.

Special Needs Children (State defined) are children who have or are at increased risk for a chronic, physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-Asthma Dx For Pediatrics
-HIV/AIDS Survey
-Pregnancy Status
-SCHIP Survey
-Smoking Status
-State-developed Survey

Performance Measures

Process Quality:
-Ace Inhibitor/ARB Therapy
-Adolescent immunization rate
-Adolescent well-care visits rates
-Appropriate testing for children with Pharyngitis
-Appropriate treatment for children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamydia screening in women
-Cholesterol screening and management
-Colorectal Cancer Screening
-Dental services
-Diabetes management/care
-HIV/AIDS care
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Adult access to preventive/ambulatory health services

Use of Services/Utilization:
-Drug Utilization

MAINE
MaineCare Primary Care Case Management

-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of dental providers to beneficiaries
-Ratio of primary care case managers to beneficiaries

-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of OB/GYN visits per adult female beneficiary
-Number of primary care case manager visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Provider Characteristics:
-Board Certification
-Languages spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM
-Pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-HIV/AIDS Prevention and/or Management
-Lead toxicity
-Otitis Media management
-Prescription drug abuse
-Prevention of Influenza
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

MINNESOTA
Minnesota Prepaid Medical Assistance Program-1932(a)

CONTACT INFORMATION

State Medicaid Contact:

David Godfrey
Minnesota Department of Human Services
(651) 431-2319

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1993

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Durable Medical Equipment, Emergency Room, EPSDT, Family Planning, Hearing, Home Health, Hospice, ICF/MR, Community-Based, IEP, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Preventive Visits, Respiratory Therapy, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Enrolled in another managed care program
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Foster Care Children

MINNESOTA
Minnesota Prepaid Medical Assistance Program-1932(a)

-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Blind and disabled recipients under age 65
-Medicare Dual Eligibles
-Non-documented alien recipients who receive only emergency MA under Minn. Stat. 256B.06(4)
-Non-institutionalized recipients eligible on spend down basis
-Recipients residing in state institutions
-Recipients with private coverage through a MCO not participating in Medicaid
-Recipients with terminal or communicable diseases at time of enrollment
-Refugee Assistance Program recipients

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-None - managed care entity provides standard prescription drug coverage

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus	Health Partners
Itasca Medical Care	Medica
Metropolitan Health Plan	PrimeWest Health System
South Country Health Alliance	UCARE

MINNESOTA
Minnesota Prepaid Medical Assistance Program-1932(a)

ADDITIONAL INFORMATION

PCP provider types are designated by MCO, not the State. County staff perform enrollment function.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Assess program results
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track access and utilization

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
    Child with Special Needs Questionnaire
-Disenrollment Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-None

MCO/HIO conducts data accuracy check(s) on specified data elements:
-None

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Adult Preventive Visits
-Antidepressant medication management

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

MINNESOTA
Minnesota Prepaid Medical Assistance Program-1932(a)

-Appropriate treatment for Children with Upper Respiratory
Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Colorectal Cancer Screening
-Dental services
-Diabetes Screening
-Immunizations for two year olds
-Mental Health Discharges
-Osteoporosis Care After Fracture
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
-Chemical Dependency Initiation or Treatment
-Mental Health Discharges
-Postpartum Visits
-Primary Care Visits 3 to 6-Year-Olds
-Well Care Visits, Adolescents
-Well Chile Visits - First 15 Months

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own
choosing

Clinical Topics:
-Aspirin Therapy
-Asthma - Reduction of Emergency Department Visits
-Asthma management
-Breast cancer screening (Mammography)
-Calcium and Vitamin C
-Cervical cancer screening (Pap Test)
-Choleserol Screening and Management
-Colon Cancer Screening
-Depression management
-Diabetes management
-Diabetic Statin Use - 40 to 75 Year Olds
-Human Papillomavirus
-Hypertension management
-Lead toxicity
-Mental Health/Chemical Dependency Dual-Diagnoses
-Obesity
-Pneumococcal Vaccine
-Sexually transmitted disease screening

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services

Standards/Accreditation

MINNESOTA
Minnesota Prepaid Medical Assistance Program-1932(a)

MCO Standards:
-NCQA (National Committee for Quality Assurance)
Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-MetaStar (QIO)
-Michigan Performance Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance
program with MCO

Program Payers:
MCOs
Medicaid has collaborated with a public sector entity to
support the P4P program

Population Categories Included:
A subset of MCO members, defined by disease and
medical condition

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Cardiac Care
Diabetes

Measurement of Improved Performance:
Assessing improvements in, or reaching established
standards in, administrative processes (e.g., timeliness
of MCO response to grievances, improving customer
service, etc.)
Using clinically-based outcome measures (e.g., HEDIS,
NQF, etc.)

Initial Year of Reward:
1999

Evaluation Component:
The State HAS NOT conducted an evaluation of the
effectiveness of its P4P program

Member Incentives:
Not Applicable

MISSISSIPPI
MississippiCAN

CONTACT INFORMATION

State Medicaid Contact:

Phyllis Williams
Division of Medicaid
(601) 359-5244

State Website Address:

www.medicaid.ms.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 2011

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Laboratory, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
None

MISSISSIPPI
MississippiCAN

-Breast and Cervical Cancer Group
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Magnolia Health Plan   United HealthCare

ADDITIONAL INFORMATION

MississippiCAN is a statewide Medicaid coordinated care program. The program It is limited to no more than 15% of the entire Medicaid population. Currently, beneficiaries in the following categories of eligibility are eligible to participate: SSI, Disabled Child Living at Home, Working Disabled, Department of Human Services Foster Care, and Breast/Cervical Cancer Group. There are exclusions to this program. Beneficiaries in these categories of eligibility cannot participate if they are locked-in to any waiver program, dual eligible (Medicare/Medicaid), and those who at the time of application are institutionalized (i.e., Nursing Facility, ICF-MR, Correctional Facility, etc.). The program is voluntary and there is an annual open enrollment period.

The Mississippi Division of Medicaid has contracted with Magnolia Health Plan and United HealthCare to provide services to Medicaid beneficiaries enrolled in MississippiCAN. These health plans must provide, at a minimum, the same comprehensive services as Medicaid, with the exception of inpatient hospital services, mental health services and non-emergency transportation which are carved out of the program and covered by Medicaid. Both Magnolia and United offer additional benefits, i.e., additional office visits, additional prescriptions, etc. Both are required to have disease management programs which include, but are not limited to, diabetes, asthma, hypertension, organ transplants, obesity, hemophilia and congestive heart disease.

MISSISSIPPI
MississippiCAN

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Focused Studies
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Does Not Use the Data Collected

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

MISSISSIPPI
MississippiCAN

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Children's access to primary care practitioners

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards
-URAC Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Not Applicable

EQRO Organization:
-No EQRO Organization

EQRO Mandatory Activities:
-Not Applicable

EQRO Optional Activities:
None

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

MISSISSIPPI
MississippiCAN

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

CONTACT INFORMATION

State Medicaid Contact:

Heather Leschinsky
Nebraska Medicaid
(402) 471-9337

State Website Address:

http://www.dhhs.state.ne.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Medicaid Enrollment Center

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Clients Participating in the State Disability Program
-Clients Participating in the Subsidized Adoption Program
-Clients Receiving Medicaid Hospice Services
-Clients with Excess Income
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Presumptive Eligibility
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (State defined)
-Transplant Recipients

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Title V Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coventry Nebraska   Share Advantage

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Fraud and Abuse
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-CAHPS
   Adult Medicaid AFDC Questionnaire

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Immunizations for two year olds
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
None

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Childhood Immunization
-Diabetes management
-Pediatric Obesity
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
-Department of Insurance Certification
-NCQA (National Committee for Quality Assurance)
-URAC

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)
-URAC

EQRO Name:
-Island Peer Review Organization (IPRO)

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
None

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

NEBRASKA
Nebraska Medicaid Medical Home Pilot

CONTACT INFORMATION

State Medicaid Contact:

Pat Taft
Medicaid and Long-Term Care
402-471-9247

State Website Address:

http://dhhs.ne.gov/medicaid/Pages/med_pilot_index.

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
February 01, 2011

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Primary Care Case Management Fee

Service Delivery

Included Services:
Case Management

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaskan Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Populations Mandatorily Enrolled:
None

NEBRASKA
Nebraska Medicaid Medical Home Pilot

-Special Needs Children (State defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Retroactive Eligibility

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Nebraska Medicaid Medical Home Pilot

ADDITIONAL INFORMATION

Children under 19 years of age who are-1) Eligible for SSI under title XVI; 2) In foster care or other out-of-state home placement; 3) Receiving foster care or adoption assistance; or 4) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Provider Data

Use of Collected Data:
-Program Evaluation

Consumer Self-Report Data:
-State-developed Survey

NEVADA
Mandatory Health Maintenance Program

CONTACT INFORMATION

State Medicaid Contact:

Tom Sargent
Division of Health Care Financing and Policy
(775) 684-3698

State Website Address:

http://www.nv.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 31, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Ambulatory Surgery Center, Case Management, Certified Registered Nurse Practitioner, Chiropractic, Dental, Disposable Medical Supplies, Durable Medical Equipment, End Stage Renal Disease Facilities, EPSDT, Family Planning, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Intravenous Therapy, Laboratory, Medical Rehabilitation Center, Mental Health Rehabilitative, Noninvasive Diagnostic Centers, Nurse Anesthetist, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Personal Care Aide, Pharmacy, Physical Therapy, Physician, Physician Assistants, Podiatry, Prosthetics, Pyschologist, Radiology, Residential Treatment Center, Respiratory Therapy, Rural Health Clinics, Skilled Nursing Facility, Special Clinics, Speech Therapy, Swing Beds, Transitional Rehabilitative Center, Transportation, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Obstetricians/Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

NEVADA
Mandatory Health Maintenance Program

Enrollment

Populations Voluntarily Enrolled:

-American Indian
-Seriously Mentally Ill Adults
-Severely Emotionally Disturbed Children
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Residents in Nursing Facilities beyond 45 Days

Medicare Dual Eligibles Included:

None

Populations Mandatorily Enrolled:

-Child Health Assurance Program (CHAP)
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Excluded:

Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Community Care   Health Plan of Nevada

ADDITIONAL INFORMATION

NEVADA
Mandatory Health Maintenance Program

Temporary Assistance for Needy Families/Child Health Assurance Program is included in the Mandatory Program. Severely Emotionally Disturbed Children, Seriously Mentally Ill Adults, Children with Special Health Care Needs and American Indians are provided voluntary enrollment and/or disenrollment at any time.

Transportation is included but for emergency only.

Special Needs Children (State defined) is any child with a parent that deems them to have a special need.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-State's Quality Assessment and Performance Improvement Strategy and Work Plan

Use of Collected Data:
-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for

NEVADA
Mandatory Health Maintenance Program

submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Check-ups after delivery
-Dental services
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Mental Health Utilization
-Percentage of beneficiaries receiving inpatient, day/night care and ambulatory service
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Screening for Human Immunodeficiency Virus
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Blood Lead Screening
-Diabetes
-Improving Immunization Rates

Access/Availability of Care:
-Children's access to primary care practitioners

Use of Services/Utilization:
-Avoilable emergency room visits
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

NEVADA
Mandatory Health Maintenance Program

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Childhood Immunization
-Decreasing avoidable emergency ER visits
-Diabetes management
-Lead toxicity

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Assessment of MCO information systems
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-FFS HEDIS Rates
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by beneficiary age
A subset of MCO members, defined by disease and medical condition

Rewards Model:
Payment incentives/differentials to reward MCOs

NEVADA
Mandatory Health Maintenance Program

Clinical Conditions:
Annual Dental Visits
Childhood immunizations
Well-child visits

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2006

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

NEW JERSEY
NJ FamilyCare - 1932(a)

CONTACT INFORMATION

State Medicaid Contact:

Karen Brodsky
Office of Managed Health Care
(609) 588-2705

State Website Address:

http://www.state.nj.us/humanservices/dmahs/index.h

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Affiliated Computer Services, Incorporated (ACS)

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Assistive Technology, Audiology, Chiropractic, Dental, Durable Medical Equipment, Emergency Medical Care, EPSDT, Family Planning, Hearing Aid, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medical Day Care, Medical Supplies, Optical Appliances, Optometrist, Organ Transplants, Outpatient Hospital, Outpatient Mental Health, Outpatient Rehabilitation Therapies, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physician, Podiatrist, Post-acute care, Preventive Health Care and Counseling and Health Promotion, Prosthetics, Orthotics, Rehabilitation and Specialty Hospitals, Transportation, Vision, X-Ray

Allowable PCPs:
-Certified Nurse Specialists
-Family Practitioners
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants

Enrollment

NEW JERSEY
NJ FamilyCare - 1932(a)

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Foster Care Children
-Non-dual DDD/CCW Adults
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-American Indian/Alaskan Native
-Enrolled in Another Managed Care Program
-Institutionalized in inpatient psychiatric facility
-Medically needy and presumptive eligibility beneficiaries
-Medicare Dual Eligibles
-Participate in HCBS Waiver except for CCW
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus

Medicare Dual Eligibles Excluded:
SLMB Plus
Medicaid-only
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Self-Referral
-Surveys medical needs of enrollee to identify members of these groups
-Use of Data Mining
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Developmental Disabilities Agency
-Division of Youth and Family Services Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMERIGROUP New Jersey, Inc.

Healthfirst Health Plan of New Jersey, Inc.

Horizon NJ Health

UnitedHealthCare Community Plan

NEW JERSEY
NJ FamilyCare - 1932(a)

ADDITIONAL INFORMATION

Lock-in Period: 12 month lock-in is for AFDC/TANF, Title XXI population, and SSI, Aged, Blind, Disabled, DDD or DYFS populations. Populations Excluded: Those that participate in HCBS Waiver except DDD/CCW non-duals.   Phamacy services are for Blind/Disabled Adults and Children.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Appointment Availability Studies
-Care Management
-Consumer Self-Report Data (see below for details)
-Data Analysis
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Geographic Mapping
-Independent Assessment
-MCO Marketing Material Approval Requirement
-Medical and Dental Provider Spot Checks
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Utilization Review

Use of Collected Data:
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
    Child Medicaid AFDC Questionnaire
-Disenrollment Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

NEW JERSEY
NJ FamilyCare - 1932(a)

-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Reported Changes of Reasonable and Custormary Fees

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-BMI Assessment for Children/Adolescents
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Childhood Immunizations
-Chlamdyia screening in women
-Comprehensive Diabetes Care
-Follow-up after hospitalization for mental illness
-Followup Care fr Children Prescribed ADHD Medication (Initial Phase Only)
-Frequency of Ongoing Prenatal Care
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Prenatal and Postpartum Care
-Quality and utilization of dental services
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Children with Special Needs Focused Study including DYFS Children
-EPSDT Quality Study/Dental and Lead

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries
-Ratio of pharmacies to number of beneficiaries

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Percentage of children who received one or more visits with a PCP during the measurement year
-Percentage of enrollees who receive appropriate immunizations
-Percentage of enrollees who received a blood lead test
-Percentage of enrollees who received one or more dental services during the measurement year
-Percentage of enrollees with one or more emergency room visit
-Percentage of enrollees with one or more inpatient admissions
-Pharmacy services/per beneficiaries
-Physician visits/per 1,000 beneficiaries

NEW JERSEY
NJ FamilyCare - 1932(a)

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient,
ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs

Performance Measures - Others:
-EPSDT Performance
-Lead Screening

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are
required to conduct a common performance improvement
project(s) prescribed by State Medicaid agency

Clinical Topics:
-Adolescent Well Care/EPSDT
-Birth Outcomes
-Child/Adolescent Dental Screening and Services
-Lead Screenings
-Postnatal care
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics:

-Children's access to primary care practitioners
-Encounter Data Improvement
-Health information technology (e.g. state implementation of
immunization and other registries, telemedicine initiatives,
etc…)

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care
(QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation:
-Department of Banking and Insurance

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization (IPRO)

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures
-Conduct studies on access that focus on a particular aspect of
clinical and non-clinical services
-Conduct studies on quality that focus on a particular aspect of
clinical or non-clinical services
-Medical Record Review
-Technical Assistance to MCOs to assist them in conducting
quality improvement activities

NEW JERSEY
NJ FamilyCare - 1932(a)

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Member Incentives:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

NORTH CAROLINA
Carolina ACCESS

CONTACT INFORMATION

State Medicaid Contact:

Betty West
Division of Medical Assistance
(919) 855-4784

State Website Address:

http://www.ncdhhs.gov/dma/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1991

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Dialysis, Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Private Duty Nursing, Speech Therapy, X-Ray

Allowable PCPs:
-Community Health Centers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Health Clinics
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Public Health Departments
-Rural Health Centers (RHCs)

Enrollment

NORTH CAROLINA
Carolina ACCESS

Populations Voluntarily Enrolled:

-Aged and Related Populations
-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Special Needs Children (BBA defined)

Populations Mandatorily Enrolled:

-Blind/Disabled Adults and Related Populations
-Qualified Aliens
-Section 1931 Adults and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise
Included Populations:**

-Any Recipient Currently Under a Deductible
-Eligibility Period that is only Retroactive
-MAF-D Family Planning Waiver Program
-MAF-W Breast and Cervical Cancer Control Program
-Medicare Dual Eligibles
-Refugees
-Reside in Nursing Facility or ICF/MR
-SAA Special Assistance to the Aged

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

Medicaid-only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI
QMB Plus
SLMB Plus

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid
Managed Care Contracts:**
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex
(Special) Needs:**
Yes

**Strategies Used to Identify Persons with
Complex (Special) Needs:**

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these
groups
-Uses provider referrals to identify members of these
groups

**Agencies with which Medicaid Coordinates the
Operation of the Program:**

-Aging Agency
-Community Care of North Carolina Networks
-Division of Mental Health
-Maternal and Child Health Agency
-Office of Rural Health and Community Care
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carolina Access

NORTH CAROLINA
Carolina ACCESS

ADDITIONAL INFORMATION

The recipient must choose and enroll with or be assigned to a primary care provider who is paid a monthly case management fee of $1.00 for each enrollee in addition to regular fee for service payments. Hearing services do not include hearing aids for recipients age 21 years and above.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
     Adult Medicaid AFDC Questionnaire
     Child Medicaid AFDC Questionnaire

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
None

Provider Characteristics:
-Board Certification
-Languages spoken (other than English)

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Measures - Others:
-Afterhours
-Enrollment
-Overrides

Performance Improvement Projects

Clinical Topics:
None

Non-Clinical Topics:
None

NORTH CAROLINA
Community Care of North Carolina (ACCESS II/III)

CONTACT INFORMATION

State Medicaid Contact:

Betty West
Community Care of NC
(919) 855-4784

State Website Address:

http://www.ncdhhs.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Dental, Dialysis, Disease Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Personal Care, Pharmacy, Physical Therapy, Physician, Private Duty Nursing, Speech Therapy, Vision, X-Ray

Allowable PCPs:
-Community Health Centers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Health Clinics
-Health Departments
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

Enrollment

NORTH CAROLINA
Community Care of North Carolina (ACCESS II/III)

Populations Voluntarily Enrolled:

-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-QMB Plus
-SLMB Plus
-Special Needs Children (BBA defined)

Subpopulations Excluded from Otherwise Included Populations:

-Any Recipient Currently Under a Deductible
-Eligibillity Period that is only Retroactive
-MAF-D Medicaid Family Planning Waiver Program
-MAF-W Breast and Cervical Cancer Control Program
-Medicare Dual Eligibles
-Refugees
-Reside in Nursing Facility or ICF/MR
-SAA Special Assistance to the Aged

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Qualified Aliens
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses health assessment forms and claims data to identify members
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Community Care of North Carolina Networks
-Division of Mental Health
-Maternal and Child Health Agency
-North Carolina Community Care Networks, Inc
-Office of Rural Health and Community Care
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care of North Carolina (Access II/III)

NORTH CAROLINA
Community Care of North Carolina (ACCESS II/III)

ADDITIONAL INFORMATION

An Administrative Entity is paid an additional PCCM case management fee of at least $3.72 per recipient participating in Access II/III to monitor care and implement disease management initiatives and target preventive studies. ACCESS II/III manages the highest risk Medicaid enrollees to improve coordination and continuity of care. Hearing services do not include hearing aids for recipients age 21 years and older.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
-Consumer/beneficiary Focus Groups

Performance Measures

Process Quality:
-Adolescent well-care visits rates
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Colon Cancer screening rates
-Controlling high blood pressure
-Depression medication management
-Diabetes management/care
-Hearing services for individuals less than 21 years of age
-Heart Failure care
-Influenza vaccination rate
-Percentage of beneficiaries with at least one dental visit
-primary cesarean section rates among term patients with a singleton, vertex fetus
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Asthma Emergency Department Visit Rates
-Asthma Inpatient Rates
-Congestive Heart Failure
-Diabetes eye exams
-ED & Hospitalization Rates
-HbA1C Testing
-Patient satisfaction with care
-Percentage of low birth weight infants
-Preventable Hospital Readmissions

Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary only Aged, Blind, Disabled population
-Drug Utilization
-Emergency room visits/1,000 beneficiaries

NORTH CAROLINA
Community Care of North Carolina (ACCESS II/III)

-Ratio of primary care case managers to beneficiaries

-Inpatient admission for MH/SUD conditions per 100 members/month for Aged, Blind, Disabled population
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Inpatient Readmission
-Inpatient Stays
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries under 21 with at least one dental visit

Provider Characteristics:
-Best Practices for Asthma and Diabetes
-Best Practices for Heart Failure/Cardiovascular disease
-Board Certification
-Languages spoken (other than English)

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of enrollees with chronic illnesses, asthma, diabetes, CHF and COPD

Performance Measures - Others:
None

Performance Improvement Projects

Clinical Topics:
-Adolescent Well Care/EPSDT
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Cariovascular Disease Management
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Cholesterol screening and management
-Colorectal Cancer Screening
-Coordination of primary and behavioral health care
-Depression management
-Developmental Screening
-Diabetes management
-Emergency Room service utilization
-Hospital Discharge Planning
-Hypertension management
-Low birth weight baby
-Palliative Care
-Pharmacy management
-Post natal care
-Pre-natal care
-Prevention of Influenza
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners
-Health Information Technology
-Practice Readiness for Quality Improvement
-Reducing health care disparities

NORTH DAKOTA
North Dakota Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

Eric Elkins
Department of Human Services Medical Services Division
(800) 755-2604

State Website Address:

http://www.nd.gov/dhs

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
Continuous eligibility for children under age 19

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Primary Care Case Management Fee

Service Delivery

Included Services:
Ambulatory Surgical Centers, Chemical Dependency, Chiropractic, Dental, Durable Medical Equipment, Emergency Follow Up Care, EPSDT, Family Planning, Follow Up/Post Stabilization Care, Hearing, Home Health, Hospice, Immunization, Inpatient Admissions, Inpatient Hospital, Inpatient Mental Health, Institutional, Laboratory, Mid-level Practitioner, Nutritional, Observation/Hospital, Occupational Therapy, Oral Surgery, Outpatient Hospital, Outpatient Mental Health, Partial Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Private Duty Nursing, Prosthetic Devices, Radiology, Reconstructive Surgery, Rehabilitation Hospital, Skilled Nursing Facility, Speciality Care Physician, Speech Therapy, Transportation, Urgent Care/After Hours, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Rural Health Centers (RHCs)

Enrollment

NORTH DAKOTA
North Dakota Medicaid Managed Care Program

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-American Indian/Alaska Native
-Medically Needy
-Optional Categorically Needy
-Poverty Level
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Transitional Medicaid

Subpopulations Excluded from Otherwise Included Populations:
-Adoption Assistance
-Aged
-Blind
-Disabled
-Eligiblity Period that is only Retroactive
-Enrolled in Another Managed Care Program
-Enrolled in CDC BCCT Program
-Foster Care
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Refugee Assistance
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Primary Care Case Management

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Focused Studies
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Fraud and Abuse
-Health Services Research

-Program Evaluation
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data:

-State-developed Survey

OHIO
State Plan Amendment for Ohio's full-risk managed care program

CONTACT INFORMATION

State Medicaid Contact:

John McCarthy
Ohio Department of Job and Family Services
(614) 466-4443

State Website Address:

http://jfs.ohio.gov/OHP/index.stm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health Systems, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 2005

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Care Management, Certified Family Nurse Practitioner, Certified Pediatric Nurse Practitioner, Chiropractic, Dental, Developmental Therapy, Durable Medical Equipment, EPSDT, Family Planning, FQHC, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Podiatry, Prescription Drugs Administered In A Provider Setting, Private Duty Nurse, RHC, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Clinical Nurse Specialists
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

OHIO
State Plan Amendment for Ohio's full-risk managed care program

-American Indian/Alaska Native
-Foster Care Children

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Enrolled in CDC BCCT Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Care management identification and assessment
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups
-Uses self referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-National Alliance on Mental Illness
-Ohio Academy of Family Physicians
-Ohio Association of Community Healthcenters
-Ohio Association of County Behavioral Health Authorities
-Ohio Association of Health Plans
-Ohio Chapter of the American Academy of Pediatrics
-Ohio Childrens Hospital Association
-Ohio Council of Behavioral Healthcare Providers
-Ohio County Departments of Job and Family Services
-Ohio Hospital Association
-Ohio Psychological Association
-Ohio State Medical Association
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agencies

OHIO
State Plan Amendment for Ohio's full-risk managed care program

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Ohio

CareSource

Paramount Advantage

WellCare of Ohio

Buckeye Community Health Plan

Molina Healthcare of Ohio

United Healthcare Community Plan of Ohio

ADDITIONAL INFORMATION

Regarding Program Service Area:
Services are provided in all eighty-eight Ohio counties which are divided into eight regions.

Regarding Included Services:
Between February 1, 2010 and September 30, 2011, pharmacy benefits (specified prescribed drugs and certain medical supplies) for MCP enrollees were carved out of the risk-based managed care program. During this time, MCP enrollees accessed the carved-out pharmacy benefits through the Medicaid fee-for-service delivery system. However, pharmaceuticals administered in certain provider settings continued to be provided by MCPs.

Services provided in a nursing facility are covered by MCPs only when they are provided for short-term stays up to 62 days.

Mental health and substance abuse services are covered through the MCP when a member is unable or unwilling to access such services through the Ohio Department of Mental Health (ODMH) community mental health centers and Ohio Department of Alcohol and Drug Abuse Services (ODADAS) certified Medicaid providers.

Transportation services include ambulance and ambulette services.

Regarding State Quality Assessment and Improvement Activities:
On July 1, 2011, Ohio required contracting MCPs to be NCQA accredited by July 1, 2014.

Regarding Managed Care Entity Name:
Unison Health Plan of Ohio changed their name to United Healthcare Community Plan of Ohio effective April 1, 2011.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Care management
-Consumer complaints and grievances
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Non-compliance penalties
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Pay 4 performance (P4P) program
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider complaints
-Provider Data
-State hearings

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Health Services Research
-Monitor Quality Improvement
-Performance Incentive System Determination
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-State Medicaid Managed Care Quality Strategy
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS

Child Medicaid AFDC Questionnaire
Child with Special Needs Questionnaire
-State-developed Survey

measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Actuarial reviews
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Encounter Data Testing
-EQRO accuracy studies
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-ISCAT (EQRO), as needed
-Requirements for data validation
-Requirements for MCO data certification
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Certification Letters for Encounter Data Submissions
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Delivery Payment Submission Specifications
-Encounters to be submitted based upon national standardized forms (e.g., UB-92, NCPDP, NSF)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Payment data submission specifications
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92, electronic media claims 4.0

Validation - Methods:
-Actuarial review
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-EQRO studies
-ISCAT (EQRO), as needed
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Type of Provider, Specialty Code

State conducts general data completeness assessments:
Yes

OHIO
State Plan Amendment for Ohio's full-risk managed care program

Performance Measures

Process Quality:
-Adolescent well-care visit rates
-Antidepressant medication management
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Care management of high-risk members
-Care management of members
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Heart Attack care
-Heart Failure care
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Spirometry testing in the assessment and diagnosis of COPD
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Emergency hospital discharge rates, inpatient hospital discharge rates, and inpatient hospital readmission rates, for chronic disease conditions
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Provider Panel Requirements for PCP Capacity and Provider Type, by Region and County

Use of Services/Utilization:
-Adult preventive care visit rates
-Ancillary services/1,000 member months
-Behavioral health services/1,000 member months
-Care management of high-risk members
-Care management of members
-Child primary care visit rates
-Dental visits/1,000 member months
-Drug Utilization
-Durable medical equipment/supply services/1,000 member months
-Emergency department utilization rates for chronic disease conditions
-Emergency room visits/1,000 member months
-Follow up after hospitalization for mental illness
-Initiation and engagement of AOD treatment
-Inpatient discharges/1,000 member months
-Inpatient hospital discharge rates for chronic disease conditions
-Inpatient hospital readmission rates for chronic disease conditions
-Maternity/deliveries/1,000 member months
-Percentage of beneficiaries with at least one dental visit
-Perinatal care visit rates
-Pharmacy prescriptions/1,000 member months
-Primary care visits/1,000 member months
-Vision visits/1,000 member months
-Well child visit rates

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Administrative Expense Ratio
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Overall Expense Ratio

Health Plan/ Provider Characteristics:
-Provider Panel by specialty and service area and capacity

OHIO
State Plan Amendment for Ohio's full-risk managed care program

-Prompt payment requirements
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Members with special health care needs
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for
women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are
required to conduct a common performance improvement
project(s) prescribed by State Medicaid agency

Clinical Topics:
-Adolescent Well Care/EPSDT
-Diabetes management
-Well Child Care/EPSDT

Non-Clinical Topics:

-Timely identification, assessment, and care management for
members with special health care needs

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance)
Standards
-State-Developed/Specified Standards
-URAC Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)
-URAC

EQRO Name:
-Health Services Advisory Group

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Technical assistance to MCOs to assist them in conducting
quality activities
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance
program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by beneficiary age

Rewards Model:
Payment incentives/differentials to reward MCOs

OHIO
State Plan Amendment for Ohio's full-risk managed care program

A subset of MCO members, defined by disease and medical condition
Covers all MCO members

Preferential auto-enrollment to reward MCOs
The state takes back premiums at risk should an MCP fail to meet P4P standards.

Clinical Conditions:

Adult preventive care visits
Asthma
Cardiac Care
Care management of high-risk members
Child preventive care visits
Dental care
Diabetes
Inpatient hospital discharge rate (chronic conditions composite)
Lead screening
Mental health
Perinatal Care
Well-child visits

Measurement of Improved Performance:

Assessing achievement in access to care
Assessing improvement in care management of high risk members over time
Assessing improvement in clinical quality (by condition) overtime
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:

2002

Evaluation Component:

The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

Member Incentives:

Not Applicable

SOUTH CAROLINA
Health Maintenance Organization (HMO)

CONTACT INFORMATION

State Medicaid Contact:

Jennifer Campbell
Managed Care
(803) 898-2593

State Website Address:

http://www.scdhhs.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
August 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Alcohol and Drug Screening, Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Interactive Psychiatric Interview Exam with other Mechanisms of Communication, Laboratory, Outpatient Hospital, Pharmacy, Physical Exam through the SC Department of Alcohol and other Drug Abuse, Physician, Psychiatric Diagnostic Interview Exam, Skilled Nursing Facility, Transportation, X-Ray

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

SOUTH CAROLINA
Health Maintenance Organization (HMO)

Subpopulations Excluded from Otherwise Included Populations:

-Age 65 Or Older
-Enrolled In An HMO Through Third Party Coverage
-Hospice Recipients
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
9 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Family Connections
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Absolute Total Care

First Choice by Select Health of South Carolina, Inc.

BlueChoice Health Plan

United HealthCare of SC

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

SOUTH CAROLINA
Health Maintenance Organization (HMO)

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State generates from encounter data ALL of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-NSF (National Standard Format)
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Date of Admission Invalid
-Date of Discharge Invalid
-Dollar amount billed not greater than zero

State conducts general data completeness assessments:
Yes

SOUTH CAROLINA
Health Maintenance Organization (HMO)

-Drug Quantity Units not greater than zero
-Invalid Drug Unit Type
-Prescribing Provider Number Not on File
-Submitting Provider Not on File

Performance Measures

Process Quality:
-Ace Inhibitor/ARB Therapy
-Adolescent immunization rate
-Adolescent well-care visit rate
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Heart Attack care
-Heart Failure care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-State minimum reserve requirements

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

SOUTH CAROLINA
Health Maintenance Organization (HMO)

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

-(Newborn) Failure to thrive
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Coronary artery disease prevention
-Depression management
-Diabetes management
-Emergency Room service utilization
-Hypertension management
-Inpatient maternity care and discharge planning
-Lead toxicity
-Low birth-weight baby
-Otitis Media management
-Pharmacy management
-Post-natal Care
-Pregnancy Prevention
-Pre-natal care
-Prescription drug abuse
-Sickle cell anemia management
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics:

None

Standards/Accreditation

MCO Standards:

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards
-URAC Standards

Accreditation Required for Participation:

-AAAHC (Accreditation Association for Ambulatory Health Care)
-NCQA (National Committee for Quality Assurance)
-URAC

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Carolinas Center for Medical Excellence

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Assessment of MCO information systems
-Calculation of performance measures
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

SOUTH CAROLINA
Health Maintenance Organization (HMO)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Member Incentives:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

SOUTH CAROLINA
Medical Homes Network

CONTACT INFORMATION

State Medicaid Contact:

Jennifer Campbell
Managed Care
(803) 898-2593

State Website Address:

http://www.scdhhs.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaskan Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
None

SOUTH CAROLINA
Medical Homes Network

-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agencies
-Developmental Disabilities Agency
-Educational Agencies
-Family Connections
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carolina Medical Homes
South Carolina Solutions

Palmetto Physician Connections

ADDITIONAL INFORMATION

Children with special health care needs are those who have a chronic physical, developmental, behavioral, or emotional condition and

SOUTH CAROLINA
Medical Homes Network

who also require heatlh and related services of a type or amount beyond that required by children generally.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
None

Performance Measures

Process Quality:
-Ace Inhibitor/ARB Therapy
-Adolescent immunization rate
-Adolescent well-care visits rates
-Appropriate testing for children with Pharyngitis
-Appropriate treatment for children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia screening in women
-Cholesterol screening and management
-Colorectal Cancer Screening
-Controlling high blood pressure
-Dental services
-Depression medication management
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Provider Characteristics:
-Board Certification
-Languages spoken (other than English)

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-Weeks of pregnancy at time of enrollment in PCCM, for women

-Provider turnover   giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

Clinical Topics: **Non-Clinical Topics:**
-Asthma management   None
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-Low birth-weight baby
-Pharmacy management
-Post-natal Care

SOUTH DAKOTA
PRIME

CONTACT INFORMATION

State Medicaid Contact:

Valerie Osterkamp
Office of Medical Services
(605) 773-3495

State Website Address:

http://dss.sd.gov/sdmedx/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 1993

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Laboratory, Opthalmology, Outpatient Hospital, Outpatient Mental Health, Physician, Residential Treatment Centers, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

SOUTH DAKOTA
PRIME

-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (BBA defined)

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Provider contacts - Medically fragile protocol
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

PRIME

ADDITIONAL INFORMATION

None

TEXAS
PCCM

CONTACT INFORMATION

State Medicaid Contact:

Joseph Vesowate
Texas Health and Human Services Commission
(512) 491-1379

State Website Address:

http://www.hhsc.state.tx.us/medicaid/care_case_pro

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 2005

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
-Aged and Related Populations

TEXAS
PCCM

-Blind/Disabled Adults and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

PCCM

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance

TEXAS
PCCM

-Focused Studies
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

-Fraud and Abuse
-Monitor Quality Improvement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Child Medicaid AFDC Questionnaire

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Controlling high blood pressure
-Dental services
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of OB/GYN visits per adult female beneficiary

Provider Characteristics:
-Board Certification
-Languages spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization

Non-Clinical Topics:
-Children's access to primary care practitioners

-Hypertension management
-Newborn screening for heritable diseases
-Pre-natal care
-Well Child Care/EPSDT

WASHINGTON
Chronic Care Management Program (CCMP)

CONTACT INFORMATION

State Medicaid Contact:

Barbara Lantz
Health Care Authority
(360) 725-1640

State Website Address:

http://www.hca.wa.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 2007

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

Disease Management PAHP - Risk-based Capitation

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-TANF

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

WASHINGTON
Chronic Care Management Program (CCMP)

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Housing Agencies
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

City of Seattle Human Services

Cowlitz County Guidance Association

ADDITIONAL INFORMATION

Chronic Care Management program provides disease management services to clients who are categorically needy, aged, blind and disabled and who receive Medicaid and other services through fee-for-service system. The program provides intensive educational services, coordination with other needed services and assistance in accessing care.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Monitoring of PAHP Standards
-On-Site Reviews
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

WASHINGTON
Chronic Care Management Program (CCMP)

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid SSI Questionnaire
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries satisfied with their ability to obtain care and self-manage care

Access/Availability of Care:
None

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Hospitalizations/1,000 benificiaries

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to PAHPs

Performance Measures - Others:
None

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

WASHINGTON
Healthy Options

CONTACT INFORMATION

State Medicaid Contact:

Michael Paulson
Division of Health Care Services/Health Care Authority
(360) 725-1641

State Website Address:

www.hca.wa.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility months guaranteed
eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 2002

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable
Granted:**
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT,
Family Planning, Home Health, Hospice, Immunization,
Inpatient Hospital, Laboratory, Outpatient Hospital,
Pharmacy, Physician, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Special Needs Children (State defined)

Populations Mandatorily Enrolled:
-Optional Children

WASHINGTON
Healthy Options

-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Aged, Blind and Disabled SSI Related Programs
-Enrolled in Another Managed Care Program
-Foster Care/Adoption Support Children Programs
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Obtains an electronic listing from Department of Health, a separate agency
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Asuris Northwest Health

Columbia United
Providers

Community Health
Plan

Group Health
Cooperative

Kaiser Foundation Health Plan

Molina
Healthcare

Regence Blue Shield

WASHINGTON
Healthy Options

ADDITIONAL INFORMATION

Children with special health care needs are those who have are at increased rish for a chronic, physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Conduct Performance Improvements Projects
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

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Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Use of Medicaid Identification Number for beneficiaries
-Use of Medicaid Provider Identification Numbers for providers

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service

State conducts general data completeness assessments:
Yes

WASHINGTON
Healthy Options

-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Diabetes medication management
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-HbA1c Controll

Access/Availability of Care:
-Prenatal/postpartum measures

Use of Services/Utilization:
-Ambulatory Care Utilization
-Inpatient Acute Care Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient Non-acute Care Utilization
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own
choosing
-All MCOs participating in the managed care program are
required to conduct a common performance improvement
project(s) prescribed by State Medicaid agency

Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Childhood Immunization
-Depression management
-Diabetes management
-Emergency Room service utilization
-Obesity management
-Well Child Care/EPSDT
-Well Infant Care/EPSDT

Non-Clinical Topics:
-Access to Care
-Customer Service
-Reducing health care disparities via health literacy,
education campaigns, or other initiatives

Standards/Accreditation

MCO Standards:
-BBA Protocols Supplemented with NCQA Standards

Accreditation Required for Participation:
None

WASHINGTON
Healthy Options

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Acumentra (formerly known as OMPRO)
-Qualis Health

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance measures

EQRO Optional Activities:
-Conduct of performance improvement projects

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by beneficiary age

Rewards Model:
Withholds as an incentive

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
Not Applicable

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

WASHINGTON
Washington Medicaid Integration Partnership (WMIP)

CONTACT INFORMATION

State Medicaid Contact:

Michael Paulson
Health Care Authority
(360) 725-1641

State Website Address:

http://www.dshs.wa.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 2005

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Disease Management, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Longterm Care, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

WASHINGTON
Washington Medicaid Integration Partnership (WMIP)

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles
-Poverty Level Pregnant Woman
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-TANF

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Benzodiazepines
-Nonprescription drugs

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Housing Agencies
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Molina Healthcare (WMIP)

ADDITIONAL INFORMATION

The state contracts with Molina Healthcare of Washington to provide an integrated managed care program that covers a full scope of medical services, long-term care, inpatient, and outpatient mental health and chemical dependency services. The program includes an intensive care management component to assist enrollees with multiple health needs to access needed services.

QUALITY ACTIVITIES FOR MCO/HIO

WASHINGTON
Washington Medicaid Integration Partnership (WMIP)

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Medical Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire with Suplemental Questions

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Required use of Medicaid Provider Identification numbers for service providers
-Use of Provider Identification Numbers for providers

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Antidepressant medication management
-Follow-up after hospitalization for mental illness
-Initiation and engagement of SUD treatment

Health Status/Outcomes Quality:
-Comprehensive Diabetes Care

WASHINGTON
Washington Medicaid Integration Partnership (WMIP)

-Use of High-Risk Medications in the Elderly

Access/Availability of Care:
-Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate

Performance Measures - Others:
-Effectiveness of Care
-Experience of Care

Performance Improvement Projects

Project Requirements:
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Increasing depression assessments
-Increasing Influenza vaccine participation

Non-Clinical Topics:
-Improve the rate of completion of Documented Care Plans.
-Increasing successful initial contacts between WMIP members and Care Coordination Team

Standards/Accreditation

MCO Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Acumentra formerly known as OMPRO

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance measures

EQRO Optional Activities:
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

WASHINGTON
Washington Medicaid Integration Partnership (WMIP)

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

WISCONSIN
BadgerCare Plus

CONTACT INFORMATION

State Medicaid Contact:

Brett Davis
Division of Health Care Access and Accountability
(608) 266-8922

State Website Address:

http://dhs.wisconsin.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health Systems

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
February 01, 2008

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Obstetricians/Gynecologists
-Pediatricians
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

WISCONSIN
BadgerCare Plus

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-Enrolled in Another Managed Care Program
-Foster Care Children
-Medicare Dual Eligibles
-Migrant workers
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Residents residing in FFS counties
-Special Needs Children (BBA defined)

Lock-In Provision:

9 month lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Outreach and Access
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency (County departments)
-Mental Health Agency (County departments)
-Public Health Agency (County departments)
-Social Services Agency (County departments)
-Substance Abuse Agency (County departments)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Children's Community Health Plan - Medicaid HMO

CommunityConnect Health Plan - Medicaid HMO

Compcare -- Medicaid HMO

Dean Health Plan -- Medicaid HMO

Group Health Cooperative Of Eau Claire -- Medicaid HMO

Group Health Cooperative Of South Central WI -- Medicaid HMO

Gundersen Lutheran Health Plan - Medicaid HMO

Health Tradition Health Plan -- Medicaid HMO

Independent Care (iCare) - Medicaid HMO

Managed Health Services -- Medicaid HMO

MercyCare Insurance Company -- Medicaid HMO

Molina Health Plan -- Medicaid HMO

Network Health Plan -- Medicaid HMO

Physicians Plus Health Plan - Medicaid HMO

Security Health Plan -- Medicaid HMO

UnitedHealthcare Community Plan of WI - Medicaid HMO

Unity Health Insurance -- Medicaid HMO

WISCONSIN
BadgerCare Plus

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Satisfaction Survey
-External Quality Review
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Non-Duplication of mandatory EQR Activities Base on Accreditation
-Ombudsman
-On-Site Reviews
-Pay for Performance
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Quality Improvement Goal Setting

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

WISCONSIN
BadgerCare Plus

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Admission source
-Admission type
-Days supply
-Modifier codes
-Patient status code
-Place of service codes
-Quantity

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Children with at least one comprehensive EPSDT well child visit in the look-back period at age 3-5 years, 6-14 years, and 15-20 years
-Children with at least one non-EPSDT well-child visit in the look-back period at ages birth-1 year, 1-2 years, 3-5 years, 6-14years and 15-20 years
-Comprehensive EPSDT well-child visits for children age birth to two years for those receiving 5, 6 and 7 or more visits
-Dental services
-Diabetes management
-Follow-up after hospitalization for mental illness
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals of all ages
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Antidepressant medication management
-Breast malignancies detected
-Cervix/uterus malignancies detected
-HPV infections detected
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Children's access to primary care practitioners
-Provider network data on geographic distribution
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Percent of beneficiaries with at least one PCP visit
-Percent of beneficiaries with at least one specialist visit
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-OCI certification
-Review of medical loss ratios

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:
None

Performance Measures - Others:
-Accreditation

-Enrollee Satisfaction Survey

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

-Asthma management
-Breast cancer screening (Mammography)
-Breast cancer treatment
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment
-Childhood Immunization
-Depression management
-Diabetes management
-Emergency Room service utilization
-Improving Birth Outcome Project
-Increase Utilization of Preventative Dental Care
-Inpatient maternity care and discharge planning
-Lead toxicity
-Low birth-weight baby
-Newborn screening for heritable diseases
-Post-natal Care
-Pre-natal care
-Prescription drug abuse
-Smoking prevention and cessation
-Substance Use Disorders treatment after detoxification service
-Treatment of myocardial infraction
-Well Child Care/EPSDT

Non-Clinical Topics:

-Health living individual incentive program

Standards/Accreditation

MCO Standards:

-State-Developed/Specified Standards

Accreditation Required for Participation:

None

Non-Duplication Based on Accreditation:

-AAAHC (Accreditation Association for Ambulatory Health Care)
-NCQA (National Committee for Quality Assurance)
-URAC

EQRO Name:

-MetaStar, Inc.

EQRO Organization:

-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:

-Assessment of MCO information systems
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of Tobacco Registries

Pay for Performance (P4P)

Implementation of P4P:

The State has implemented a Pay-for-Performance program with MCO

Program Payers:

Medicaid is the only payer

WISCONSIN
BadgerCare Plus

Population Categories Included:

A subset of MCO members, defined by disease and medical condition
Covers all MCO members

Clinical Conditions:

AMM- Depression
Asthma
Blood Lead Testing
Breast Cancer Screening
Childhood immunizations
Dental
Diabetes
Perinatal Care
Tobacco Cessation
Well-child visits

Initial Year of Reward:

1996

Member Incentives:

Not Applicable

Rewards Model:

Payment incentives/differentials to reward MCOs
Public reporting to reward MCOs
Withholds as an incentive

Measurement of Improved Performance:

Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing the timely submission of complete and accurate electronic encounter/claims data
Delivery of EPSDT Services
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:

The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

WISCONSIN
Medicaid SSI Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

Brett Davis
Division of Health Care Access and Accountability
(608) 266-8922

State Website Address:

http://dhs.wisconsin.gov

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
Not Applicable

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Implementation Date:
April 01, 2005

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
Not Applicable

Enrollment Broker:
Automated Health Systems

Sections of Title XIX Waived:
Not Applicable

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Coordination With Non-Medicaid Services (Social & Vocational), Recreational & Wellness Prog, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pediatricians, Personal Care, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-American Indians
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

WISCONSIN
Medicaid SSI Managed Care Program

Subpopulations Excluded from Otherwise Included Populations:

-Beneficiaries Who After Enrollment Are Placed In A Nursing Home For Longer Than 90 Days
-Children Under Age 19
-Enrolled in Another Managed Care Program
-In Family Care
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Comprehensive Assessment Required At Time of Enrollment
-Only SSI-Disabled Adult Recipients May Enroll
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
-Local Public Health Agency
-Mental Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Compcare -- SSI

Independent Care Health Plan -- SSI

Molina Health Plan -- SSI

UnitedHealthcare Community Plan of WI -- SSI

Group Health of Eau Claire -- SSI

Managed Health Services -- SSI

Network Health Plan -- SSI

ADDITIONAL INFORMATION

WISCONSIN
Medicaid SSI Managed Care Program

SSI Managed Care Program is for SSI and SSI-related Medicaid recipients, age 19 or older not living in an institution and not participating in a home and community based waiver. Dually eligible persons and Medicaid Purchase Plan recipients may enroll on a voluntary basis. Targeted Case Management, Community Support Program Services, and Crisis Intervention Services are covered under fee-for-service for enrollees in this program.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data ALL of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service

State conducts general data completeness assessments:
Yes

WISCONSIN
Medicaid SSI Managed Care Program

-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Admission Source
-Admission Type
-Days Supply
-Modifier Codes
-Patient Status Code
-Place of Service Codes
-Quantity

Performance Measures

Process Quality:
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Diabetes management/care
-Follow-up after hospitalization for mental illness and
substance abuse at 7 and 30 days
-Initiation and engagement of SUD treatment

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
None

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Number of hospital admissions per member per year
-Number of hospital days per member per year
-Percentage of beneficiaries with at least one dental visit
-Percentage of people living at home, CBRF/group home,
nursing home

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient,
ER, pharmacy, lab, x-ray, dental, vision, etc.)
-OCI certification
-Review of medical loss ratios

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Beneficiary need for interpreter
-MCO/PCP-specific disenrollment rate

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own
choosing
-Individual MCOs are required to conduct a project prescribed
by the State Medicaid agency

Clinical Topics:
-Breast cancer screening (Mammography)
-Diabetes management
-ETOH and other substance abuse screening and treatment
-Follow-up After Mental Health Hospitalization
-Substance Use Disorders treatment after detoxification service

Non-Clinical Topics:

-Access to and availability of services
-Care Management for SSI Members
-Cultural competency of the HMO and its providers
-Enrollee satisfaction with the HMO customer service
-Grievances, appeals and complaints

WISCONSIN
Medicaid SSI Managed Care Program

-Satisfaction with services for enrollees with special health care needs

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-MetaStar

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Assessment of MCO information systems
-Case Management Review
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by disease and medical condition
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

Rewards Model:
Member incentives in the MCO P4P program
Payment incentives/differentials to reward MCOs
Public reporting to reward MCOs
Withholds as an incentive

Clinical Conditions:
Breast cancer screening
Diabetes
Follow-up after MH Hospitalization
Substance abuse

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
Not Applicable

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

Member Incentives:
HMOs pay a max of $25 pmpm for disease prev. activities.

CALIFORNIA
AIDS Healthcare Foundation

CONTACT INFORMATION

State Medicaid Contact:

Margaret Tatar
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Hospice, Immunization, Laboratory, Long Term Care, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Personal Care, Pharmacy, Physical Therapy, Physician, Skilled Nursing Facility, Specialty Mental Health, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

CALIFORNIA
AIDS Healthcare Foundation

-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Period Less Than 3 Months
-Medicare Dual Eligibles
-Member approved for a Major Organ Transplant
-Poverty Level Pregnant Woman

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Plan is responsible to identify this group

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Positive Healthcare/AHF Healthcare Centers

ADDITIONAL INFORMATION

PCPs contract to provide and assume risk for primary care, specialty physician services, and selected outpatient preventive and treatment services. The Program is designed for people living with AIDS. All categories of federally eligible Medi-Cal are eligible to participate.

QUALITY ACTIVITIES FOR MCO/HIO

CALIFORNIA
AIDS Healthcare Foundation

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-Plan-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes

State conducts general data completeness assessments:
Yes

Performance Measures

CALIFORNIA
AIDS Healthcare Foundation

Process Quality:
-Colorectal Cancer Screening
-Controlling high blood pressure

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-None

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient,
ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own
choosing

Clinical Topics:
-Advance Care Directives
-CD4 and Viral Load Testing

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting
quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance
program with the MCO

Program Payers:
Not Applicable

CALIFORNIA
AIDS Healthcare Foundation

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

CALIFORNIA
Family Mosaic

CONTACT INFORMATION

State Medicaid Contact:

Margaret Tatar
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Emotional and Mental Health Support PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, Emotional Support, Inpatient Mental Health, Mental Health Rehabilitation, Mental Health Support, Outpatient Mental Health, Pharmacy

Allowable PCPs:
-N/A

Contractor Types:
None

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

CALIFORNIA
Family Mosaic

-Populations residing outside plans service area defined by
contract
-Reside in Nursing Facility or ICF/MR

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid
Managed Care Contracts:**
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex
(Special) Needs:**
Yes

**Strategies Used to Identify Persons with
Complex (Special) Needs:**
-Plan is responsible to identify this group

**Agencies with which Medicaid Coordinates the
Operation of the Program:**
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

San Francisco City & CO/Family Mosaic

ADDITIONAL INFORMATION

San Francisco City and County/Family Mosaic only provides emotional and mental support to severely emotionally disturbed children.

CALIFORNIA
Prepaid Health Plan Program

CONTACT INFORMATION

State Medicaid Contact:

Jon Chin
Medi-Cal Dental Services Division
(916) 464-3888

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
Health Care Options/Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1972

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Dental PAHP - Risk-based Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Dentists

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise
Included Populations:**

Populations Mandatorily Enrolled:
None

Lock-In Provision:

CALIFORNIA
Prepaid Health Plan Program

-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Populations residing outside plans service area defined by
contract
-Reside in Nursing Facility or ICF/MR (after 30 days)

No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid
Managed Care Contracts:**
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex
(Special) Needs:**
Yes

**Strategies Used to Identify Persons with
Complex (Special) Needs:**
-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the
Operation of the Program:**
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan-LA

American Health Guard-Dental Plan-LA

Care 1st Health Plan-Dental-LA

Community Dental Services-LA

Health Net of CA-Dental-LA

Liberty Dental Plan of CA-LA

Safeguard Dental-LA

Western Dental Services-LA

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement
Activities:**
-Encounter Data (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

CALIFORNIA
Prepaid Health Plan Program

-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing

Collection: Standardized Forms:
None

Validation - Methods:
-Verify provider data with Provider Master File

PAHP conducts data accuracy check(s) on specified data elements:
None
-Provider ID

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
-Number of procedures provided and monthly and yearly unduplicated users

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

CALIFORNIA
Senior Care Action Network

CONTACT INFORMATION

State Medicaid Contact:

Joseph Billingsley
Long Term Care Division
(916) 440-7538

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
Zip Code

Initial Waiver Approval Date:
Not Applicable

Operating Authority:
1915(a) - Voluntary

Implementation Date:
January 01, 2008

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
Not Applicable

Enrollment Broker:
No

Sections of Title XIX Waived:
None

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Chiropractic, Dental, Durable Medical Equipment, Emergency Care, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Clinical Social Workers
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Addiction Professionals (i.e. Substance Use Disorder counselors, alcohol and drug counselors,
-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants
-Podiatrists
-Psychiatrists
-Psychologists

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

CALIFORNIA
Senior Care Action Network

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

None

**Subpopulations Excluded from Otherwise
Included Populations:**

-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Poverty Level Pregnant Woman
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid
Managed Care Contracts:**

-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal
vitamins and fluoride preparations

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex
(Special) Needs:**
Yes

**Strategies Used to Identify Persons with
Complex (Special) Needs:**

-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the
Operation of the Program:**

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Senior Care Action Network (SCAN)

ADDITIONAL INFORMATION

SCAN Health Plan was formerly a Social HMO operating under an 1115(a)-Demonstration waiver program authority which expired
December 31, 2007. Effective January 1, 2008, SCAN Health Plan is now a Medicare Advantage Special Needs Plan that contracts with
the Department of Health Care Services to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los
Angeles, San Bernardino, and Riverside counties. SCAN is a managed care organization operating under Section 1915(a) of the Social
Security Act. SCAN provides all services in the Medi-Cal State Plan; inlcuding home and community based services to SCAN members

CALIFORNIA
Senior Care Action Network

who are assessed at the Nursing Facility Level of Care and nursing home custodial care, following the member in the nursing facility. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCANs approved service areas of Los Angeles, Riverside, and San Bernardino counties. SCAN does not enroll individuals with End Stage Renal Disease.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-MCO-developed Surveys

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility

State conducts general data completeness assessments:
Yes

CALIFORNIA
Senior Care Action Network

-Procedure Codes

Performance Measures

Process Quality:
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient,
ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own
choosing

Clinical Topics:
-Care for Older Adults
-Prevention of Stroke and Transient Ischemic Attack

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting
quality activities

CALIFORNIA
Senior Care Action Network

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

COLORADO
Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

Valerie Baker-Easley
Department. of Health Care Policy and Financing
(303) 866-3684

State Website Address:

http://www.colorado.gov/hcpf

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS, INC.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 1983

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

**Sections of Title XIX Costs Not Otherwise Matchable
Granted:**
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Family Planning,
Hearing, Home Health, Immunization, Inpatient Hospital,
Laboratory, Occupational Therapy, Outpatient Hospital,
Pharmacy, Physical Therapy, Physician, Speech Therapy,
Telemedicine, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Gerontologists
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
None

COLORADO
Managed Care Program

-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

COLORADO
Managed Care Program

Medical-only PIHP (risk or non-risk, non-comprehensive) - Non-risk Capitation

Service Delivery

Included Services:

Case Management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Telemedicine, Transportation, Vision, X-Ray

Allowable PCPs:

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Gerontologist
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:

None

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Excluded:

SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:

No

Scope of Part D Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

Provides Part D Benefits:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

Agencies with which Medicaid Coordinates the Operation of the Program:

COLORADO
Managed Care Program

-Surveys medical needs of enrollee to identify members
of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these
groups
-Uses provider referrals to identify members of these
groups

-Developmental Disabilities Agency
-Mental Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Denver Health and Hospital Authority

Rocky Mountain Health Plan Authority

ADDITIONAL INFORMATION

MCO options and PIHP options are available and varies by county. The State Agency makes a full capitated payment for
comprehensive physical health services on behalf of each client enrolled in the MCO. The State Agency makes a partially capitated
payment for administrative services on behalf of each client enrolled in the non-risk PIHP.

QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement
Activities:**
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-CAHPS
     Adult Medicaid SSI Questionnaire
     Child Medicaid SSI Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for
Medicaid
-The State DOES NOT generate from encounter data any of the
HEDIS measures, but plans to generate SOME or ALL of the
HEDIS measures listed for Medicaid in the future
-State modifies/requires MCOs to modify some or all NCQA
specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may
have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter
data
-Specifications for the submission of encounter data to the
Medicaid agency
-Standards to ensure complete, accurate, timely encounter
data submission

Collections: Submission Specifications:
-Data submission requirements including documentation
describing set of encounter data elements, definitions, sets
of acceptable values, standards for data processing and
editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national
standardized forms (e.g. UB-04, NCPDP, ASC X12 837,
ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

COLORADO
Managed Care Program

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Medical record validation

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Revenue Codes
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Annual Monitoring for Patients on Persistent Medications
-Childhood Immunization Status
-Chlamdyia screening in women
-Controlling high blood pressure
-Depression management/care
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-CAHPS Health Plan
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Survey 4.0 H -Adult
-Survey 4.0 H -Child

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Prenatal and Postpartum Care

Use of Services/Utilization:
-Antibiotic Utilization
-Frequency of Selected Procedures
-Inpatient Utilization - General Hospital/Acute Care Ambulatory Care

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Managed Care is performing a focus study

COLORADO
Managed Care Program

Non-Clinical Topics:
-Coordination of Care

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group, Inc.

EQRO Organization:
-QIO-like entity

EQRO Mandatory Activities:
-Site Reviews
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2007

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

COLORADO
Managed Care Program

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid 4.0 H
    Child Medicaid 4.0 H

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Annual Monitoring for Patients on Persistent Medications
-Antidepressant medication management
-Childhood Immunization Status
-Chlamdyia screening in women
-Controlling high blood pressure
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-CAHPS Health Plan
-Survey 4.0 H- Adult
-Survey 4.0 H- Child

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Prenatal and Postpartum Care

Use of Services/Utilization:
-Ambulatory Care
-Antibiotic Utilization
-Frequency of Selected Procedures
-Inpatient Utilization-General Hospital/Acute Care
-Use of Imaging Studies for lower back pain

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing
-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Improving well care visits for Children and Adolescents

Non-Clinical Topics:
-Improving coordination of care for members with Behavorial Health Conditions

Standards/Accreditation

PIHP Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
None

COLORADO
Managed Care Program

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-QIO-like entity

EQRO Name:
-Health Services Advisory Group, Inc.

EQRO Mandatory Activities:
-Site Reviews
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

DISTRICT OF COLUMBIA
Children and Adolescent Supplemental Security Income Program

CONTACT INFORMATION

State Medicaid Contact:

Lisa Truitt
Department of Health Care Finance
(202) 442-9109

State Website Address:

http://www.dchealth.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
February 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PIHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

DISTRICT OF COLUMBIA
Children and Adolescent Supplemental Security Income Program

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Services For Children with Special Needs

ADDITIONAL INFORMATION

This is no longer a demonstration program but a cost-base reimbursement program and there is no risk involved for providers. Program provides Emergency Transportation only and Skilled Nursing Facility for first 30 days.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires PIHPs to follow NCQA specifications for all

of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across PIHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Diabetes medication management
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

DISTRICT OF COLUMBIA
Children and Adolescent Supplemental Security Income Program

-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care:
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Standards/Accreditation

PIHP Standards:
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Delmarva Foundation for Medical Care

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

ILLINOIS
Voluntary Managed Care

CONTACT INFORMATION

State Medicaid Contact:

Michelle Maher
Illinois Department of Healthcare and Family Services
(217) 524-7478

State Website Address:

http://www.hfs.illinois.gov/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
Illinois Client Enrollment Broker

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
November 01, 1974

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Assistive/Augmentative Communication Devices, Audiology, Blood and Blood Components, Case Management, Chiropractic, Clinic, Diagnosis and treatment of medical conditions of the eye, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Psychiatric Care, Inpatient Substance Use Disorders, Laboratory, Medical procedures performed by a dentist, Non-Durable Medical Equipment and Supplies, Nurse Midwives, Occupational Therapy, Orthotic/Prosthetic Devices, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplants, Transportation, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Clinics including certain Hospitals and Cook County Bureau of Health Service Clinics
-Other Provider Types as allowed by the Department
-Pediatricians
-Rural Health Clinics (RHCs)
-Specialist upon approval of Medical Director

Enrollment

ILLINOIS
Voluntary Managed Care

Populations Voluntarily Enrolled:

-American Indian/Alaska Native
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Populations Mandatorily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-All Kids Premium Levels 2 through 8
-All Kids Rebate and Family Care Rebate
-Blind Disabled Children and Related Population
-Enrolled in CDC BCCT Program
-Individuals enrolled in presumptive eligible programs
-Individuals enrolled in programs with limited benefits
-Medicare Dual Eligibles
-Non-citizens only receiving emergency services
-Other Insurance - High Level
-Pace Participants
-Participate in HCBS Waiver
-Refugees
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Spenddown Eligibles
-Transitional Assistance, Age 19 and Older
-Veterans Care Program

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:

Not Applicable

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Family Health Network   Harmony Health Plan

Meridian Health Plan

ADDITIONAL INFORMATION

Nursing facility services are provided up to 90 days annually.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Access to Care Standards Monitoring
-Consumer Self-Report Data (see below for details)

Use of Collected Data:

-Contract Standard Compliance
-Data Mining - HEDIS calculations

ILLINOIS
Voluntary Managed Care

-Customer Satisfaction Survey
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
No

Performance Measures

ILLINOIS
Voluntary Managed Care

Process Quality:
-Adolescent well-care visit rates
-adult preventive care
-Asthma care- medication use
-Breast Cancer Screening Rate
-Cervical Cancer Screening Rate
-check ups after delivery - Prenatal and Postpartum care
-childhood immunization status
-Chlamydia screening in women
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in 3, 4, 5 and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants
-Percentage of very low birth weight infants

Access/Availability of Care:
-Access and Availability of Care: Prenatal and Postpartum
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Birth and average length of stay - newborns
-chemical dependency utilization
-Discharge and average length of stay - maternity care
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-mental health utilization
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Admitting and delivery privileges
-Languages Spoken (other than English)
-Provider license number
-Specialty of providers

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-special needs population

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Asthma management
-EPSDT/Content of care for under age three
-Follow-up After Hospitalization for Mental Illness/ PCP Communication
-Prenatal Depression Screening and referral

Non-Clinical Topics:

None

ILLINOIS
Voluntary Managed Care

Standards/Accreditation

MCO Standards:
-CMS Quality Improvement Systems - for performance improvement
-NCQA for HEDIS
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group

EQRO Organization:
-External Quality Review Organization

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Assessment of MCO information systems
-Calculation of performance measures
-Technical Assistance - to state for Readiness Review
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Health Care and Family Services is the only payer

Population Categories Included:
Covers all MCO members meeting the P4P criteria

Rewards Model:
Payment for well child visits under age 5
Payment of Withold as an incentive for meeting P4P criteria

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Use of services, e.g., immunization rates
well child visits under the age of 5

Initial Year of Reward:
2006

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

Member Incentives:
Not Applicable

MINNESOTA
Special Needs Basic Care

CONTACT INFORMATION

State Medicaid Contact:

David Godfrey
Minnesota Department of Human Services
(651) 431-2319

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 2008

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Child & Teen Check-Up, Chiropractic, Dental, Disease Management, Durable Medical Equipment, Emergency Room, Family Planning, Hearing, Home Health (Skilled Nurse Visit, Home health Aid), Inpatient Hospital, Inpatient Substance Use Disorders, Interpreter, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Preventive Visit, Respiratory Therapy, Skilled Nursing Facility (100 days), Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable; Contractors Not Required to Identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

MINNESOTA
Special Needs Basic Care

-Medicaid Only
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Eligible for Medicare Part A or Part B Only
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-QMB, SLMB not Otherwise Eligible for Medicaid
-Residing in a State Institution

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Mental Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus

Metropolitan Health Plan

South Country Health Alliance

Medica

PrimeWest Health System

UCARE

ADDITIONAL INFORMATION

None

MINNESOTA
Special Needs Basic Care

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Assess program results
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track access and utilization

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
-Disenrollment Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-None

MCO/HIO conducts data accuracy check(s) on specified data elements:
None

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Adult preventive visits
-Antidepressant medication management
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Colorectal cancer screening

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

MINNESOTA
Special Needs Basic Care

-Dental services
-Diabetes screening
-Mental health discharges
-Osteoporosis care after fracture

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services

Use of Services/Utilization:
-CD initiating and treatment
-Mental health discharges
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Aspirin therapy
-Asthma management
-Asthma-reduction of emergency department visits
-Breast cancer screening (Mammography)
-Calcium/Vitamin D
-Cholesterol screening and management
-Colon cancer screening
-Depression management
-Diabetes management
-Diabetic statin use, 40 to 75 year olds
-Human papillomavirus
-Hypertension management
-Mental health/chemical dependency dual diagnoses
-Obesity
-Pneumococcal vaccine

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-MetaStar (QIO)
-Michigan Performance Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys

MINNESOTA
Special Needs Basic Care

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance
program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

NEW YORK
Managed Long Term Care Program

CONTACT INFORMATION

State Medicaid Contact:

Linda Gowdy
Division of Long Term Care
(518) 474-6965

State Website Address:

http://www.nyhealth.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Long Term Care PIHP - Risk-based Capitation

Service Delivery

Included Services:
Adult Day Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Meals, Medical Social, Nutrition, Occupational Therapy, Personal Care, Personal Emergency Response System, Physical Therapy, Podiatry, Private Duty Nursing, Respiratory Therapy, Skilled Nursing Facility, Social and Environmental Supports, Speech Pathology, Transportation, Vision

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

NEW YORK
Managed Long Term Care Program

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Community Connections

ElderPlan/Managed Long Term Care

CCM Select

Elderserve

Fidelis Care at Home

Health Advantage/Elant Choice

Independent Care Systems

Senior Network Health

VNS Choice

Guildnet

HHH Choices

Senior Health Partners

Total Aging in Place

WellCare Advocate

ADDITIONAL INFORMATION

To be eligible for this program, a person must be age 18+ and eligible for nursing home placement but able to live in the community upon enrollment. Beneficiaries may receive services at home or in a Nursing Home in the plan network.

QUALITY ACTIVITIES FOR PIHP

NEW YORK
Managed Long Term Care Program

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-Consumer satisfaction survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Influenza vaccination rate
-Semi-annual assessment (SAAM index)

Health Status/Outcomes Quality:
-Depression
-Emergent care
-Experience pain daily
-Incontinence
-Independence in medication management
-Living alone
-Mean ADLs score
-One or more falls
-Percentage of members confused
-Percentage of members not alert
-Percentage of members with anxiety

NEW YORK
Managed Long Term Care Program

Access/Availability of Care:
-Provider networks and updates are collected quarterly and reviewed for accuracy

Use of Services/Utilization:
-Drug Utilization
-Number of home health visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Upon enrollment and semi-annual assessment

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Diabetes management
-Improve dental utilization
-Reduction of Hosp/ER for CHF
-Standardized pain assessment tool

Non-Clinical Topics:
-Advanced Directives
-DME tracking
-Effective use of PERS
-Improving SASM scoring

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-IPRO - Island Peer Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance improvement projects

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

NEW YORK
Medicaid Advantage Plus (MAP)

CONTACT INFORMATION

State Medicaid Contact:

Linda Gowdy
Division of Long Term Care
(518) 474-6965

State Website Address:

http://www.nyhealth.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 2007

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Long Term Care PIHP - Risk-based Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Meals, Medical Social, Nutrition, Occupational Therapy, Personal Care, Personal Emergency Response System, Pharmacy, Physical Therapy, Podiatry, Private Duty Nursing, Respiratory Therapy, Skilled Nursing Facility, Social and Environmental Supports, Speech Pathology, Transportation, Vision

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

NEW YORK
Medicaid Advantage Plus (MAP)

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriGroup Advantage Plus/Medicaid Advantage Plus

Elder Plan/Medicaid Advantage Plus

GuildNet/Medicaid Advantage Plus

HIP Health Plan/Medicaid Advantage Plus

NYS Catholic Health Plan/Fidelis/Medicaid Advantage Plus

Senior Whole Health/Medicaid Advantage Plus

VNS Choice Plus/Medicaid Advantage Plus

WellCare Advantage Plus/Medicaid Advantage Plus

ADDITIONAL INFORMATION

To be eligible for this program, a person must be age 18+ and eligible for nursing home placement but able to live in the community upon enrollment. Beneficiaries may receive services at home or in a Nursing Home in the plan network.

Non-Prescription Drugs covered as a wrap benefit: ANALGESIC AND ANTIPYRETIC , ANTACID, ANTI-DIARRHEAL ANTIHISTAMINE , ANTI-VERTIGO, ARTIFICIAL TEARS AND OCCULAR/ORAL LUBRICANTS , CHRONIC RENAL DISEASE, COUGH AND COLD , DERMATOLOGICAL, FAMILY PLANNING, FECAL SOFTENER AND LAXATIVE, HEMATINIC, INSULIN , INSULIN BIOSYNTHETIC HUMAN, PEDICULOCIDE, SMOKING CESSATION AGENTS , VITAMIN/MINERAL , and UNCLASSIFIED .

QUALITY ACTIVITIES FOR PIHP

NEW YORK
Medicaid Advantage Plus (MAP)

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Grievance and Appeal Data
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-Consumer satisfaction survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Influenza vaccination rate

Health Status/Outcomes Quality:
-Daily pain
-Depression
-Incontinence
-Independence in medication management
-Living alone
-Mean ADLs score
-One or more falls
-Percentage members not alert
-Percentage members with anxiety
-Percentage members with confusion
-Received emergent care
-Semi-annual assessment (SAAM index)

NEW YORK
Medicaid Advantage Plus (MAP)

Access/Availability of Care:
-Provider networks and updates are collected quarterly and reviewed for accuracy

Use of Services/Utilization:
-Drug Utilization
-Number of home health visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Upon enrollment and semi-annual assessment.

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Diabetes management
-Improve Dental Utilization
-Pain Management

Non-Clinical Topics:
-Advance Directives

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-IPRO - Island Peer Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance improvement projects

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

PENNSYLVANIA
Living Independence for the Elderly (LIFE) Program (PIHP)

CONTACT INFORMATION

State Medicaid Contact:

Randy Nolen
PA Department of Public Welfare, Office of Long Term Living
(717) 772-2543

State Website Address:

http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County
Zip Code

Initial Waiver Approval Date:
Not Applicable

Operating Authority:
1915(a) - Voluntary

Implementation Date:
October 01, 1998

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
Not Applicable

Enrollment Broker:
No

Sections of Title XIX Waived:
None

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

SERVICE DELIVERY

Medical-only PIHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Adult Day Care, Case Management, Chiropractic, Dental, Durable Medical Equipment, Hearing, Hospice, Immunization, In-home Supportive Care, Institutional, Occupational Therapy, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

PENNSYLVANIA
Living Independence for the Elderly (LIFE) Program (PIHP)

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Albright LIFE

Viecare Butler

LIFE Northwestern PA

ADDITIONAL INFORMATION

The pre-PACE sites listed are identified as Medical-only PIHP. Program provides capitated institutional services not capitated inpatient hospital services.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)

Use of Collected Data:
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the

PENNSYLVANIA
Living Independence for the Elderly (LIFE) Program (PIHP)

HEDIS measure listed for Medicaid

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics:
None

Non-Clinical Topics:
-Appeals and Grievances
-Falls

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-IPRO

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting quality activities

PENNSYLVANIA
Voluntary HMO Contracts

CONTACT INFORMATION

State Medicaid Contact:

Joan Morgan
Pennsylvania Department of Welfare
(717) 772-6300

State Website Address:

http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
Not Applicable

Operating Authority:
1915(a) - Voluntary

Implementation Date:
January 01, 1972

Statutes Utilized:
1915(b)(4), Selective Contracting

Waiver Expiration Date:
Not Applicable

Enrollment Broker:
Maximus

Sections of Title XIX Waived:
None

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-State Only Categorically Needy
-State Only Medically Needy

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Enrolled in Health Insurance Premium Payment (HIPP) with HMO Coverage
-Enrolled in Long Term Care Capitated Program (LTCCP)
-Incarceration
-Medicare Dual Eligibles
-Monthly Spend Downs
-Reside in Nursing Facility or ICF/MR
-Residence in a State Facility
-State Blind Pension Recipients

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only (under age 21)

Medicare Dual Eligibles Excluded:
QMB (age 21 and over)
SLMB, QI, and QDWI (age 21 and over)

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan -

PENNSYLVANIA
Voluntary HMO Contracts

VOL

United Healthcare of PA, Inc. -
VOL

Gateway Health Plan, Inc. -VOL

UPMC Health Plan, Inc./UPMC for You - VOL

ADDITIONAL INFORMATION

Included Services: Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, and Outpatient Substance Use Disorders are provided on a Fee-For-Service basis or through Behaviorial Health MCOs where implemented.

Special Needs Children: (state defined) Broadly defined non-categorical to include all children. Skilled Nursing Facility is provided for the first 30 days. Transportation services only includes emergency ambulance services.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    4.0H Adult
    4.0H Children
-Plan-developed survey

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:
-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

PENNSYLVANIA
Voluntary HMO Contracts

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-All use of services in HEDIS measures
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient,
ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for
women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-All MCOs participating in the managed care program are
required to conduct a common performance improvement
project(s) prescribed by State Medicaid agency

Clinical Topics:
-Adolescent Pregnancy
-Asthma management
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Hypertension management
-Smoking prevention and cessation

Non-Clinical Topics:
-Adults Access to Dental Care
-Childrens Access to Dental Care

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for Managed Care
(QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of
Healthcare Organizations) Standards
-NAIC (National Association of Insurance
Commissioners) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization (IPRO)

PENNSYLVANIA
Voluntary HMO Contracts

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
2006

Evaluation Component:
The State has conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

PUERTO RICO
Medicare Platino

CONTACT INFORMATION

State Medicaid Contact:

Miguel Negron-Rivera
PR Department of Health - Medicaid Office
(787) 250-0453

State Website Address:

http://www.asespr.org

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Diagnosis and Treatment of tuberculosis and leprosy, Disease Management, EPSDT, Family Planning, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Maternity, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Exam, Physician, Preventive, Surgery, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

Populations Mandatorily Enrolled:
None

Lock-In Provision:

PUERTO RICO
Medicare Platino

-All populations who are not dual eligibles

No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Barbituates
-Benzodiazepines
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

American Health Medicare

First Medical/First Plus

Humana Puerto Rico

MCS Advantage

MMM Healthcare Inc.

PMC Medicare Choice

Triple S

ADDITIONAL INFORMATION

Medicare Platino is a program contracted with Medicare Advantage Plans to provide coverage to qualified beneficiaries from the Puerto Rico Health Care Program. Medicare Platino provides Medicaid wrap services that are not provided by the Medicare Advantage Plans to ensure the same level of service and coverage as in the Puerto Rico's Health Care Program. Program is strictly for dual eligibles.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for

PUERTO RICO
Medicare Platino

Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Annual monitoring of patients on persistent medications
-Antidepressant medication management
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cholosterol management for patients with cardiovascular conditions
-Colorectal Cancer Screening
-Comprehensive Diabetes Care
-Controlling high blood pressure
-Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis
-Follow-up after hospitalization for mental illness
-Glaucoma screening in older adults
-Osteoporosis management in women who had a fracture
-Pharmacotherapy Management of COPD Exacerbation
-Potentially Harmful Drug-Disease Interactions in the Elderly
-Use of High-Risk Medications in the Elderly
-Use of spirometry testing in assessment and diagnosis of COPD

Health Status/Outcomes Quality:
-Effectiveness of care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Call abandoment
-Call answer timeliness

Use of Services/Utilization:
-Ambulatory care
-Antibiotic utilization
-Drug Utilization

PUERTO RICO
Medicare Platino

-Inititation and engagement of alcohol and other drug dependence treatment

-Frequency of selected procedures
-Identification of Alcohol and Other Drug Services
-Inpatient Utilization - General Hospital / Acute Care
-Inpatient Utilization - Non-Acute Crae
-Mental Health Utilization

Health Plan Stability/ Financial/Cost of Care:
-Relative resources used for people with cardiac conditions
-Relative resources used for people with COPD
-Relative resources used for people with diabetes
-Relative resources used for people with uncomplicated hypertension

Health Plan/ Provider Characteristics:
-Board Certification
-Enrollment by Product Line
-Enrollment by State
-Language Diversity of Membership
-Race / Ethnicity Diversity of Membership

Beneficiary Characteristics:
None

Performance Measures - Others:
-Effectiveness of care

Performance Improvement Projects

Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:

-Chronic Care Improvement Program (CCIP): Targeting high risk members with Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Bronchial Asthma (BA), High Blodd Pressure (HBP) and Chronic Obstructive Pulmonary Disease (COPD)
-Comprehensive Diabetes Care: Poor HbA1c control
-Improving the Quality of Care of Part D Enrollees Diagnosed with High Blood Pressure Receiving Diuretics Therapy
-Increasing the Number of Enrollees that Received an Influenza Vaccination and Pneumonia Vaccination
-Lowering the Drug-Drug Interaction (DDI) and teh Ptentially Inapproriate Medication (PIM) on Medicare Claims Part D
-Members High Risk / SNP Program Diabetes Special Needs Plans
-Polypharmacy Program in Medicare Members
-Retinopathy Screening and Long Term Control in Diabetic Population

Non-Clinical Topics:

None

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Calculation of performance measures

Pay for Performance (P4P)

PUERTO RICO
Medicare Platino

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance
program with the MCO

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Member Incentives:
Not Applicable

Program Payers:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

PUERTO RICO
Mi Salud

CONTACT INFORMATION

State Medicaid Contact:

Miguel Negron-Rivera
PR Department of Health - Medicaid Office
(787) 250-0453

State Website Address:

http://www.asespr.org

PROGRAM DATA

Program Service Area:
Region

Initial Waiver Approval Date:
Not Applicable

Operating Authority:
1915(a) - Voluntary

Implementation Date:
February 01, 1994

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
Not Applicable

Enrollment Broker:
No

Sections of Title XIX Waived:
None

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Disease Management, EPSDT, Family Planning, Immunization, Inpatient Hospital, Laboratory, Maternity, Outpatient Hospital, Pharmacy, Physical Exam, Physician, Preventive, Surgery, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Individual/Families up to 200% of Puerto Rico poverty level
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

PUERTO RICO
Mi Salud

-Police
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

PUERTO RICO
Mi Salud

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:

Case Management, Crisis, Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Prevention Programs (MH), Transportation

Allowable PCPs:

-Psychiatrists
-Psychologists

Contractor Types:

-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Individual/families up to 200% of the Puerto Rico poverty line
-Medicare Dual Eligibles
-Police
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Populations Mandatorily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Public Health Agency

PUERTO RICO
Mi Salud

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

APS
Healthcare

Humana Health Plans of Puerto Rico, Inc.

MCS Health Management Options, Inc.

ADDITIONAL INFORMATION

Puerto Rico's Health Care Program is not a voluntary program. It is a mandatory managed care program which requires no waiver authority because Puerto Rico is statutory exempt from Freedom of Choice requirements. PRHIA main duty is to obtain health insurance coverage for the medically indigent. Vision and hearing services are only included under physician services and other ancillary services. Mental Health and Abuse program is separated and handled by MBHOs. There are no QMBs dual eligibles in Puerto Rico.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Monitoring of MCO Standards
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
No

PUERTO RICO
Mi Salud

Performance Measures

Process Quality:
-Ambulatory Care
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Call Abandonment
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Immunizations for two year olds
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Adolescent Well-Care Visits
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
-Inpatient Utilization - General Hospital / Acute Care
-Inpatient Utilization - Non-Acute Care
-Relative Resource Use for People with Asthma
-Relative Resource Use for People with Cardiovascular Conditions
-Relative Resource Use for People with Diabetes

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
-Board Certification

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Asthma management
-Diabetes management
-Hypertension management
-Retinopathy Screening and Long Term Control in Diabetic Population

Non-Clinical Topics:
-Clinical Edits Improvement Project

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization

PUERTO RICO
Mi Salud

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Assessment of education and prevention programs

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Monitoring of PIHP Standards
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:
-Antidepressant medication management
-Follow-up after hospitalization for mental illness
-Follow-up Care for Children Prescribed ADHD Medication
-Identification of Alcohol and Other Drug Services
-Initiation and engagement of SUD treatment

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
-Mental Health Utilization

PUERTO RICO
Mi Salud

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics:

-Ambulatory Follow-up and Readmissions within 30 days
-Depression and Diabetes Disease Management Pilot
-Patient Safety and Reduction of Medical Errors in Hospitals

Non-Clinical Topics:

Not Applicable - PIHPs are not required to conduct common project(s)

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Assessment of education and prevention programs
-Technical assistance to PIHPs to assist them in conducting quality activities

TEXAS
STAR Health

CONTACT INFORMATION

State Medicaid Contact:

Joe Vesowate
Texas Health and Human Services Commission
(512) 491-1379

State Website Address:

http://www.hhs.state.tx.us/medicaid/StarHealth.shtml

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 2008

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Service Management, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Children and young adults in DFPS conservatorship

Populations Mandatorily Enrolled:
None

TEXAS
STAR Health

-Emancipated minors or members age 18-22 who voluntarily
agree to continue in foster placement
-Young adults age 21 through the month of their 23rd birthday
who are participating in the Former Fos
-Young adults who have exited care and are participating in
the foster care youth transitional progra

**Subpopulations Excluded from Otherwise
Included Populations:**
-Medicare Dual Eligibles
-Placed with TYC or TJPC
-Reside in a state school or other 24 hour facility
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid
Managed Care Contracts:**
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex
(Special) Needs:**
Yes

**Strategies Used to Identify Persons with
Complex (Special) Needs:**
-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the
Operation of the Program:**
-Department of Aging and Disability Services(DADS)
-Department of Family and Protective Service(DFPS)
-Department of State Health Services(DSHS)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Superior HealthPlan (STAR Health)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement
Activities:**
-Consumer Self-Report Data (see below for details)

Use of Collected Data:
-Contract Standard Compliance

TEXAS
STAR Health

-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Child Medicaid Questionnaire
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-837 transaction format
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-837 transaction format
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-Behavioral health layout
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO
-State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Preparing HEDIS and risk adjustment software

State conducts general data completeness assessments:
Yes

TEXAS
STAR Health

Performance Measures

Process Quality:
-Access to behavioral health treatment
-Access to Dental care
-Access to emergent care
-Access to routine care
-Access to specialist care
-Access to urgent care
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Depression management/care
-Diabetes care and control
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in adolescents

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-None

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Provider Turnover
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Measures - Others:
-Health Status/Outcomes Process

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Diabetes care and management
-Influenza Immunizations

-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Institute for Child Health Policy

EQRO Organization:
-Institute for Child Health Policy, University of Florida

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

UTAH
Healthy Outcomes Medical Excellence (HOME)

CONTACT INFORMATION

State Medicaid Contact:

Emma Chacon
Division of Medicaid and Health Financing
(801) 538-6577

State Website Address:

http://www.health.utah.gov/medicaid

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 01, 2001

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Diabetes Self-management, Disease
Management, Durable Medical Equipment, EPSDT, Family
Planning, Hearing, Home Health, Hospice, Immunization,
Inpatient Hospital, Inpatient Mental Health, Laboratory,
Occupational Therapy, Outpatient Hospital, Outpatient Mental
Health, Personal Care, Physical Therapy, Physician,
Podiatry, Skilled Nursing Facility if less than 30 days, Speech
Therapy, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
None

UTAH
Healthy Outcomes Medical Excellence (HOME)

-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Eligible only for TB-related Services
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-All clients enrolled with HOME are people with special needs.

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Education Agency
-Housing Agencies
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Outcomes Medical Excellence (HOME)

ADDITIONAL INFORMATION

Enrollees with special health care needs are enollees who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require services of a type or amount beyond that required by adults and children in general.

The Medicaid agency pays HOME a monthly prepayment for each HOME client. Total prepayments made to HOME are reconciled against its covered encounter records total costs.

QUALITY ACTIVITIES FOR MCO/HIO

UTAH
Healthy Outcomes Medical Excellence (HOME)

State Quality Assessment and Improvement Activities:
-MCO Standards (see below for details)
-Performance Improvement Projects (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Program Evaluation

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-HQE

EQRO Organization:
-QIO-like entity

EQRO Mandatory Activities:
-Validation of performance improvement projects

EQRO Optional Activities:
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

WISCONSIN
Children Come First (CCF)

CONTACT INFORMATION

State Medicaid Contact:

Brett Davis
Division of Health Care Access and Accountability
(608) 266-8922

State Website Address:

http://dhs.wisconsin.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1993

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Community Support Program (CSP), Crisis, Emergency, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Medical Day Treatment, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Contractor Types:
-County Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaska Native
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Children and Related Populations
-Title XXI CHIP

Populations Mandatorily Enrolled:
None

WISCONSIN
Children Come First (CCF)

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver

Medicare Dual Eligibles Included:
None

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Community Partnerships
-Dane County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
-Mental Health Agency
-Other Public And Private Agencies Are On The Statewide Children Come First Advisory Committee.
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Dane County Human Services Department -- CCF

ADDITIONAL INFORMATION

Program goal is to keep children with severe emotional disturbances out of institutions and to serve these children and their families in the community. The state reallocates previous funding for institutional placement into community based care. It uses a "wraparound," integrated services approach with multi-agency and multi-disciplinary collaboration. Key components include intensive case management, crisis intervention, and a flexible array of services and supports (including some not traditionally covered under Medicaid) based on highly individualized plans of care. This mental health and substance abuse carve-out program does not designate a primary care provider for physical health care. All enrollees must have a special needs to be eligible for enrollment.

QUALITY ACTIVITIES FOR PIHP

WISCONSIN
Children Come First (CCF)

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Performance Measures

Process Quality:
-Collaboration and teamwork
-Family-based and community-based sevice delivery
-Follow-up after hospitalization for mental illness
-Identification and process=service/care coordinators (case managers)
-Membership and process=child and family reams (plan of care teams)
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Process and content=plans of care
-Process and content=service authorization plans

Health Status/Outcomes Quality:
-Cost-effectiveness comparison of this managed care program to non-managed care program
-Criminal offenses and juvenile justice contracts of enrollees, pretest and post-test
-Functional impairment of enrollees, pre-test, post-test
-Patient satisfaction with care
-Restrictiveness of living arrangements for enrollees, pre-test, and post-test
-School attendance and performance of enrollees, pre-test, and post-test

Access/Availability of Care:
-Internal and external quality assurance audits of access and of monitoring plans of care

Use of Services/Utilization:
-Internal and external quality assurance audits of monitoring plans of care and tracking actual service utilization

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
-Internal quality assurance review of sub-contracted providers

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Other demographic, clinical, and service system characteristics of enrollees
-PIHP/PCP-specific disenrollment rate

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics:
None

Non-Clinical Topics:
-Program Transition

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

WISCONSIN
Children Come First (CCF)

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Name:
-MetaStar

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance meassures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

WISCONSIN
Wraparound Milwaukee

CONTACT INFORMATION

State Medicaid Contact:

Brett Davis
Division of Health Care Access and Accountability
(608) 266.8922

State Website Address:

http://dhs.wisconsin.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 01, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Community Support Program (CSP), Crisis, Emergency, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Medical Day Treatment, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Contractor Types:
-County Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Children and Related Populations
-Title XXI CHIP

Populations Mandatorily Enrolled:
None

WISCONSIN
Wraparound Milwaukee

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Mental Health Agency
-Milwaukee County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
-Other Public And Private Agencies Are On The Statewide Children Come First Advisory Committee
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Milwaukee County Human Services Department --
Wraparound Milwaukee

ADDITIONAL INFORMATION

Program goal is to keep children with severe emotional disturbances out of institutions and to serve these children and their families in the community. The state reallocates previous funding for institutional placement into community based care. It uses a "wraparound," integrated services approach with multi-agency and multi-disciplinary collaboration. Key components include intensive case management, crisis intervention, and a flexible array of services and supports (including some not traditionally covered under Medicaid) based on highly individualized plans of care. This mental health and substance abuse carve-out program does not designate a primary care provider for physical health care. All enrollees must have a special needs to be eligible for enrollment.

QUALITY ACTIVITIES FOR PIHP

WISCONSIN
Wraparound Milwaukee

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-Annual family satisfaction survey through Families United Inc. (advocacy agency)
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Performance Measures

Process Quality:
-Collaboration And Teamwork
-Family-Based And Community-Based Service Delivery
-Follow-up after hospitalization for mental illness
-Identification And Process= Service/Care Coordinators (Case Managers)
-Membership And Process= Child And Family Teams (Plan Of Care Teams)
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Process And Content= Plans Of Care
-Process And Content= Service Authorization Plans

Health Status/Outcomes Quality:
-Cost-Effectiveness Comparison Of This Managed Care Program To Non-Managed Care
-Criminal Offenses And Juvenile Justice Contracts Of Enrollees, Pre-Test And Post-Test
-Functional Impairment Of Enrollees, Pre-Test And Post-Test
-Patient satisfaction with care
-Restrictiveness Of Living Arrangements For Enrollees, Pre-Test And Post-Test
-School Attendance And Performance Of Enrollees, Pre-Test And Post-Test

Access/Availability of Care:
-Internal And External Quality Assurance Audits Of Access And Of Monitoring Plans Of Care

Use of Services/Utilization:
-Internal And External Quality Assurance Audits Of Monitoring Plans Of Care And Tracking Actual Service Utilization

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
-Internal Quality Assurance Review Of Sub-Contracted Providers

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Other Demographic, Clinical, And Service System Characteristics Of Enrollees.
-PIHP/PCP-specific disenrollment rate

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Transition to Adulthood

Non-Clinical Topics:
-Transitional Plan

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

WISCONSIN
Wraparound Milwaukee

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Name:
-MetaStar

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

FLORIDA
Florida Comprehensive Adult Day Health Care Program

CONTACT INFORMATION

State Medicaid Contact:

GP Mendie
Florida Agency for Health Care Administration
(850) 412-4252

State Website Address:

http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 24, 2003

Implementation Date:
April 01, 2004

Waiver Expiration Date:
March 31, 2012

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Adult Day Health Care - Fee-for-Service

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Medical
Direction, Nutrition, Personal Care, Rehabilitation Therapy,
Social, Transportation

Allowable PCPs:
-Adult Day Health Care Centers

Enrollment

Populations Voluntarily Enrolled:
-Aged 60 or older

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

FLORIDA
Florida Comprehensive Adult Day Health Care Program

-Other Insurance
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Sunrise Community, Inc.

ADDITIONAL INFORMATION

The Adult Day Health Care facilities are not managed care entities, as defined by the State statutues. They are licensed pursuant to chapter 400 Part 5 of the Florida Statutes. The b/c program will be terminated on March 31, 2012.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

GP Mendie
Medical Health Care Program Analyst
Agency for Healthcare Administration
(850) 412-4252

State Operating Agency Contact:

Laura Noyes

FLORIDA
Florida Comprehensive Adult Day Health Care Program

Analyst

Florida Department of Elder Affairs
(850) 414-2335

PROGRAM DATA

Program Service Area:
County

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

Initial Waiver Effective Date:
April 01, 2005

Waiver Expiration Date:
March 31, 2012

Service Delivery

Target Group:
Aged 60 or older

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

The 1915(b) waiver allows Florida to selectively contract vendors for selected counties to provide the 1915(c) services.

KANSAS
Mental Health and Substance Abuse Services

CONTACT INFORMATION

State Medicaid Contact:

Elizabeth Phelps
Department of Social and Rehabilitation Services
(785) 296-4552

State Website Address:

http://www.srskansas.org

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 24, 2006

Implementation Date:
July 01, 2007

Waiver Expiration Date:
June 30, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Substance Use Disorders (SUD) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Detoxification, Inpatient Substance Use Disorders, Outpatient Substance Use Disorders, Residential Substance Use Disorders Treatment Programs, Substance Use Disorders Support

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Adoption Support
-Aged and Related Populations

KANSAS
Mental Health and Substance Abuse Services

-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Breast/Cervical Cancer
-Foster Care Children
-Medically Impoved
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Presumptive XIX
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Working Disables

Subpopulations Excluded from Otherwise Included Populations:

-No State Payment Adult Care Home Resident
-Nursing Facility Head Injury
-Nursing Facility Mental Health
-Nursing Facilty Swing Bed
-PACE
-Reside in Nursing Facility or ICF/MR
-State Hospital Developmentally Disabled
-State Hospital Mental Health

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

KANSAS
Mental Health and Substance Abuse Services

Mental Health (MH) PAHP - Non-risk Capitation

Service Delivery

Included Services:
Case Conferencing, Crisis, Evidence-based Mental Health Practices, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Peer Support for Mental Health, Personal Care, SED Waiver, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Adoption Support
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Breast/Cervical Cancer
-Foster Care Children
-Medically Improved
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Presumptive XIX
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Working Disables

Subpopulations Excluded from Otherwise Included Populations:
-No State Payment Audit Care Home Resident
-Nursing Facility Head Injury
-Nursing Facility Mental Heatlh
-Nursing Facility Swing Bed
-PACE
-Reside in Nursing Facility or ICF/MR
-State Hospital Developmentally Disabled
-State Hospital Mental Health

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

KANSAS
Mental Health and Substance Abuse Services

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Adult Corrections Systems
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Employment Agencies
-Housing Agencies
-Juvenile Justice Agencies
-Maternal and Child Health Agency
-Mental Health Agency
-Physical Health MCOs and Providers
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Kansas Health Solutions   ValueOptions-Kansas

ADDITIONAL INFORMATION

The Value Options (Substance Use Disorders PIHP) is connected to the 1915(b) portion and the Kansas Health Solutions (Mental Health PAHP) is connected to the 1915(c) portion of the 1915(b)/(c) Mental Health and Substance Abuse Services program. Both plans include the same number of eligible members.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Rita Haver Kamp
Contract Manager
KS Department of Health and Environment
(785) 296-4813

State Operating Agency Contact:

Sandy Hashman
Assistant Director
KS Department of Social
and Rehabilitation Services
(785) 296-7926

PROGRAM DATA

Program Service Area:

Statewide

Initial Waiver Effective Date:

July 01, 2007

KANSAS
Mental Health and Substance Abuse Services

Statutes Waived:

1902(a)(10)(B) Comparability of Services
1902(a)(10)(C)(i)(III) Income and Resource Rules

Waiver Expiration Date:

September 30, 2015

Service Delivery

Target Group:

Seriously Emotional Disturbance

Level of Care:

Hospital

ADDITIONAL INFORMATION

The administration and oversight of both the 1915(b) and 1915(c) program is conducted by the same program unit; the service array and provider/member services activities are conducted by the same PAHP contractor. The 1915(c) program infrastructure was transferred, with very little modification visible to beneficiaries and providers to the PAHP program contractors.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PIHP Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-Member Satisfaction Survey
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Access to Services
-Adult's access to preventive/ambulatory health services
-Network capacity to serve members
-Ratio of addictions professionals to number of beneficiaries

Use of Services/Utilization:
-Over and Under Utilization of intensive services
-Over and Under Utilization of lower levels of care

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
-Annual assessment of provider network
-Geoaccess

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-HEDIS Based Initiation and Engagement

Non-Clinical Topics:
-Accuracy of encounter data

Standards/Accreditation

PIHP Standards:
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards
-URAC Standards

Accreditation Required for Participation:
None

KANSAS
Mental Health and Substance Abuse Services

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Kansas Foundation for Medical Care

EQRO Organization:
-Kansas Foundation for Medical Care

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of Performance Measures
-Validation of state/contractor data systems

EQRO Optional Activities
-Validation of encounter data

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Cross-agency MCO Oversight Group
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Fraud and Abuse Monitoring and Collaboration with MFCU
-Georgraphic Mapping
-Monitoring of PAHP Standards
-Network Data
-Ombudsman
-On-Site Reviews
-PAHP Standards (see below for details)
-Performance Measures (see below for details)
-Provider Data
-State Quality Committee
-Utilitzation Review and Corporate Compliance Plan

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-Consumer/Beneficiary Focus Groups
-Member Satisfaction Survey
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g.

617

codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Decreased utilization of institutional care
-Rates of competitive employment for adults
-Rates of school attendance for youth
-Rates of youth residing in permanent family home

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Service penetration rates
-Service utilization post-inpatient care

Health Plan Stability/ Financial/Cost of Care:
-Business continuity plan
-Corporate Compliance Plan, including Fraud and Abuse
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (ER, pharmacy, lab, x-ray, dental, vision, etc.)
-IBNR claims report (lag report)
-Key Personnel Changes
-Net income
-Net worth
-Subcontractor terms and conditions
-TPL/COB information

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PAHPs

Performance Measures - Others:
None

Standards/Accreditation

KANSAS
Mental Health and Substance Abuse Services

PAHP Standards:
-CMS's Quality Improvement System for managed Care
(QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

MARYLAND
Living at Home Case Management Waiver

CONTACT INFORMATION

State Medicaid Contact:

Marlana Hutchinson
DHMH Long Term Care and Waiver Services
(410) 767-4003

State Website Address:

http://www.dhmh.state.md.gov/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 01, 2009

Implementation Date:
November 01, 2009

Waiver Expiration Date:
September 30, 2013

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Selective Contract - Fee-for-Service

Service Delivery

Included Services:
Case Management

Allowable PCPs:
-Case Managers

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
None

MARYLAND
Living at Home Case Management Waiver

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

The Coordinating Center

ADDITIONAL INFORMATION

The Department of Health and Mental Hygiene, Office of Health Services has full administrative authority over the Living at Home Waiver program, located within the Living at Home Waiver Division. Historically, the Living at Home Waiver program was responsible for procuring, maintaining, and monitoring contracts for two administrative services available for waiver participants. Fiscal intermediary and case management contractors are selected through a competitive bid process and are available statewide. On October 31, 2009, the contract for case management services ended; the program moved from the administrative case management model to providing administrative, transitional, and ongoing case management as billable services to eligible applicants and participants effective November 1, 2009.

Reimbursement for case management waiver services in the amendment to the 1915(c) Living at Home Waiver (MD 0353) will be based on a rate defined in COMAR. Maryland used a competitive solicitation process to select its case management provider that will be providing case management as an administrative and waiver service.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Marlana Hutchinson
Division Chief
DHMH Long Term Care and Waiver Services
(410) 767-4003

State Operating Agency Contact:

MARYLAND
Living at Home Case Management Waiver

PROGRAM DATA

Program Service Area:
Statewide

Statutes Waived:
1902(a)(10)(B) Comparability of Services

Initial Waiver Effective Date:
July 01, 2009

Waiver Expiration Date:
June 30, 2014

Service Delivery

Target Group:
Disabled

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

Case management is a covered service under the 1915(c) waiver. However, in order to restrict freedom of choice under the 1915(c) waiver, a 1915(b) waiver has to be in place for a selective provider or provider

MICHIGAN
Specialty Prepaid Inpatient Health Plans

CONTACT INFORMATION

State Medicaid Contact:

Elizabeth Knisely
MDCH, Bureau of Community Mental Health Services
(517) 335-8401

State Website Address:

http://www.michigan.gov/mdch

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
June 26, 1998

Implementation Date:
October 01, 1998

Waiver Expiration Date:
September 30, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Assertive Community Treatment, Assessments, Assistive Technology *, Behavior Management Review, Child Therapy, Clubhouse, Community Living Supports *, Crisis Interventions, Crisis Residential, Enhanced Pharmacy *, Environmental Modifications *, Family Support and Training *, Fiscal Intermediary Services, Health, Home-based, Housing Assistance *, ICF/MR, Inpatient Psychiatric, Intensive Crisis Stabilization, Medication admin/review, MH Therapies, Nursing Facility Monitoring, Occupational, Physical and Speech Therapies, Outpatient Partial Hospitalization, Peer-delivered Support *, Personal care in specialized residential, Prevention-Direct Models *, Respite Care *, Skill-building Assistance *, Substance Abuse, Support and Service Coordination *, Supported Employment *, Targetted Case Management, Transportation, Treatment Planning, Wrap-around for Children and Adolescents *

Allowable PCPs:
-Addictionologists
-Clinical Social Workers
-Other Specialists Approved on a Case-by-Case Basis
-Psychiatrists
-Psychologists

MICHIGAN
Specialty Prepaid Inpatient Health Plans

Contractor Types:
-County Community Mental Health Services

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Children Enrolled in Childrens Waiver (Section 1915(c))
-Residing in ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Agents when used for anorexia, weight loss, weight gain

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Identified through other health care agencies
-Outreach
-Referred through other health care practitioners/agencies
-Self-referral

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Department of Corrections
-Education Agency
-Housing Agencies
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Rehabilitation Services
-Social Services Agencies
-Specialty Employment Agency (Supported Employment)
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Alliance of Michigan   CMH Affiliation of Mid-Michigan

MICHIGAN
Specialty Prepaid Inpatient Health Plans

CMH for Central Michigan	CMH Partnership of Southeast Michigan
Detroit-Wayne County CMH Agency	Genesee County CMH Services
Lakeshore Behavioral Health Alliance	LifeWays
Macomb County CMH Services	Network 180
North Care	Northern Affiliation
Northwest CMH Affiliation	Oakland County CMH Authority
Saginaw County CMH Authority	Southwest Affiliation
Thumb Alliance PIHP	Venture Behavioral Health

ADDITIONAL INFORMATION

Southwest Michigan Urban & Rural Consortium had a name change since the last submission and is now Southwest Affiliation.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Elizabeth Knisely
Director
MDCH, Bureau of Community Mental Health
Services
(517) 335-8401

State Operating Agency Contact:

Debra Ziegler
HSW Specialist
Bureau of Community Health Services
Michigan Department of Community Health
(517) 373-5322

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Effective Date:
December 12, 2002

Statutes Waived:
1902(a)(10)(B) Comparability of Services

Waiver Expiration Date:
September 30, 2015

Service Delivery

Target Group:
Developmental Disabled

Level of Care:
ICFMR

ADDITIONAL INFORMATION

Under the Michigan Managed Specialty Support and Services Program, PIHPs administer state plans, 1915(b)(3) and 1915(c) waiver services. This managed mental health services program provides support and services to person with serious mental illness, developmental disability and substance use disorders, and children with serious emotional disturbance. Persons served through the 1915(b) waiver use a combination of state plan and 1915 (b)(3) services. Persons enrolled in the C waiver, called the Habilitation

MICHIGAN
Specialty Prepaid Inpatient Health Plans

Supports Waiver (HSW) use a combination of C waiver services, state plan and 1915 (b)(3) servic

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-CMHSP Certification for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-External Quality Review
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)

Use of Collected Data:
-Actuarial analysis
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-MHSIP Consumer Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of electronic file formats
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-5010 - transaction set format for transmitting health care claims data
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

PIHP conducts data accuracy check(s) on specified data elements:
None
-Provider ID
-Type of Service
-Medicaid Eligibility
-Diagnosis Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Age
-Gender
-Race/Ethnicity
-Social Security

State conducts general data completeness assessments:
Yes

MICHIGAN
Specialty Prepaid Inpatient Health Plans

Performance Measures

Process Quality:
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percent readmitted to inpatient care within 30 days of discharge
-Rates of rights complaints/1000 served
-Rates of sentinel events/1000 served

Access/Availability of Care:
-Penetration rates for special populations
-Timelines and screening for inpatient
-Wait time for commencement of service(s)
-Wait time for first appointment with PCP

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing
-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
None

Non-Clinical Topics:
-Each PIHP performs two PIP within the 2-year cycle

Standards/Accreditation

PIHP Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Service Advisory Group, Phoenix, AZ

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-ER and Hospitalization Use Study

MINNESOTA
Minnesota Senior Care/Minnesota Senior Care Plus

CONTACT INFORMATION

State Medicaid Contact:

David Godfrey
Minnesota Department of Human Services
(651) 431-2319

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1), Freedom of Choice

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 21, 2005

Implementation Date:
June 01, 2005

Waiver Expiration Date:
June 30, 2016

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Community Based, Dental, Disease Management, Durable Medical Equipment, Emergency Room, ESRD, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter Service, Laboratory, Medication Therapy Management, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care Assistant, Pharmacy, Physical Therapy, Physician, Podiatry, Preventive Visite, Prosthetic and Orthotic Devices, Public Health, Reconstructive Surgery, Respiratory Therapy, Skilled Nursing Facility, Speech Therapy, Transplants, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable. Contractors Not Required to Identify PCPs

Enrollment

MINNESOTA
Minnesota Senior Care/Minnesota Senior Care Plus

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles
-Populations Aged 65+

Subpopulations Excluded from Otherwise Included Populations:
-CHIP Title XXI Children
-Enrolled in Another Managed Care Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Other Insurance
-Poverty Level Pregnant Woman
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Itasca Medical Care
Metropolitan Health Plan
South Country Health Alliance

Health Partners
Medica
PrimeWest Health System
UCARE

ADDITIONAL INFORMATION

MINNESOTA
Minnesota Senior Care/Minnesota Senior Care Plus

None

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Ann Berg
Deputy Medicaid Director
Minnesota Department of Human Services
(651) 431-2183

State Operating Agency Contact:

David Godfrey
Medicaid Director

Minnesota Department of Human Services
(651) 431-2319

PROGRAM DATA

Program Service Area:
County

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

Initial Waiver Effective Date:
April 01, 2005

Waiver Expiration Date:
June 30, 2013

Service Delivery

Target Group:
Aged

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

1915(c) services must be part of the MCOs provider network. The 1915(c) Elderly Waiver services are included in MCO contracts in some counties. In the remaining counties, person eligible for EW services receive them through their county or tribe

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QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Annual HCBS quality assurance plan
-Care plan audits
-Care system reviews
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-HCBS self-assessment QA survey
-MCO Standards (see below for details)

Use of Collected Data:
-Assess program results
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

MINNESOTA
Minnesota Senior Care/Minnesota Senior Care Plus

-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
-Disenrollment Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Payment

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Adult preventive visits
-Antidepressant medication management
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Colorectal Cancer Screening
-COPD-spirometry testing
-Dental services
-Diabetes screening
-Number of Mental Health Inpatient Discharges
-Osteoporosis care after fracture
-Percentage of beneficiaries with at least one dental visit

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

MINNESOTA
Minnesota Senior Care/Minnesota Senior Care Plus

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP

Use of Services/Utilization:
-CD initiating and treatment
-Mental health discharges
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Aspirin therapy
-Asthma management
-Asthma-reduction of emergency department visits
-Breast cancer screening (Mammography)
-Calcium/Vitamin D
-Cholesterol screening and management
-Colon cancer screening
-Depression management
-Diabetes management
-Diabetic statin use, 40 to 75 year olds
-Human Papillimavirus
-Hypertension management
-Mental health/chemical dependency dual diagnoses
-Obesity
-Pneumococcal vaccine

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-MetaStar
-Michigan Performance Reiview Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid has collaborated with a public sector entity to support the P4P program

MINNESOTA
Minnesota Senior Care/Minnesota Senior Care Plus

Population Categories Included:
A subset of MCO members, defined by disease and medical condition

Clinical Conditions:
Dental

Initial Year of Reward:
1999

Member Incentives:
Not Applicable

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

NEW MEXICO
Coordination of Long-Term Services

CONTACT INFORMATION

State Medicaid Contact:

Paula McGee
NM HSD/Medical Assistance Division
(505) 827-6234

State Website Address:

http://www.hsd.state.nm.us/mad/CCoLTSDetail.html

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
August 01, 2008

Implementation Date:
August 01, 2008

Waiver Expiration Date:
July 31, 2012

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Disease
Management, Durable Medical Equipment, EPSDT, Family
Planning, Hearing, Home Health, Hospice, Immunization,
Inpatient Hospital, Institutional, Laboratory, Occupational
Therapy, Outpatient Hospital, Personal Care, Pharmacy,
Physical Therapy, Physician, Podiatry, Skilled Nursing
Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives Certified
-Nurse Practioners Certified
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

NEW MEXICO
Coordination of Long-Term Services

None

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in another Managed Care Program
-Medicare Dual Eligible without full Medicaid Benefits
-Participate in HCBS Waiver for DD and Medically Fragile
-Reside in ICF/MR

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

Medicaid Only

Medicare Dual Eligibles Excluded:

SLMB, QI, and QDWI
QMB
QMB Plus
SLMB Plus

Part D Benefit

MCE has Medicare Contract:

Yes

Provides Part D Benefits:

Yes

Scope of Part D Coverage:

Basic Alternative Coverage

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

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SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Department of Health
-Indian Health Services
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMERIGROUP Community Care of New Mexico, Inc.

NEW MEXICO
Coordination of Long-Term Services

Evercare of New Mexico

ADDITIONAL INFORMATION

Individuals with Special Health Care Needs (ISHCN) are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition and who require health and related services of a type or amount beyond that required by other individuals. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO/SE can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Paula McGee
Healthcare Operations Manager
HSD Medicaid
(505) 827-6234

State Operating Agency Contact:

PROGRAM DATA

Program Service Area:
Statewide

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(23) Freedom of Choice

Initial Waiver Effective Date:
August 01, 2008

Waiver Expiration Date:
July 25, 2012

Service Delivery

Target Group:
Aged
Disabled
Aged and Disabled

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

Coordination of Long-Term Services is a managed care program designed to provide and coordinate services to specific Medicaid recipients. Services include doctor visits, hospital services, home and community-based services and long term care services. The intent of the program is to improve the quality of life for enrollees by offering long-term services to meet the individuals needs, allowing the individual to decide whether to received services in their home, community, or in a nursing or assisted living facility. 1915(b) allows New Mexico to implement the Coordinated Long-Term Services program under a managed care model. 1915(c) Home and Community-Based Waiver allows New Mexico to have long-term care services delivered in community settings, an alternative to providing

NEW MEXICO
Coordination of Long-Term Services

comprehensive long-term services in institutional setting

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult with Special Needs Questionnaire
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service

State conducts general data completeness assessments:
Yes

NEW MEXICO
Coordination of Long-Term Services

-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Performance Measures

Process Quality:
-Asthma care - medication use
-Diabetes medication management
-Influenza vaccination
-Influenza vaccination rate
-Pneumonia care
-Pneumonia vaccination

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of home health visits per beneficiary

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Cholesterol screening and management
-Coordination of Primary and Behavioral Health care
-Diabetes management

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
None

NEW MEXICO
Coordination of Long-Term Services

Non-Duplication Based on Accreditation:
None

EQRO Name:
-HealthInsight dba New Mexico Medical Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

NORTH CAROLINA
Mental Health Developmental Disabilities & Substance Abuse Services

CONTACT INFORMATION

State Medicaid Contact:

Judy Walton
Division of Medical Assistance
(919) 855-4265

State Website Address:

http://www.ncdhhs.gov/dma

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
October 06, 2004

Implementation Date:
April 01, 2005

Waiver Expiration Date:
March 31, 2013

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Assistive Technology Equipment and Supplies, Care Giver Training, Community Guide, Community Networking, Community Transitions Support, Crisis, Detoxification, Financial Management, Habilitation, Home Modifications, ICF/MR, IMD, Individual Directed Goods and, In-Home Intensive Supports, In-Home Skill Building, Inpatient Mental Health, Inpatient Substance Use Disorders, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Natural Supports Education, Opioid Treatment Programs, Outpatient Substance Use Disorders, Personal Care, Residential Substance Use Disorders Treatment Programs, Respite, Specialized Consultation, Supported Employment, Vehicle Modifications

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

NORTH CAROLINA
Mental Health Developmental Disabilities & Substance Abuse Services

Contractor Types:
-Regional Authority Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Adoption Assistance
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children

Subpopulations Excluded from Otherwise Included Populations:
-Family Planning Waiver Participants
-Medicare Dual Eligibles
-Refugees

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Piedmont Behavioral Healthcare

ADDITIONAL INFORMATION

NORTH CAROLINA
Mental Health Developmental Disabilities & Substance Abuse Services

None

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Judy Walton
Program Administrator
Division of Medical Assistance
(919) 855-4265

State Operating Agency Contact:

PROGRAM DATA

Program Service Area:

Region

Initial Waiver Effective Date:

April 01, 2005

Statutes Waived:

1902(a)(10)(B) Comparability of Services
1902(a)(10)(C)(i)(III) Income and Resource Rules
1902(a)(1) Statewideness

Waiver Expiration Date:

March 31, 2013

Service Delivery

Target Group:

Disabled
Aged and Disabled
Mentally Retarded
Developmental Disabled
Mentally Retarded and Developmentally Disabled
Seriously Mentally Ill or Substance Use Disorders

Level of Care:

Hospital
ICFMR

ADDITIONAL INFORMATION

The Mental Health, Developmental Disabilities and Substance Abuse Services Health Plan (NC MH/DD/SAS), which is a 1915(b) waiver, and the NC Innovations waiver operate concurrently and has been authorized to allow for expansion of the capitated program to other areas of the state over time. The MH/DD/SAS waiver enables the State to mandate beneficiaries into a single Prepaid Inpatient Health Plan (PIHP). The PIHP is the State's MH/DD/SAS authority that serves the counties covered by the waivers. Thus, NC Innovations home and community based services are administered by the MH/DD/SAS authority in a capitated, managed care environment along with Medicaid State Plan mental health and substance abuse services.

QUALITY ACTIVITIES FOR PIHP

NORTH CAROLINA
Mental Health Developmental Disabilities & Substance Abuse Services

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Monitoring of PIHP Standards
-Network Data
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-State Approved Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:
-Ambulatory follow up within 7 days after discharge from mental health facility
-Ambulatory follow up within 7 days after discharge from substance abuse facility
-Follow-up after hospitalization for mental illness
-Number of Consumers moved from institutional care to community care
-Readmission rates for mental health
-Readmission rates for substance abuse

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
-Call Abandonment
-Call Answer Timeliness
-Initiation and Engagement of Alcohol and other drug dependence treatment
-Out of Network Services
-Service Availability/Accessibility
-Timeliness of initial service delivery

Use of Services/Utilization:
-Chemical dependency services utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-MH Utilization percentage of members receiving inpatient, day/night, ambulatory and other support services
-Percentage of members receiving inpatient, day/night, ambulatory and support services for chemical dependency
-Utilization management of the provision of high use services

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements

Health Plan/ Provider Characteristics:
-Network Capacity

Beneficiary Characteristics:
-Diversity of Medicaid Membership

Performance Measures - Others:
None

Performance Improvement Projects

NORTH CAROLINA
Mental Health Developmental Disabilities & Substance Abuse Services

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

-Decrease admission rate to PTF and/or Inpatient for Consumers discharged from residential level III placement
-Improve community tenure for enrollees with multi-systemic therapy and intensive in-home services

Non-Clinical Topics:

-Improved provider compliance with coordination of benefits and sliding fee schedules

Standards/Accreditation

PIHP Standards:

-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation:

None

Non-Duplication Based on Accreditation:

-Accreditation Agencies Recognized by CMS for Non-Duplication

EQRO Name:

-Carolina Centers for Medical Excellence (CCME)

EQRO Organization:

-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:

-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities

None

TEXAS
STAR+PLUS

CONTACT INFORMATION

State Medicaid Contact:

Joe Vesowate
Texas Health and Human Services Commission
(512) 491-1379

State Website Address:

http://www.hhsc.state.tx.us/starplus/starplus.html

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Enrollment Broker:
Maximus

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 30, 1998

Implementation Date:
January 01, 1998

Waiver Expiration Date:
December 11, 2011

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

TEXAS
STAR+PLUS

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Reside in a Nursing Facility or ISF/MR, Reside in a state school or other 24 hour facility, Participating in a HCBS waiver other than the 1915 (c) Nursing Facility Waiver

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Dept. of Aging and Disability Services (DADS)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup (STAR+PLUS)

Bravo

Evercare

Molina (STAR+Plus)

Superior HealthPlan (STAR+Plus)

ADDITIONAL INFORMATION

Blind/disabled/aged adults who are SSI or deemed SSI by CMS are mandatory to participate in the MCO model. Blind/disabled children who are SSI or deemed SSI by CMS have the choice of participating in the MCO model or the PCCM model.

Concurrent Operating 1915(c) Program

TEXAS
STAR+PLUS

CONTACT INFORMATION

State Medicaid Agency Contact:

DJ Johnson
STAR+Plus Project Specialist
Health & Human Services Commission
(512) 491-1301

State Operating Agency Contact:

PROGRAM DATA

Program Service Area:
County

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

Initial Waiver Effective Date:
February 01, 1998

Waiver Expiration Date:
August 31, 2012

Service Delivery

Target Group:
Aged and Disabled

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

Both b&c waivers are operating through the STAR&Plus program which integrates acute and long term care services for SSI enrollees in Harris County. In February 2011, the STAR+Plus 1915(b) ad 1915(c) waivers expanded to the Harris contiguous, Bexar, Nueces and Travis SDA. In February 2011, the Star+Plus 1915(b) and 1915(c) waivers expanded to the Dallas and Tarrant SDA

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

TEXAS
STAR+PLUS

-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Medicaid Eligibility
-Plan Enrollment
-Preparing HEDIS and risk adjustment software

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Depression management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in adolescents

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to LTSS providers
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-None

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics:
-Diabetes care and management
-Influenza Immunizations

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Institute for Child Health Policy

EQRO Organization:
-Institute for Child Health Policy, University of Florida

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational

standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

WISCONSIN
Family Care

CONTACT INFORMATION

State Medicaid Contact:

Monica Deignan
Wisconsin Department of Health Services
(608) 261-7807

State Website Address:

http://dhs.wisconsin.gov/LTCare/INDEX.HTM

PROGRAM DATA

Program Service Area:
Region by MCO Contract

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Enrollment Broker:
Aging and Disability Resource Centers

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 01, 2001

Implementation Date:
January 01, 2001

Waiver Expiration Date:
December 31, 2011

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Family Care PIHPs - Risk-based Capitation

Service Delivery

Included Services:
1915(c) Waiver, Case Management, Disposable Medical Supplies, Durable Medical Equipment, Duty Nursing, Home Health, ICF-MR, In-home Psychotherapy, Language Pathology, Mental Health Community Support Program, Occupational Therapy, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Physical Therapy, Respiratory Therapy, Skilled Nursing, Skilled Nursing Facility, Speech Therapy, Transportation

Allowable PCPs:
-Not applicable, primary care is carved out

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

WISCONSIN
Family Care

-Adults with Developmental Disability or Mental Retardation
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

None

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Have an Eligibility Period that Is Only Retroactive

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-All Target Groups Are Persons with Complex Special Needs

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Mental Health Agency
-Physicians & Clinics
-Protective Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Care Wisconsin First, Inc. (FC)

CHP-LTS, Inc. (FC)

Community Care of Central Wisconsin (FC)

Community Care, Inc. (FC)

Lakeland Care District

Milwaukee County Department of Family Care

Northern Bridges

Southwest Family Care Alliance

Western Wisconsin Cares

ADDITIONAL INFORMATION

None

WISCONSIN
Family Care

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Monica Deignan
Deputy Director Office of Family Care Expansion
WI Department of Health Services
(608) 261-7807

State Operating Agency Contact:

PROGRAM DATA

Program Service Area:
Region by PIHP Contract

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

Initial Waiver Effective Date:
January 01, 2001

Waiver Expiration Date:
December 31, 2014

Service Delivery

Target Group:
Aged and Disabled
Mentally Retarded
Developmental Disabled

Level of Care:
Nursing Home
ICFMR

ADDITIONAL INFORMATION

The 1915(b) waiver allows for restriction of freedom of choice of providers under the Family Care risk-based prepaid inpatient health plan contract, which allows Family Care PIHPs to deliver care through a managed care model. Services provided include 1915(c) waiver services and the longterm care Medicaid State Plan services - nursing home and ICF-MR, home health, personal care, therapies, mental health services, AODA services, durable medical equipment, medical supplies and transportation services (except ambulance).

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Individualized Service Plan Reviews
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation

WISCONSIN
Family Care

-PIHP Standards (see below for details)
-Provider Data
-Structured Member Outcome Interviews

Consumer Self-Report Data:
-Member satisfaction survey
-Structured Member Outcome Interviews

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires PIHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Certification
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Certification of Data Submissions
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Member LTC outcomes present
-Support for member LTC outcomes provided

Health Status/Outcomes Quality:
-Member health and safety outcomes present
-Patient satisfaction with care
-Support for member health and safety outcomes provided

Access/Availability of Care:
-State assessment of adequate network capacity

Use of Services/Utilization:
-NF and ICF-MR utilization

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-State minimum reserve requirements

Health Plan/ Provider Characteristics:
-Board Certification
-State review for cultural competency

WISCONSIN
Family Care

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-PIHP/PCP-specific disenrollment rate

Performance Measures - Others:
-Structured Member Outcome Interviews

Performance Improvement Projects

Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
-Fall Prevention

Non-Clinical Topics:
-Increasing employment
-Notice of Action
-Service Authorization

Standards/Accreditation

PIHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-MetaStar, Inc.

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance meassures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

FLORIDA
Nursing Home Diversion Program

CONTACT INFORMATION

State Medicaid Contact:

GP Mendie
Florida Agency for Health Care Administration
(850) 412-4252

State Website Address:

http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(a)/1915(c)

Statutes Utilized:
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
December 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
1902(a)(1) Statewideness
1902(a)(10)(b) Comparability of Services

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Long Term Care PIHP - Risk-based Capitation

Service Delivery

Included Services:
Dental, Emergency, Escort, Family Training, Financial Assessment and Risk Reduction, Hearing, Home Health, Hospice, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physicians, Respite Care, Skilled Nursing Facility, Speech Therapy, Vision, X-ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Aged 65 or older
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

FLORIDA
Nursing Home Diversion Program

Subpopulations Excluded from Otherwise Included Populations:

-Adults age 64 or younger
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title CHIP XXI

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Department of Children and Family Services
-Department of Elder Affairs

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

American Eldercare	Amerigroup (NHD)
Humana Medical Plan	Humana Senior's Choice
Life Hope Care	Little Havana Activities and Nutrition Centers
Neighborly Care Network	Project Independence at Home
Sunrise Home Health	Sunshine State Health Plan, Inc. (NHD)
United Health Care (NHD)	United Home Care Services
Universal Health Care (NHD)	Urban Jacksonville
Vista Independence Plan	World Net, Inc.
YourCare Brevard	

ADDITIONAL INFORMATION

None

Concurrent Operating 1915(c) Program

FLORIDA
Nursing Home Diversion Program

CONTACT INFORMATION

State Medicaid Agency Contact:

GP Mendie
Medical Health Care Program Analyst
Agency for Healthcare Administration
(850) 412-4252

State Operating Agency Contact:

Laura Noyes
Analyst

Florida Department of Elder Affairs
(850) 414-2335

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Effective Date:
July 01, 1998

Waiver Expiration Date:
September 28, 2011

Service Delivery

Target Group:
65 or older
Medicare Dual Eligibles

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

The 1915 (a) authority permits managed care organizations to offer home and community care services to program recipients through their provider networks. The Nursing Home Diversion waiver coordinates acute and long-term care services for dual eligible beneficiaries through managed care organizations under the 1915(a) waiver authority. Under the 1915(c) authority, the waiver provides home and community-based services to recipients in order to prevent or delay nursing home placement.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Focused Studies
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

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FLORIDA
Nursing Home Diversion Program

Encounter Data

Collection: Requirements:
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for initial encounter data submission

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Controlling high blood pressure
-Diabetes medication management
-Influenza vaccination rate
-Pneumonia vaccination

Health Status/Outcomes Quality:
-Patient satisfaction with care

Access/Availability of Care:
None

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)
-Verify Provider compliance with State surplus account and reserve requirements

Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-PIHP/PCP-specific disenrollment rate

Performance Measures - Others:
-Contractual Compliance

FLORIDA
Nursing Home Diversion Program

Performance Improvement Projects

Project Requirements:

-PIHPs are required to conduct a project(s) of their own choosing
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

None

Non-Clinical Topics:

-Availability of language interpretation services

Standards/Accreditation

PIHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group (HSAG)

EQRO Organization:
-Health Services Advisory Group (HSAG)

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Assessment of MCO Organizations

MASSACHUSETTS
Senior Care Options (SCO)

CONTACT INFORMATION

State Medicaid Contact:

Ken Smith
Office of Medicaid
(617) 222-7508

State Website Address:

http://www.mass.gov/masshealth

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a)/1915(c)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 2004

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
1902(a)(1) Statewideness
1902(a)(10)(b) Comparability of Services

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Adult Day Health, All Medicare and Medicaid Covered, Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Geriatricians
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

MASSACHUSETTS
Senior Care Options (SCO)

-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-A Medicare dual eligible who is excluded would be buy in only.
-Diagnosed with End Stage Renal Disease (ESRD)
-Enrolled in Another Managed Care Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Reside in ICF/MR
-Special Needs Children (BBA defined)
-Under 65 years old

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Housing Agencies
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Commonwealth Care Alliance

NaviCare

Evercare SCO

Senior Whole Health
(Upham's)

MASSACHUSETTS
Senior Care Options (SCO)

ADDITIONAL INFORMATION

All four of the Senior Care Organizations are also Medicare Advantage Special Needs Plans, serving MassHealth Standard members aged 65 or older. If an enrollee has Medicare A and B (in addition to MassHealth Standard), that enrollee must be enrolled in the SNP and the SCO. Enrollment is voluntary. There are no carve out or wrap services. A member must have full MassHealth benefits in order to enroll. All buy in categories are excluded.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Ken Smith
Director of Long Term Services and Supports
Office of Medicaid
(617) 222-7508

State Operating Agency Contact:

Not Applicable

PROGRAM DATA

Program Service Area:
County

Initial Waiver Effective Date:
January 01, 2009

Waiver Expiration Date:
December 31, 2013

Service Delivery

Target Group:
Aged
Disabled individuals age 65 and older
Mentally Retarded age 65 and older
Developmental Disabled age 65 and older
Seriously Mentally Ill age 65 and older
Serious Emotional Disturbance age 65 and older

Level of Care:
Nursing Home
Hospital
ICFMR

ADDITIONAL INFORMATION

The commonwealth offers a variety of services to consumers under a home and community-based services waiver program and the number of services that can be provided is not limited. These programs may provide a combination of both traditional medical services (i.e. dental services, skilled nursing) as well as non-medical services (i.e. respite, case management, environmental modifications).

QUALITY ACTIVITIES FOR MCO/HIO

MASSACHUSETTS
Senior Care Options (SCO)

State Quality Assessment and Improvement Activities:
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
None

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:
-Ace Inhibitor/ARB Therapy
-Antidepressant medication management
-Beta-blocker treatment after heart attack
-Diabetes medication management
-Heart Failure care
-Influenza vaccination rate
-Pneumonia vaccination

Health Status/Outcomes Quality:
-Mortality rates
-Patient satisfaction with care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-MH/SUD facility
-Number of days in ICF or SNF per beneficiary over 64 years
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
-Adult hearing and vision screening
-Asthma management
-Beta Blocker treatment after a heart attack

-Breast cancer screening (Mammography)
-Breast cancer treatment
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment
-Cholesterol screening and management
-Coordination of care for persons with physical disabilities
-Coronary artery disease prevention
-Coronary artery disease treatment
-Depression management
-Diabetes management
-Domestic violence
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment
-Hepatitis B screening and treatment
-Hip fractures
-HIV Status/Screening
-HIV/AIDS Prevention and/or Management
-Hospital Discharge Planning
-Hypertension management
-Hysterectomy
-Medical problems of the frail elderly
-Motor vehicle accidents
-Otitis Media management
-Pharmacy management
-Prescription drug abuse
-Prevention of Influenza
-Sexually transmitted disease screening
-Sexually transmitted disease treatment
-Sickle cell anemia management
-Smoking prevention and cessation
-Substance Use Disorders treatment after detoxification service
-Treatment of myocardial infraction
-Tuberculosis screening and treatment

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance)
Standards
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-APS Healthcare

EQRO Organization:
-QIO-like entity

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Assessment of MCO information systems
-Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance
program with the MCO

Program Payers:
Not Applicable

MASSACHUSETTS
Senior Care Options (SCO)

Population Categories Included:
Not Applicable

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Member Incentives:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

MINNESOTA
Minnesota Senior Health Options

CONTACT INFORMATION

State Medicaid Contact:

David Godfrey
Minnesota Department of Human Services
(651) 431-2319

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(a)/1915(c)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 01, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
 1902(a)(10)(b) Comparability of Services

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Community Based Services, Dental, Disease Management, Durable Medical Equipment, Emergency Room, Family Planning, Hearing, Home Health (Skilled Nurse Visit, Home health Aid), Inpatient Hospital, Inpatient Substance Use Disorders, Interpreter, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Preventive Visit, Respiratory Therapy, Skilled Nursing Facility (100 days), Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable; Contractors Not Required to Identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

MINNESOTA
Minnesota Senior Health Options

-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-QMB, SLMB not Otherwise Eligible for Medicaid
-Residing in a State Institution

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Mental Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus

Metropolitan Health Plan

South Country Health Alliance

Medica

PrimeWest Health System

UCARE

ADDITIONAL INFORMATION

None

Concurrent Operating 1915(c) Program

MINNESOTA
Minnesota Senior Health Options

CONTACT INFORMATION

State Medicaid Agency Contact:

Pamela Parker
Special Needs Purchasing Manager
Minnesota Department of Human Se
(651)431-2512

State Operating Agency Contact:

Not Applicable

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Effective Date:
March 01, 1997

Waiver Expiration Date:
June 30, 2013

Service Delivery

Target Group:
Aged

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Assess program results
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track access and utilization

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
-Disenrollment Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

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MINNESOTA
Minnesota Senior Health Options

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-None

MCO/HIO conducts data accuracy check(s) on specified data elements:
None

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
-Adult preventive visits
-Antidepressant medication management
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Colorectal cancer screening
-Dental services
-Diabetes screening
-Mental health discharges
-Osteoporosis care after fracture

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services

Use of Services/Utilization:
-CD initiating and treatment
-Mental health discharges
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own

Clinical Topics:
-Aspirin therapy

MINNESOTA
Minnesota Senior Health Options

choosing

-Asthma management
-Asthma-reduction of emergency department visits
-Breast cancer screening (Mammography)
-Calcium/Vitamin D
-Cholesterol screening and management
-Colon cancer screening
-Depression management
-Diabetes management
-Diabetic statin use, 40 to 75 year olds
-Human papillomavirus
-Hypertension management
-Mental health/chemical dependency dual diagnoses
-Obesity
-Pneumococcal vaccine

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance)
Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)

EQRO Name:
-MetaStar (QIO)
-Michigan Performance Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance
program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

WISCONSIN
Wisconsin Partnership Program

CONTACT INFORMATION

State Medicaid Contact:

Monica Deignan
DHS/DLTC
(608) 261-7807

State Website Address:

http://dhs.wisconsin.gov/wipartnership

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932(a)/1915(c)

Statutes Utilized:
Not Applicable

Enrollment Broker:
Aging and Disability Resource Centers

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
1915(c) Waiver Services, Case Management, Clinic, Dental, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Internists

Enrollment

Populations Voluntarily Enrolled:
-Adults with Developmental Disability or Mental Retardation
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

WISCONSIN
Wisconsin Partnership Program

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles - Have an eligibility period there is only retroactive.

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

Yes

Provides Part D Benefits:

Yes

Scope of Part D Coverage:

Standard Prescription Drug

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-Barbituates
-Benzodiazepines
-Part D excluded drugs that are covered under the Medicaid State Plan
-Selected classes of over the counter drugs by prescription

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-All target groups are persons with complex special needs
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Mental Health Agency
-Protective Services Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Care Wisconsin Health Plan, Inc. (Partnership)

Independent Care Health Plan (SNP)

Community Care Health Plan, Inc. (Partnership)

Partnership Health Plan, Inc.

ADDITIONAL INFORMATION

The Wisconsin Partnership Program began operating under a dual Medicaid--Medicare waiver in January 1999. This program provides comprehensive Medicaid and Medicare services for older adults (ages 65+) and people with disabilities (ages 18-64). The Partnership Program integrates health and long-term support services and includes home- and community-based care, physician services, and all other medical care. Services are delivered in the participants home or a setting of his or her choice. Team-based care management is a key component of the program. Enrollees must meet either a nursing home or an ICF/MR level of care. The Partnership Program goals are to: improve quality of health care and service delivery while containing costs; reduce fragmentation and inefficiency in the existing health care delivery system; increase the ability of people to live in the community and participate in decisions regarding their own

WISCONSIN
Wisconsin Partnership Program

health care. Other special characteristics: same goals as PACE Program; nurse practitioners play a key role in linking services; recipients can bring their own provider as PCP; external committee evaluation data techniques.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Monica Deignan
Deputy Director of Family Care Expansion
DHS/DLTC
(608) 261-7807

State Operating Agency Contact:

Not Applicable

PROGRAM DATA

Program Service Area:
Region by MCO Contract

Initial Waiver Effective Date:
January 01, 2001

Waiver Expiration Date:
December 31, 2014

Service Delivery

Target Group:
Aged and Disabled
Mentally Retarded and Developmentally Disabled

Level of Care:
Nursing Home
ICFMR

ADDITIONAL INFORMATION

The 1932(a) program incorporates all state plan services including the services available under the 1915(c) waiver progra

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QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement

Consumer Self-Report Data:
-Consumer satisfaction survey
-Consumer/Beneficiary Focus Groups
-Member satisfaction survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS

WISCONSIN
Wisconsin Partnership Program

-Structuredmember interviews

measures listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Member LTC outcomes present
-Support for member LTC outcomes provided

Health Status/Outcomes Quality:
-Member health and safety outcomes present
-Patient satisfaction with care
-Support for member health and safety outcomes provided

Access/Availability of Care:
-State assesment of adequate network capacity

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Number of hospital admissions per member per year
-Number of hospital days per member per year
-Percentage of beneficiaries with at least one dental visit

WISCONSIN
Wisconsin Partnership Program

-Percentage of people living at home, CBRF/group home, nursing home

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-State minimum reserve requirements

Health Plan/ Provider Characteristics:
-Board Certification
-State review for cultural competency

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-MCO/PCP specific disenrollment rate

Performance Measures - Others:
-Structured member outcome interviews

Performance Improvement Projects

Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
-Colorectal cancer screening
-Diabetes
-Medication Management
-Reducing readmission to mental health hospital

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-MetaStar

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality services

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

WISCONSIN
Wisconsin Partnership Program

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

IDAHO
Healthy Connections

CONTACT INFORMATION

State Medicaid Contact:

Meg Hall
Idaho Medicaid
(208) 665-8844

State Website Address:

http://www.healthandwelfare.idaho.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1937

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
Continuous eligibility for children under age 19

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 25, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Disease Management, Durable Medical Equipment, EPSDT, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Speech Therapy, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

IDAHO
Healthy Connections

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Period Less Than 3 Months
-Enrolled in Another Managed Care Program
-Have Existing Relationship With a Non-participating PCP
-If travel > 30 Minutes or 30 Miles
-Live in a Non-participating County
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Retro-Eligibility Only

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Initial screening upon eligibility and enrollment in PCCM program; also during annual redeterminatio
-Reviews complaints and grievances to identify members of these groups
-Screen for participation in certain programs

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Child Welfare Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Connections

IDAHO
Healthy Connections

ADDITIONAL INFORMATION

Enrollment is mandatory in 42 counties out of 44 counties. Clark and Custer Counties are voluntary.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation

Consumer Self-Report Data:
-State-developed Survey

Performance Measures

Process Quality:
-Diabetes management/care
-Immunizations for two year olds

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-24/7 access to live Health Care Professional
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization:
None

Provider Characteristics:
None

Beneficiary Characteristics:
-Disenrollment rate
-Disenrollment reasons

Performance Measures - Others:
None

IDAHO
Idaho Smiles

CONTACT INFORMATION

State Medicaid Contact:

Sara Stith
Bureau of Medical Care
(208) 287-1173

State Website Address:

http://www.healthandwelfare.idaho.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1937

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 2007

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Dental PAHP - Risk-based Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-American Indian/Alaska Native
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Poverty-Level Pregnant Women
-Resides in Nursing Facility or ICF/ID
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

IDAHO
Idaho Smiles

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles
-Medicare-Medicaid Coordinated Plan

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross of Idaho

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

IDAHO
Idaho Smiles

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Encounter Data

Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-HIPAA 834 transaction
-Use of "home grown" forms

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ADA approved or other forms approved in advance by Idaho Smiles

Validation - Methods:
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Procedure Codes
-Age-appropriate diagnosis/procedure

State conducts general data completeness assessments:
No

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

IDAHO
Medicare-Medicaid Coordinated Plan

CONTACT INFORMATION

State Medicaid Contact:

Sheila Pugatch
Idaho Medicaid
(208) 364-1817

State Website Address:

http://www.healthandwelfare.idaho.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1937

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 2007

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PAHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Family Planning, Federally Qualified Health Center, Hearing, Home Health, Immunization, Indian Health Clinic, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medicare part D Excluded Drugs Covered by Medicaid, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Rural Health Clinic, Speech Therapy, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

IDAHO
Medicare-Medicaid Coordinated Plan

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Basic Alternative Coverage

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

-None - managed care entity provides standard prescription drug coverage

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medicare-Medicaid Coordinated Plan

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)

Use of Collected Data:
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data:
-Perceived problems with program participation

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

WASHINGTON
Chronic Care Management Program (ADSA)

CONTACT INFORMATION

State Medicaid Contact:

Candace Goehring
DSHS Aging and Disability Services Administration
(360) 725-2562

State Website Address:

www.adsa.dshs.wa.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1937

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 2010

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Chronic Care Management - Risk-based Capitation

Service Delivery

Included Services:
Chronic Care Management, Disease Management

Allowable PCPs:
-Not applicables, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Medically Frail and Individuals with Special Needs

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-TANF

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

WASHINGTON
Chronic Care Management Program (ADSA)

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Health Care Provider
-Housing Agencies
-Longterm Care Services and Supports (HCS)
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Area Agencies on Aging

ADDITIONAL INFORMATION

Chronic Care Management program provides Chronic Care management services to clients who are categorically needy, medically frail and with special medical needs, blind and disabled and who receive Medicaid and other services through fee-for-service system. The program provides intensive educational services, coordination with other needed services and assistance in accessing care.

QUALITY ACTIVITIES FOR OTHER

Quality Oversight Activities:
None

Use of Collected Data:
None

Consumer Self-Report Data:
None

WEST VIRGINIA
Mountain Health Choices

CONTACT INFORMATION

State Medicaid Contact:

Brandy Pierce
Office of Managed Care, Bureau for Medical Service
(304) 356-4912

State Website Address:

http://www.wvdhhr.org/bms

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Approval Date:
Not Applicable

Operating Authority:
1937

Implementation Date:
March 01, 2007

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
Not Applicable

Enrollment Broker:
Automated Health Systems, Inc

Sections of Title XIX Waived:
None

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
12 months of guaranteed eligibility for children

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Categorically Needy Caretaker under Section 1931

Populations Mandatorily Enrolled:
-Poverty Level Infants and Children
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

WEST VIRGINIA
Mountain Health Choices

Subpopulations Excluded from Otherwise Included Populations:

-Foster Care Children
-Medically Needy
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Subsidized Adoptions under Titles IV-B and IV-E

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carelink Health Plan
Unicare Health Plan of WV

Health Plan of the Upper Ohio Valley

ADDITIONAL INFORMATION

Under this program, if the member signs the "Member Agreement" and enrolls into Enhanced services, they will receive additional benefits. The enhanced benefits include: cardiac and pulmonary rehabilitation, nutritional counseling, tobacco cessation, and weight management services. If the member chooses not to sign the "Member Agreement" they will remain in Basic for one year.

Poverty Level Infants and Children are mandatorily enrolled under Sections 1902(a)(10)(A)(i)(V)-(VII) and under Section 1902(a)(10)(A)(ii)(IX) and (XIV).

Children are guaranteed one year eligibility. Adults do not have guaranteed eligibility.

Caretaker/relatives have voluntary enrollment choices.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

WEST VIRGINIA
Mountain Health Choices

-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Child with Special Needs Questionnaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Requirements for MCOs to collect and maintain encounter data
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
None

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

WEST VIRGINIA
Mountain Health Choices

-Smoking prevention and cessation
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Average distance to PCP

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-All MCOs participating in the managed care program are
required to conduct a common performance improvement
project(s) prescribed by State Medicaid agency

Clinical Topics:

-Adolescent Immunization
-Asthma management
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization

Non-Clinical Topics:

None

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care
(QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Delmarva Foundation for Medical Care

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
None

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance
program with the MCO

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

WEST VIRGINIA
Mountain Health Choices

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

DISTRICT OF COLUMBIA
Non-Emergency Medical Transportation Program

CONTACT INFORMATION

State Medicaid Contact:

Colleen Sonosky
Department of Health Care Finance
(202) 442-5913

State Website Address:

http://www.mtm.inc.net

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1902(a)(70)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 19, 2008

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Non-risk Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

DISTRICT OF COLUMBIA
Non-Emergency Medical Transportation Program

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Mental Health Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medical Transportation Management

ADDITIONAL INFORMATION

This program serves the FFS population only.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Network Data
-Ombudsman
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Program Evaluation
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

DISTRICT OF COLUMBIA
Non-Emergency Medical Transportation Program

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
-Transportation to PCP

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:

-Individual PAHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
None

Non-Clinical Topics:

-Transportation service to PCP

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

GEORGIA
Non-Emergency Transportation Brokerage Program

CONTACT INFORMATION

State Medicaid Contact:

Barbara Lowe
GA Department of Community Health
(404) 656-4451

State Website Address:

http://www.dch.ga.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1902(a)(70)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 2007

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

Lock-In Provision:

GEORGIA
Non-Emergency Transportation Brokerage Program

-Emergency Medical Assistance Members
-Medicare Dual Eligibles
-Title XXI CHIP (PeachCare)

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation Brokerage

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

GEORGIA
Non-Emergency Transportation Brokerage Program

Encounter Data

Collection: Requirements:
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

PAHP conducts data accuracy check(s) on specified data elements:
None

State conducts general data completeness assessments:
No

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Provider Network must have suffcent providers to cover regional service area

Use of Services/Utilization:
-Collect the total number of medical related or necessary encounters

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

IDAHO
Non-Emergency Medical Transportation

CONTACT INFORMATION

State Medicaid Contact:

Sara Stith
Bureau of Medical Care
(208) 287-1173

State Website Address:

www.healthandwelfare.idaho.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1902(a)(70)

Statutes Utilized:
Not Applicable

Enrollment Broker:
American Medical Response

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 2010

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaskan Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

Populations Mandatorily Enrolled:
None

IDAHO
Non-Emergency Medical Transportation

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access2Care

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)

Use of Collected Data:
-Contract Standard Compliance

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid SSI Questionnaire

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

IDAHO
Non-Emergency Medical Transportation

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

IOWA
Non-Emergency Medical Transportation

CONTACT INFORMATION

State Medicaid Contact:

Tim Weltzin
Iowa Medicaid Enterprise
(515) 256-4633

State Website Address:

http://www.ime.state.ia.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1902(a)(70)

Statutes Utilized:
Not Applicable

Enrollment Broker:
TMS Management Group, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 2010

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Transportation Broker

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaskan Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

IOWA
Non-Emergency Medical Transportation

-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Eligible only for TB-related Services
-Medicare Dual Eligibles

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

TMS Management Group, Inc.

ADDITIONAL INFORMATION

Transportation to medicaid covered services

Those receiving comprehensive community based services from a Title V organization.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)

Use of Collected Data:
-Does Not Use the Data Collected

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

IOWA
Non-Emergency Medical Transportation

Encounter Data

Collection: Requirements:
-State DID NOT provide any requirements for encounter data collection

Collections - Submission Specifications:
None

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

PAHP conducts data accuracy check(s) on specified data elements:
None

State conducts general data completeness assessments:
No

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

KANSAS
Non-Emergency Medical Transportation (NEMT)

CONTACT INFORMATION

State Medicaid Contact:

Sharon Johnson
Division of Health Care Finance
(785) 296-3981

State Website Address:

http://www.kdheks.gov/hcf/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1902(a)(70)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
November 01, 2009

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

KANSAS
Non-Emergency Medical Transportation (NEMT)

-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-Medicare Dual Eligibles

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medical Transportation Management Inc. (MTM)

ADDITIONAL INFORMATION

The Broker handles scheduling of NEMT transportation statewide and authorizes the least expensive and most appropriate ancillary services based on confirmed eligibility. The Broker enlists a network of transportation providers acorss the state to provide service utilizing sedan, lift van, and public transportation when appropriate. The Broker has internal controls, policies and procedures in place to prevent, detect, and review and report to the Medicaid state agency instances of suspected fraud and abuse by providers, subcontractors and recipients.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)

Use of Collected Data:

-Beneficiary Plan Selection

KANSAS
Non-Emergency Medical Transportation (NEMT)

-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Network Data
-On-Site Reviews
-PAHP Standards (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
None

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Not Applicable

Health Status/Outcomes Quality:
-Not Applicable

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services

Use of Services/Utilization:
-Not Applicable

Health Plan Stability/ Financial/Cost of Care:
-Total revenue

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Performance Measures - Others:
None

-Percentage of beneficiaries who are auto-assigned to
PAHPs

Performance Improvement Projects

Project Requirements:

-PAHPs are required to conduct a project(s) of their own
choosing

Clinical Topics:

None

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services

Standards/Accreditation

PAHP Standards:

-State-Developed/Specified Standards

Accreditation Required for Participation:

None

Non-Duplication Based on Accreditation:

None

MISSISSIPPI
Non-Emergency Transportation Broker Program

CONTACT INFORMATION

State Medicaid Contact:

Alicia Crowder
Division of Medicaid
(601) 359-5243

State Website Address:

www.medicaid.ms.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1902(a)(70)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
November 01, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)

MISSISSIPPI
Non-Emergency Transportation Broker Program

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:

No

Provides Part D Benefits:

Not Applicable

Scope of Part D Coverage:

Not Applicable

Part D - Enhanced Alternative Coverage:

Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LogistiCare Solutions, LLC

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-On-Site Reviews

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
-Broker-developed Survey approved by the State

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

MISSISSIPPI
Non-Emergency Transportation Broker Program

Encounter Data

Collection: Requirements:
-Requirements for PAHPs to collect and maintain encounter data

Collections - Submission Specifications:
None

Collection: Standardized Forms:
None

Validation - Methods:
-Per member per month analysis and comparisons across PAHPs

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment

State conducts general data completeness assessments:
Yes

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

MISSOURI
Non-Emergency Medical Transportation Program (NEMT)

CONTACT INFORMATION

State Medicaid Contact:

Kristin Edwards
Department of Social Services, MO HealthNet Division
(573) 751-9290

State Website Address:

http://www.dss.mo.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1902(a)(70)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

Lock-In Provision:

MISSOURI
Non-Emergency Medical Transportation Program (NEMT)

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participants enrolled in the Hospice Program
-Participants in HCBS Waiver
-Participants who have access to transportation at no cost to the participant
-Participants who have access to transportation through a public entity

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medical Transportation Management

ADDITIONAL INFORMATION

Statewide broker services are provided through the Medicaid State Plan.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Program Evaluation

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

MISSOURI
Non-Emergency Medical Transportation Program (NEMT)

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes
-Amount Paid
-Capitation Indicator
-Charges
-Place of Service
-Statement from Date
-Statement through Date
-Units of Service

State conducts general data completeness assessments:
Yes

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

NEVADA
Mandatory Non-Emergency Transportation Broker Program

CONTACT INFORMATION

State Medicaid Contact:

Greg W. Tanner
Division of Health Care Financing and Policy, Managed Care
(775) 684-3708

State Website Address:

http://www.nv.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1902(a)(70)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 2006

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)

NEVADA
Mandatory Non-Emergency Transportation Broker Program

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligibles

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Logisticare

ADDITIONAL INFORMATION

Non-emergency transportation program open to Medicaid eligibles on a capitated basis with the exception of Nursing Facility and Stretcher non-emergent transportation which is conducted on a fee-for-service basis.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Monitoring of PAHP Standards
-PAHP Standards (see below for details)
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

NEVADA
Mandatory Non-Emergency Transportation Broker Program

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the
HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Requirements for PAHPs to collect and maintain encounter
data

Collections - Submission Specifications:
None

Collection: Standardized Forms:
None

Validation - Methods:
-Historical Analysis

**PAHP conducts data accuracy check(s) on
specified data elements:**
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility

**State conducts general data completeness
assessments:**
Yes

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

NEW JERSEY
Non-Emergency Transportation Broker Program

CONTACT INFORMATION

State Medicaid Contact:

Richard Hurd
Office of Managed Health Care
(609) 588-2550

State Website Address:

http://www.state.nj.us/humanservices/dmahs/index.h

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Approval Date:
Not Applicable

Operating Authority:
1902(a)(70)

Implementation Date:
July 01, 2009

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
Not Applicable

Enrollment Broker:
No

Sections of Title XIX Waived:
None

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

NEW JERSEY
Non-Emergency Transportation Broker Program

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LogistiCare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Monitoring of PAHP Standards

Use of Collected Data:
-Plan Reimbursement
-Program Evaluation

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

NEW JERSEY
Non-Emergency Transportation Broker Program

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

OKLAHOMA
SoonerRide

CONTACT INFORMATION

State Medicaid Contact:

Rebecca Pasternik-Ikard
Oklahoma Health Care Authority
(405) 522-7208

State Website Address:

http://www.okhca.org

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Approval Date:
Not Applicable

Operating Authority:
1902(a)(70)

Implementation Date:
June 01, 2009

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
Not Applicable

Enrollment Broker:
No

Sections of Title XIX Waived:
None

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

OKLAHOMA
SoonerRide

-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Participate in HCBS Waiver

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Employment Agencies
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

SoonerRide

ADDITIONAL INFORMATION

OHCA contracts with the vendor, LogistiCare, to establish a comprehensive public transit program, known as SoonerRide, for Oklahoma Medicaid members. LogistiCare manages the operations of the SoonerRide program, including creating a network of providers, receiving prior authorizations for transportation, and outreach.

OHCA uses a transportation brokerage system to provide the most cost-effective and appropriate form of transportation to members. The contracted transportation broker is reimbursed on a Capitation rate, per-member-per-month basis (which is broken down by ABD and TANF) members.

OKLAHOMA
SoonerRide

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-On-Site Reviews
-Provider Data

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data:
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
    Child Medicaid AFDC Questionnaire
    Child Medicaid SSI Questionnaire
    Child with Special Needs Questionnaire
-Consumer Oriented Mental Health Report Card
-Disenrollment Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

Encounter Data

Collection: Requirements:
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes

State conducts general data completeness assessments:
Yes

-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

PENNSYLVANIA
Medical Assistance Transportation Program

CONTACT INFORMATION

State Medicaid Contact:

Tyrone Williams
Managed Care Operations
(717) 772-6300

State Website Address:

http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1902(a)(70)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
November 01, 2005

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Populations Mandatorily Enrolled:
None

PENNSYLVANIA
Medical Assistance Transportation Program

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Logisticare Solutions, LLC

ADDITIONAL INFORMATION

The Medical Assistance Transportation Program only provides non-emergency transportation to medical assistance consumers.

Special Needs Children: (state defined) Broadly defined non-categorical to include all children. Skilled Nursing Facility is provided for the first 30 days. Transportation services only includes emergency ambulance services.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-On-Site Reviews
-Performance Measures (see below for details)
-Trip Summary Detail File

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement

Consumer Self-Report Data:
-Third Party Phone Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

PENNSYLVANIA
Medical Assistance Transportation Program

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
-Call Center Performance Measures
-Compliant Standards
-Timeliness of Trips

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

SOUTH CAROLINA
Non-Emergency Transportation Program

CONTACT INFORMATION

State Medicaid Contact:

Zenovia Vaughn
Hospitals, Dental, Transportation and DME Services
(803) 898-2682

State Website Address:

http://www.scdhhs.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1902(a)(70)

Statutes Utilized:
Not Applicable

Enrollment Broker:
Logisticare
MTM

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 2007

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)

SOUTH CAROLINA
Non-Emergency Transportation Program

-Special Needs Children (State defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:
Does not apply

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Family Connections
-Mental Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Logisticare

Medical Transportation Management (MTM)

ADDITIONAL INFORMATION

The state contracts with two transportation brokers. The Transportation brokerage services is divided into six regions: Logisticare covers 2/3 of the state and MTM covers 1/3 of the state.

Children with special health care needs are those who have a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

QUALITY ACTIVITIES FOR PAHP

SOUTH CAROLINA
Non-Emergency Transportation Program

State Quality Assessment and Improvement Activities:
-Advisory Committee
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-On-Site Reviews
-Performance Measures (see below for details)

Use of Collected Data:
-Track Health Service provision

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing

Collection: Standardized Forms:
None

Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Type of Service
-Medicaid Eligibility

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Standards/Accreditation

SOUTH CAROLINA
Non-Emergency Transportation Program

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

VIRGINIA
Virginia Non-Emergency Transportation Services

CONTACT INFORMATION

State Medicaid Contact:

Robert Knox
Department of Medical Assistance Services
(804) 371-8854

State Website Address:

http://www.dmas.virginia.gov

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Approval Date:
Not Applicable

Operating Authority:
1902(a)(70)

Implementation Date:
April 01, 2007

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
Not Applicable

Enrollment Broker:
No

Sections of Title XIX Waived:
None

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Home and Community Based Waivers
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

VIRGINIA
Virginia Non-Emergency Transportation Services

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in a Managed Care Program
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Not applicable

Agencies with which Medicaid Coordinates the Operation of the Program:
-Not applicable

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LogistiCare Solutions

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-None

Use of Collected Data:
-Not Applicable

Consumer Self-Report Data:
None

Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

VIRGINIA
Virginia Non-Emergency Transportation Services

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

ARKANSAS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Stephanie Blocker
Director of Aging and Adult Services
Arkansas Department of Human Services
(501) 683-7962

State Website Address:

http://www.daas.ar.gov

PACE Organization

Approved PACE Organization Name: Total Life Healthcare

Program Agreement Effective Date: June 01, 2008

PACE Contact:

Becky McDaniels, CEO
225 East Jackson #92
Jonesboro, AR 72401
(870) 207-6703

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a rate similar to the rate paid to Medicare Advantage and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. PACE organizations may charge a premium to individuals who do not have Medicaid eligibility.

The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

CALIFORNIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Joseph Billingsley
PACE/SCAN Unit
DHCS Long Term Care Division
(916) 440-7538

State Website Address:

http://www.dhcs.ca.gov

PACE Organization

Approved PACE Organization Name:

AltaMed Health Services Corporation dba Altamed Senior
BuenaCare

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Castulo de la Rocha
2040 Camfield Avenue
Los Angeles, CA 90040
(323) 889-7310

Approved PACE Organization Name:

Sutter Health Sacramento Sierra Region dba Sutter SeniorCare

Program Agreement Effective Date:

November 01, 2003

PACE Contact:

John Boyd
7000 Franklin Boulevard, Suite 1020
Sacramento, CA 95823
(916) 386-3010

Approved PACE Organization Name:

Coalition Center of Elders Independence dba Center for Elders
Independence

Program Agreement Effective Date:

November 01, 2003

PACE Contact:

Peter Szutu
510 17th Street, Suite 400
Oakland, CA 94612
(510) 433-1160 x8821

CALIFORNIA
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Community Eldercare of San Diego dba St. Pauls PACE

Program Agreement Effective Date: February 01, 2008

PACE Contact:
Cheryl Wilson
328 Maple Street
San Diego, CA 92103
(619) 239-6900

Approved PACE Organization Name: On Lok Senior Health Services dba On Lok Lifeways

Program Agreement Effective Date: November 01, 2003

PACE Contact:
Robert Edmondson
1333 Bush Street
San Francisco, CA 94109
(415) 292-8888

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

COLORADO
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Matthew Ulrich
Contract Manager
Department of Health Care Policy and Financing
(303)866-2148

State Website Address:

http://www.colorado.gov/hcpf

PACE Organization

Approved PACE Organization Name:

Total Long Term Care

Program Agreement Effective Date:

April 01, 2003

PACE Contact:

Maureen Hewitt
8950 E. Lowry Boulevard
Denver, CO 802030
(303) 869-4664

Approved PACE Organization Name:

VOANS PACE, Inc

Program Agreement Effective Date:

August 01, 2008

PACE Contact:

Craig Ammermann
2377 Robins Way
Montrose, CO 81401
(970) 252-0522

Approved PACE Organization Name:

Rocky Mountain PACE

Program Agreement Effective Date:

December 01, 2008

PACE Contact:

Laurie Tebo
2335 Robinson Street
Colorado Springs, CO 80904
(719) 457-0660 ext 1

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be

able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a rate similar to the rate paid to Medicare Advantage and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. PACE organizations may charge a premium to individuals who do not have Medicaid eligibility.

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FLORIDA
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Kym Holcomb
Medical Health Care Program Analyst
Bureau of Medicaid Services
(850) 412-4251

State Website Address:

http://ahca.myflorida.com

PACE Organization

Approved PACE Organization Name:

Florida PACE Centers

Program Agreement Effective Date:

January 01, 2003

PACE Contact:

Sandy Stewart
5200 Northeast 2nd Avenue
Miami, FL 33137
(305) 795 -8410 Ext.

Approved PACE Organization Name:

Hope PACE

Program Agreement Effective Date:

March 01, 2008

PACE Contact:

Mary Curtis
2668 Winkler Avenue
Fort Myers, FL 33901
(239) 985-6400

Approved PACE Organization Name:

Neighborly PACE

Program Agreement Effective Date:

September 01, 2009

PACE Contact:

Betty Oldanie
5771 Roosevelt Blvd
Clearwater, Fl 33760
(727) 573-2116

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be

able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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IOWA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Lin Christensen
Medicaid Program Manager
Iowa Medicaid Enterprise
(515) 256-4639

State Website Address:

http://www.ime.state.ia.us/

PACE Organization

Approved PACE Organization Name: Siouxland PACE

Program Agreement Effective Date: August 01, 2008

PACE Contact:

Randy Ehlers
4300 Hamilton Blvd
Sioux City, IA 51104
(712) 233-4144

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a rate similar to the rate paid to Medicare Advantage and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. PACE organizations may charge a premium to individuals who do not have Medicaid eligibility.

The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

KANSAS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Tracy Conklin
Manager
Division of Health Care Policy
(785) 296-7788

State Website Address:

http://www.kdheks.gov/hcf/

PACE Organization

Approved PACE Organization Name: Midland Care Services

Program Agreement Effective Date: January 01, 2007

PACE Contact:

Karren Weichert
200 SW Frazier Circle
Topeka, KS 66606
(785) 232-2044

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a rate similar to the rate paid to Medicare Advantage and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. PACE organizations may charge a premium to individuals who do not have Medicaid eligibility.

The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

LOUISIANA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Allison Vuljoin
Division Director
Office of Aging and Adult Services
(225) 219-0229

State Website Address:

http://www.dhh.louisiana.gov

PACE Organization

Approved PACE Organization Name:

Greater New Orleans

Program Agreement Effective Date:

July 01, 2008

PACE Contact:

Stephanie Smith
4201 N. Rampert
New Orlean, LA 70117
(504) 945-1531

Approved PACE Organization Name:

Francican PACE Baton Rouge

Program Agreement Effective Date:

July 01, 2008

PACE Contact:

Karen Allen
7436 Bishop Ott Dr.
Baton Rouge, MD 70806
(225) 490-0322

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a rate similar to the rate paid to Medicare Advantage and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. PACE organizations may charge a premium to individuals who do not have Medicaid eligibility.

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MARYLAND
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Susan, P Panek
Deputy Director, Long Term Care Financing
Department of Health and Mental Hygiene
(410) 767-6764

State Website Address:

http://www.dhmh.state.md.us

PACE Organization

Approved PACE Organization Name:

Hopkins Elder Plus

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Karen Armacost
4940 Eastern Ave.
Baltimore, MD 21224
410-550-7044

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

MASSACHUSETTS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Robert Holmes
Commonwealth of Massachusetts
Office of Elder Affairs
(617) 222-7750

State Website Address:

http://www.mass.gov/masshealth

PACE Organization

Approved PACE Organization Name:

Elder Service Plan of Cambridge Health Alliance

Program Agreement Effective Date:

November 01, 2003

PACE Contact:

Tom Reiter, Director of Operations
270 Green Street
Cambridge, MA 02139
(617) 575-5850

Approved PACE Organization Name:

Elder Service Plan of Harbor Health Services

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Carol Crawford
1135 Morton Street
Mattapan, MA 02126
(617) 533-2400

Approved PACE Organization Name:

Upham's Elder Service Plan

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Jay Trivedi
1140 Dorchester Ave
Dorchester, MA 02125
(617) 288-0970

MASSACHUSETTS
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Elder Service Plan of East Boston Neighborhood Health Center

Program Agreement Effective Date: November 01, 2003

PACE Contact: Laura Wagner
10 Grove Street
East Boston, MA 02128
(617) 569-5800

Approved PACE Organization Name: Elder Service Plan of the North Shore

Program Agreement Effective Date: November 01, 2003

PACE Contact: Robert Wakefield, Jr.
37 Friend Street
Lynn, MA 01902
(781) 715-6608

Approved PACE Organization Name: Summit Elder Care

Program Agreement Effective Date: November 01, 2002

PACE Contact: Karen Longo
10 Chestnut Street
Worchester, MA 01608
(508) 368-9437

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

MICHIGAN
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Peggy Peckham
Medicaid Services Administrator
Department of Community Health
(517) 335-5202

State Website Address:

http://www.michigan.gov/mdch

PACE Organization

Approved PACE Organization Name:

Henry Ford Health System Center for Senior Independence

Program Agreement Effective Date:

November 01, 2003

PACE Contact:

Michael Carson
7800 W. Outer Drive, Suite 240
Detroit, MI 48255
(313) 543-6320

Approved PACE Organization Name:

Care Resources

Program Agreement Effective Date:

September 01, 2006

PACE Contact:

Tom Muszynski, Executive Director
1471 Grace Street, SE
Grand Rapids, MI 49506
(616) 913-2006

Approved PACE Organization Name:

Life Circles

Program Agreement Effective Date:

February 01, 2009

PACE Contact:

Robert Mills, Executive Director
560 Seminole Road
Muskegon, MI 49444
(231) 733-8686

MICHIGAN
Program of All-Inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Comprehensive Senior Care Corporation

Program Agreement Effective Date: April 01, 2009

PACE Contact: Rod Auton, Executive Director
                200 W. Michigan Ave Ste 103
                Battle Creek, MI 49017
                (269) 441-9300

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a rate similar to the rate paid to Medicare Advantage and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. PACE organizations may charge a premium to individuals who do not have Medicaid eligibility.

The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

MISSOURI
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Shelley Farris
Operations Manager - MO HealthNet Managed Care
Department of Social Services, MO HealthNet Division
(573) 526-4274

State Website Address:

http://www.dss.mo.gov

PACE Organization

Approved PACE Organization Name: Alexian Brothers Community Services

Program Agreement Effective Date: November 01, 2001

PACE Contact: Mel Causey
3900 South Grand
St. Louis, MO 63118
(314) 771-5800 x127

ADDITIONAL INFORMATION

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NEW JERSEY
Program of All-inclusive Care for the Eldelry (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Paul Sullivan
County Liaison
NJ Department of Health and Senior Services
(609) 292-0217

State Website Address:

http://www.state.nj.us/health/senior/pace.shtml

PACE Organization

Approved PACE Organization Name:

LIFE at Lourdes

Program Agreement Effective Date:

May 01, 2009

PACE Contact:

Margaret Sullivan
2475 McClellan Avenue
Pennsauken, NJ 08109
(856) 675-3663

Approved PACE Organization Name:

LIFE St. Francis

Program Agreement Effective Date:

April 01, 2009

PACE Contact:

Jill Viggiano
1435 Liberty Street
Hamilton, NJ 08629
(609) 475-4701

Approved PACE Organization Name:

Lutheran Senior Life

Program Agreement Effective Date:

July 01, 2010

PACE Contact:

Beth Eichfeld
377 Jersey Avenue, 3rd floor
Jersey City, NJ 07302
(201) 706-2091

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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NEW MEXICO
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Victoria Parrill
Healthcare Operations Manager
NM HSD/Medical Assistance Division
(505) 476-7257

State Website Address:

http://www.state.nm.us/hsd/mad/Index.html

PACE Organization

Approved PACE Organization Name:

Total Community Care

Program Agreement Effective Date:

July 01, 2004

PACE Contact:

Maria Zemora-Hughes
904 A los Lomas NE
Albuquerque, NM 87102
(505)924-2606

ADDITIONAL INFORMATION

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NEW YORK
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Linda Gowdy
Director, Bureau of Continuing Care Initiatives
Division of Long Term Care
(518) 474-6965

State Website Address:

http://www.nyhealth.gov

PACE Organization

Approved PACE Organization Name:

Independent Living for Seniors, Inc.

Program Agreement Effective Date:

November 01, 2003

PACE Contact:

Kathryn McGuire
2066 Hudson Ave.
Rochester, NY 14617
(585) 922-2800

Approved PACE Organization Name:

PACE CNY

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Penny Abulencia
100 Malta Lane
North Syracuse, NY 13212
(315) 452-5800

Approved PACE Organization Name:

Eddy Senior Care

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Bernadette Hallam
504 State Street
Schenectady, NY 12305
(518) 382-3290

NEW YORK
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Comprehensive Care Management (CCM)

Program Agreement Effective Date: November 01, 2003

PACE Contact: Joseph Healy, Jr
1250 Waters Place, 6th floor
Bronx, NY 10467
(347) 640-6020

Approved PACE Organization Name: Total Senior Care

Program Agreement Effective Date: October 01, 2008

PACE Contact: Carol Mahoney
1225 West State St.
Olean, NY 14760
(716) 372-2106

Approved PACE Organization Name: ArchCare Senior Life

Program Agreement Effective Date: September 01, 2009

PACE Contact: Marcia Konrad
1432 Fifth Avenue
New York, NY 10026
(646) 289-7722

Approved PACE Organization Name: Catholic Health - LIFE

Program Agreement Effective Date: September 01, 2009

PACE Contact: Thomas Schifferli
55 Melroy Avenue
Lackawanna, NY 14218
(716) 819-5102

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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NORTH CAROLINA
Program of All-inclusive Care for the Eldelry (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Joseph Breen
Section Chief, Home and Community Care
Noth Carolina Department of Health and Human Services
(919) 855-4365

State Website Address:

http://www.ncdhhs.gov/dma/

PACE Organization

Approved PACE Organization Name:

Piedmont Health SeniorCare

Program Agreement Effective Date:

February 01, 2008

PACE Contact:

Marianne Ratcliff
1214 Vaughn Road, P.O. Box 1033
Burlington, NC 27217
(336) 532-0000

Approved PACE Organization Name:

Elderhaus

Program Agreement Effective Date:

February 01, 2008

PACE Contact:

Larry Reinhart
2222 South 17th Street
Wilmington, NC 28401
(910) 343-8209

Approved PACE Organization Name:

PACE of Guilford and Rockingham Counties, Inc. (PACE of the Triad)

Program Agreement Effective Date:

May 01, 2011

PACE Contact:

Ursula Robinson
1471 E. Cone Blvd.
Greensboro, NC 27405
(336) 550-4040

NORTH CAROLINA
Program of All-inclusive Care for the Eldelry (PACE)

Approved PACE Organization Name:　　　　　　LIFE at St. Joseph of the Pines

Program Agreement Effective Date:　　　　　　April 01, 2011

PACE Contact:　　　　　　Cindy Collins
　　　　　　4900 Raeford Road
　　　　　　Fayetteville, NC 28304
　　　　　　(910) 483-49111

ADDITIONAL INFORMATION

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NORTH DAKOTA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Tania Hellman
Administrator, Managed Care
Department of Human Services Medical Services Division
(800) 755-2604

State Website Address:

http://www.nd.gov/dhs/

PACE Organization

Approved PACE Organization Name:

Northland PACE

Program Agreement Effective Date:

August 01, 2008

PACE Contact:

Tim Cox
3811 Lockport Street, Suite 3
Bismarck, ND 58501
(701) 250-0709

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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OHIO
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Matthew Hobbs, Aging Policy
Bureau of Long Term Care Services and Supports
Ohio Department of Job and Family Services
(614) 752-3553

State Website Address:

http://jfs.ohio.gov/OHP/index.stm

PACE Organization

Approved PACE Organization Name:

McGregor PACE

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Tangi McCoy, President/CEO
2373 Euclid Heights Blvd.
Cleveland Heights, OH 44106
(216) 791-3580

Approved PACE Organization Name:

TriHealth Senior Link

Program Agreement Effective Date:

December 01, 2002

PACE Contact:

Brett Kirkpatrick
619 Oak Street
Cincinnati, OH 45206
(513) 569-6673

ADDITIONAL INFORMATION

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OKLAHOMA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Ashley Herron
Pace Research Analyst
Oklahoma Health Care Authority
(405) 522-7902

State Website Address:

http://www.okhca.org

PACE Organization

Approved PACE Organization Name: Cherokee Elder Care

Program Agreement Effective Date: August 01, 2008

PACE Contact: Rick Richards
1387 W. 4th Street
Tahlequah, OK 74464
(918)453-5554

ADDITIONAL INFORMATION

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OREGON
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Mike McCormick
Deputy Director
APD, Department of Human Services
(503) 945-6229

State Website Address:

http://www.dhs.state.or.us

PACE Organization

Approved PACE Organization Name: Providence Elder Place

Program Agreement Effective Date: November 01, 2003

PACE Contact: Ellen Garcia
4531 SE Belmont, Suite 100
Portland, OR 97215
(503) 215-3612

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Randy Nolen
Director, Division of Field Operations
PA Department of Public Welfare, Office of Long Term Living
(717) 772-2543

State Website Address:

http://www.state.pa.us

PACE Organization

Approved PACE Organization Name:

LIFE Lutheran Services

Program Agreement Effective Date:

September 01, 2008

PACE Contact:

Terry Shade
840 5th Avenue
Chambersburg, PA 17201
717) 264-8178

Approved PACE Organization Name:

Senior LIFE Johnstown

Program Agreement Effective Date:

October 01, 2005

PACE Contact:

Mark Irwin
401 South Broad Street, Suite 100
Johnstown, PA 15905
814) 535-6000

Approved PACE Organization Name:

NewCourtland LIFE

Program Agreement Effective Date:

October 01, 2010

PACE Contact:

Mary Austin
6970 Germantown Avenue
Philadelphia, PA 19119
215) 951-4405

PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: everyday LIFE

Program Agreement Effective Date: February 01, 2009

PACE Contact: John Paul Marosy
2045 Westgate Drive, Suite 100
Bethlehem, PA 18017
484) 895-4301

Approved PACE Organization Name: LIFE St Mary

Program Agreement Effective Date: April 01, 2008

PACE Contact: Emily Amerman
2500 Interplex Drive
Trevose, PA 19053
267) 991-7620

Approved PACE Organization Name: Senior LIFE Washington

Program Agreement Effective Date: May 01, 2011

PACE Contact: Mark Irwin
401 S. Broad Street
Johnstown, PA 15905
814) 535-6000

Approved PACE Organization Name: Senior LIFE York

Program Agreement Effective Date: February 01, 2009

PACE Contact: Mark Irwin
401 S. Broad Street
Johnstown, PA 15905
814) 535-6000

PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Senior LIFE Altoona

Program Agreement Effective Date: April 01, 2008

PACE Contact: Mark Irwin
401 S. Broad Street
Johnstown, PA 15906
814) 535-6000

Approved PACE Organization Name: Pittsburgh Care Partnership/Community LIFE

Program Agreement Effective Date: March 01, 2004

PACE Contact: Richard DiTommaso
2400 Ardmore Boulevard, Suite 700
Pittsburgh, PA 15221
412) 664-1448

Approved PACE Organization Name: LIFE Beaver/Lawrence

Program Agreement Effective Date: November 01, 2008

PACE Contact: Toni Hively
131 Pleasant Drive, Suite 1
Aliquippa, PA 15001
724) 378-5400

Approved PACE Organization Name: LIFE St Agnes Medical Center - Mercy LIFE

Program Agreement Effective Date: October 01, 2005

PACE Contact: Carol Quinn
1001 Baltimore Pike
Springfield, PA 19064
610) 690-2526

PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Albright Care Services

Program Agreement Effective Date: January 01, 2012

PACE Contact: Lou Ann Shively
90 Maplewood Drive
Lewisburg, PA 17837
(570) 522-2853

Approved PACE Organization Name: LIFE - University of Pennsylvania

Program Agreement Effective Date: January 01, 2002

PACE Contact: Daniel Drake
4508 Chestnut Street
Philadelphia, PA 19139
(215) 573-7200

Approved PACE Organization Name: LIFE - Pittsburgh

Program Agreement Effective Date: May 01, 2005

PACE Contact: Joann Gago
875 Greentree Road, Suite 200, One Parkway Center
Pittsburgh, PA 15220
(412) 388-8042

Approved PACE Organization Name: LIFE Geisinger

Program Agreement Effective Date: October 01, 2007

PACE Contact: Robert McQuillan
100 North Academy Avenue
Danville, PA 17822
570) 271-5531

PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: LIFE at Home

Program Agreement Effective Date: July 01, 2007

PACE Contact: Jonathan Aistrop
1100 Spruce Street
Kulpmont, PA 17834
570) 373-2100

ADDITIONAL INFORMATION

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RHODE ISLAND
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Ellen Mauro
Administrator
RI Medicaid, EOHHS Medical Services, Office of
Institutional/Comm Services and Supports
(401) 462-0140

State Website Address:

http://www.pace-Ri.org

PACE Organization

Approved PACE Organization Name:

PACE Organization of Rhode Island

Program Agreement Effective Date:

December 01, 2005

PACE Contact:

Joan Kwiakowski
225 Chapman Street
Providence, RI 02905
(401) 490-7610

ADDITIONAL INFORMATION

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SOUTH CAROLINA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Cindy Pedersen
Pace Program Administrator
South Carolina Dept of Health and Human Services
(803) 898-2033

State Website Address:

http://www.scdhhs.gov

PACE Organization

Approved PACE Organization Name:

Palmetto SeniorCare

Program Agreement Effective Date:

November 01, 2003

PACE Contact:

Suzanne Tillman
15 Richland Medical Park Drive, Suite 203
Columbia, SC 29203
(803) 434-4421

Approved PACE Organization Name:

The OAKS PACE

Program Agreement Effective Date:

March 01, 2008

PACE Contact:

Elaine Till
1000 Methodist Oaks Drive
Orangeburg, SC 29118
(803) 535-1561

ADDITIONAL INFORMATION

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TENNESSEE
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Carolyn Fulghum
Director of Quality and Administration
TennCare
(615) 507-6671

State Website Address:

http://www.tn.gov/tenncare

PACE Organization

Approved PACE Organization Name: Alexian Brothers Community Services

Program Agreement Effective Date: November 01, 2002

PACE Contact: Viston Taylor
425 Cumberland Street Suite 110
Chattanooga, TN 37404
(423) 698-0802

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a rate similar to the rate paid to Medicare Advantage and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. PACE organizations may charge a premium to individuals who do not have Medicaid eligibility.

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TEXAS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Lori Roberts
PACE Contact
Department of Aging and Disability Services
(512) 438-5391

State Website Address:

http://www.dads.state.tx.us/provider/PACE/index.cf

PACE Organization

Approved PACE Organization Name:

Bienvivir Senior Health Services

Program Agreement Effective Date:

November 01, 2003

PACE Contact:

Rosemary Castillo
2300 Mckinley Ave.
El Paso, TX 78751
(915) 562-3444

Approved PACE Organization Name:

La Paloma

Program Agreement Effective Date:

May 01, 2010

PACE Contact:

Annette Gary
4010 22nd Street
Lubbock, TX 79410
(806) 740-1500

Approved PACE Organization Name:

The Basics at Jan Werner

Program Agreement Effective Date:

March 01, 2004

PACE Contact:

Krissy Jones
3108 South Fillmore
Amarillo, TX 79110
(806) 374-5516

ADDITIONAL INFORMATION

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VERMONT
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Kathy Rainville
Aging and Disability Program Supervisor
Department of Disabilities, Aging, and Independent Living
(802) 786-5052

State Website Address:

http://dail.vermont.gov

PACE Organization

Approved PACE Organization Name:

PACE Vermont

Program Agreement Effective Date:

March 01, 2007

PACE Contact:

Sharon Essi
786 College Parkway
Colchester, VT 05446
(802) 655-6700

ADDITIONAL INFORMATION

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VIRGINIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Yvonne Goodman
Program Supervisor
Department of Medical Assistance Services
(804) 786-0503

State Website Address:

http://www.dmas.virginia.gov/

PACE Organization

Approved PACE Organization Name:

Sentara Senior Community Care

Program Agreement Effective Date:

November 01, 2007

PACE Contact:

Bruce Robertson
251 Newtown Road
Norfolk, VA 23502
(757) 892-5400

Approved PACE Organization Name:

Mountain Empire

Program Agreement Effective Date:

March 01, 2008

PACE Contact:

Tony Lawson
P.O. Box 888
Big Stone Gap, VA 24219
(276) 523-0599

Approved PACE Organization Name:

AllCare for Seniors

Program Agreement Effective Date:

May 01, 2008

PACE Contact:

Dana Collins
P.O. Box 765
Cedar Bluff, VA 24609
(276) 964-4915

VIRGINIA
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Centra

Program Agreement Effective Date: February 01, 2009

PACE Contact: Debra Maddox
407 Federal Street
Lynchburg, VA 24501
(434) 200-6516

Approved PACE Organization Name: Riverside PACE

Program Agreement Effective Date: February 01, 2008

PACE Contact: Stacy Brinkley
1300 MacTavish Ave
Richmond, VA 23230
(804) 977-5900

ADDITIONAL INFORMATION

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WASHINGTON
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Kristi Knudsen
Program Manager
ADSA
(360) 725-3213

State Website Address:

http://www.dshs.wa.gov

PACE Organization

Approved PACE Organization Name:　　　Providence Elderplace - Seattle

Program Agreement Effective Date:　　　November 01, 2002

PACE Contact:

Susan Tuller
4515 Martin Luther King Jr. Way So., Suite 100
Seattle, WA 98108
(206) 320-5325

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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WISCONSIN
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Dana Badger
Contract Administrator
Wisconsin Department of Health Services
(608) 261-6751

State Website Address:

http://dhs.wisconsin.gov

PACE Organization

Approved PACE Organization Name: Community Care Organization

Program Agreement Effective Date: November 01, 2003

PACE Contact: Kirby Shoaf
1555 South Layton Boulevard
Milwaukee, WI 53215
(414) 385-6600

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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Arkansas
- SafetyNet Benefit Program, 1115 program is now Connectcare.

California
- Effective November 1, 2010 CMS approved "California's Bridge to Reform" section 1115 Medicaid Demonstration waiver. As part of the demonstration waiver the State incorporated 4 out of their 5 1915(b) waivers into the 1115. These 4 former 1915(b) waivers that now have authority through the 1115 were the: 1) Health Plan San Mateo Waiver, 2) Santa Barbara San Lois Obispo Waiver, 3) Health Insuring Organizations Waiver, and 4) Two Plan/ Geographic Managed Care (formerly California Children Services/Sacramento Dental Geographic Managed Care) Waiver. The "Bridge to Reform" Demonstration also gave authority to for the State to expand coverage to eligible low income adults through the Low Income Health Program (LIHP). LIHP is an optional, county-based program. There were 10 LIHPs offering coverage for residents up to 200% of the federal poverty level as of July 1, 2011. The program summary has been reformatted from the 2010 report to reflect the elimination of the four 1915(b) waivers and the creation of the LIHPs. The 1115 Demonstration Waiver has managed care model subsections since each model type has different service delivery requirements, plans, and quality standards.

Colorado
- Accountable Care Collaborative (ACC) Program is a new 1932(a) program.

District of Columbia
- Childless Adults 1115 Demonstration is a new program.
- Health Services for Children with Special Needs program, 1915(a) program is now Children and Adolescent Supplemental Security Income Program.

Hawaii
- The PACE program was terminated.

Idaho
- Non-Emergency Transportation (NEMT) is a new 1902(a)(70) program.

Illinois
- Integrated Care Program is a new 1932(a) is a new program.

Indiana
- Care Select program (PCCM) has converted from a 1915(b) to a 1932(a).

Iowa
- Non-Emergency Transportation (NEMT) is a new program operating under waiver authority 1902(a)(70).

Kentucky
- KY's Human Service Transportation Delivery Program and plan was converted from 1902(a)(70) to a 1915(b) program.

Minnesota
- Minnesota Disability Health Options (MNDHO), 1915(a) program was terminated.

Mississippi

- MississippiCan is a new 1932(a)/1915(c) program.

Montana

- The PACE program was terminated.

Nebraska
- The Nebraska Medicaid Medical Home Pilot is a new program operating under waiver authority 1932(a).
- The Nebraska Health Connection Combined Waiver – 1915(b) and the Nebraska Health Connection Combined Waiver – 1932(a) both discontinued their PCCM portion.

New York
- The Partnership Plan – Family Health Plus, 1115 program's PPO managed care entity type no longer operates under this program.

North Carolina
- Mental Health Developmental Disabilities & Substance Abuse Waiver, 1915b/c is now Mental Health Developmental Disabilities & Substance Abuse Services Health Plan.

Puerto Rico
- Puerto Rico Health Care Plan, 1915(a) program was changed to Mi Salud.

Rhode Island
- Global Consumer Choice Compact, 1115, is now reported as Rite Care. Effective January 16, 2009 RI Global Consumer Choice Compact 1115 Demonstration encompasses almost the entire RI Medicaid Program. It includes Connect Care Choice, Rhody Health Partners, RIte Smiles, and Rite Care.

Texas
- Texas Medicaid Enhanced Care Program, 1915(b) program was terminated and replaced by Texas Medicaid Wellness Program, 1915(b) program.
- The Non-Emergency Transportation program was operating under the 1915(4) and the reimbursement arrangement was fee-for-service. The program started a pilot to use two full-risk brokers for two service areas operating under 1902(a)(70).

Washington
- The Chronic Care Management Program (ADSA) is a new 1937 program.
- Bridge to Reform: The Basic Health Plan demonstration program is a new 1115(a) program.
- Bridge to Reform: Medical Care Services demonstration program is a new 1115(a) program.

National Summary of State Medicaid Managed Care Programs
Glossary as of July 1, 2011

Section: Program Data--Operating Authority Terms

1915(b)   **Mandatory managed care program** which has restrictions on beneficiaries' freedom of choice provider.

1915(b)(1)   ***Service Arrangement provision***. The State may restrict the provider from or through whom beneficiaries may obtain services.

1915(b)(2)   ***Locality as Central Broker provision***. Under this provision, localities may assist beneficiaries in selecting a primary care provider.

1915(b)(3)   ***Sharing of Cost Savings provision***. The State may share cost savings, in the form of additional services, with beneficiaries.

1915(b)(4)   ***Restriction of Beneficiaries to Specified Providers provision***. Under this provision, States may require beneficiaries to obtain services only from specific providers.

1115(a)   ***Research and Demonstration Clause***. The State utilizes specific authority within Section 1115(a) of the Social Security Act to allow the State to provide services through the vehicle of a Research and Demonstration Health Care Reform waiver program.

1932(a)   ***State Option to use Managed Care***. This section of the Act permits States to enroll their Medicaid beneficiaries in managed care entities on a mandatory basis without section 1915(b) or 1115 waiver authority.

1915(a)   **Voluntary managed care program** in which enrollment is voluntary and therefore does not require a waiver.

1915(b)/1915(c)   Concurrent waiver programs, or portions thereof, operating under both 1915(b) managed care and 1915c) home and community-based services waivers.

1915(a)/1915(c)   Concurrent waiver programs, or portions thereof,

operating under both 1915(a) voluntary managed care and 1915(c) home and community-based services waivers.

1905(t)   **Voluntary PCCM managed care program** in which enrollment is voluntary and therefore does not require a waiver.

1937   **Alternative Benefit Package Benchmark Program** – Managed care program operates under this authority through a State plan amendment.

1902(a)(70)   Option for States to amend their Medicaid state plans to establish **Non-Emergency Medical Transportation Brokerage program** without regard to the statutory requirements for comparability, statewideness, and freedom of choice.

1902(a)(1)   *Statewideness*. This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. Waiving 1902(a)(1) indicates that this waiver program is not available throughout the State.

1902(a)(10)(B)   *Comparability of Services*. This section of the Act requires State Medicaid plans to permit all individuals eligible for Medicaid to obtain medical assistance. Waiving 1902(a)(10)(B) indicates that the scope of services offered to beneficiaries enrolled in this program are broader than those offered to beneficiaries not enrolled in the program.

1902(a)(23)   *Freedom of Choice*. This section of the Act requires State Medicaid plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted.

Section: Service Delivery--Managed Care Entity Terms

PCCM   *Primary Care Case Management (PCCM) Provider* is usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners,

nurse midwives, or physician assistants who contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category include PCCMs and those PIHPs which act as PCCMs.

PIHP — **Prepaid Inpatient Health Plan (PIHP)** – A PIHP is a prepaid **inpatient** health plan that provides less than comprehensive services on an at-risk or other than state plan reimbursement basis; and provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are define in 42 CFR 438.2} There are several types of PIHPs that States use to deliver a range of services (i.e. Mental Health (MH) PIHP is a managed care entity provides only mental health services**.**

PAHP — **Prepaid Ambulatory Health Plan (PAHP)** – A PAHP is a prepaid **ambulatory** health plan that provides less than comprehensive services on an at-risk or other than state plan reimbursement basis, and does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are defined in 42 CFR 438.2} There are several types of PAHPs that States use to deliver a range of services. For example, a Dental PAHP is a managed care entity that provides only dental services.

MCO — *Managed Care Organization* is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare-Choice organization, a provider sponsored organization or any other private or public organization which meets the requirements of §1902 (w) to provide comprehensive services.

HIO — *Health Insuring Organization* is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

Section: Service Delivery--Reimbursement Arrangement Terms

Fee-For-Service	The managed care entity is paid for providing services to enrollees solely through fee-for-service payments, plus in a PCCM, a case management fee.
Risk-based Capitation	The managed care entity is paid for providing services to enrollees primarily through capitation. (There may be other payments under the contract such as incentive arrangements or risk-sharing.)
Non-risk Capitation	The managed care entity is paid for providing services to enrollees through capitation, but payments are settled at the end of the year at amounts that do not exceed the FFS cost for services actually provided, plus an amount for administration.

Section: Quality Activity Terms

Accreditation for Deeming	Some States use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as "deemed compliance" with a standard.
Accreditation for Participation	State requirement that plans must be accredited to participate in the Medicaid managed care program.
Consumer Self-Report Data	Data collected through survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a MCO, PIHP, or PAHP. The survey may be conducted by the State or a contractor to the State.
Encounter Data	Detailed data about individual services provided to individual beneficiaries at the point of the beneficiary's interaction with a MCO, PIHP, PAHP institutional or practitioner provider. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims".
Enrollee Hotlines	Toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they

encounter a problem with their MCO, PIHP, PAHP. The people who staff hotlines are knowledgeable about program policies and may play an "intake and triage" role or may assist in resolving the problem.

Focused Studies

State required studies that examine a specific aspect of health care (such as prenatal care) for a defined point in time. These projects are usually based on information extracted from medical records or MCO, PIHP, PAHP administrative data such as enrollment files and encounter /claims data. State staff, EQRO staff, MCO, PIHP, PAHP staff or more than one of these entities may perform such studies at the discretion of the State.

MCO/PIHP/PAHP

These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each MCO/PIHP/PAHP must have in order to participate in the Medicaid program.

Monitoring of Standards

Activities related to the monitoring of standards that have been set for plan structure, operations, and quality improvement/assurance to determine that standards have been established, implemented, adhered to, etc.

Ombudsman

An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PIHP/PAHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PIHP/PAHP, and the provider (as appropriate) to resolve individual enrollee problems.

On-Site Reviews

Reviews performed on-site at the MCO/PIHP/PAHP health care delivery system sites to assess the physical resources and operational practices in place to deliver health care.

Performance Improvement Projects

Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and

outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MCO/PIHP/PAHPs choosing or prescribed by the State.

Performance Measures   Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PIHP/PAHP.

Provider Data   Data collected through a survey or focus group of providers who participate in the Medicaid program and have provided services to enrolled Medicaid beneficiaries. The State or a contractor of the State may conduct survey.

HEDIS Measures from Encounter Data   *Health Plan Employer Data and Information Set (HEDIS)* measures from encounter data as opposed to having the plans generate HEDIS measures. HEDIS is a collection of performance measures and their definitions produced by the National Committee for Quality Assurance (NCQA).

EQRO   Federal law and regulations require States to use an *External Quality Review Organization (EQRO)* to review the care provided by capitated managed care entities. EQROs may be Peer Review Organizations (PROs), another entity that meets PRO requirements, or a private accreditation body.

Pay for Performance (P4P)   P4P programs are designed to improve patients' quality of care by recognizing and rewarding high standards of care. This section identifies the States' implementation of a P4P program with any MCOs participating in the State's managed care program.