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ALABAMA
Maternity Care Program

CONTACT INFORMATION

State Medicaid Contact:

Kim Davis-Allen
Alabama Medicaid Agency
(334) 242-5011

State Website Address:

http://www.medicaid.state.al.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

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:
June 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:
Case Management, Inpatient Hospital, Outpatient Hospital, Physician

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Poverty Level Pregnant Women

ALABAMA
Maternity Care Program

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Special Needs Children
-American Indian/Alaskan Native
-Other Insurance
-Foster Children

Lock-In Provision:
3 months lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Maternity Care Program

ADDITIONAL INFORMATION

This program has been converted from a 1915(b) to a 1932.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE

DELIVERY SYSTEMS

Quality Oversight Activities:
-On-Site Reviews
-Performance Improvements Projects (see below for details)

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data
None

Performance Improvement Projects

Clinical Topics
None

Non-Clinical Topics
-Access to early prenatal care

ALABAMA
Partnership Hospital Program

CONTACT INFORMATION

State Medicaid Contact:
Kim Davis-Allen
Alabama Medicaid Agency
(334) 242-5011

State Website Address:
http://www.medicaid.state.al.us

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
October 01, 1996

Implementation Date:
October 01, 1996

Waiver Expiration Date:
December 24, 2001

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

Medical-only PHP - Full Capitation

Service Delivery

Included Services:
Inpatient Hospital

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

ALABAMA
Partnership Hospital Program

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Poverty Level Pregnant Woman

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

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:
-Aging Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Partnership Hospital Program

ADDITIONAL INFORMATION

Due to the nature of the waiver which is a limited carve-out for a segment of inpatient hospital services, the program does not designate a primary care provider. Individuals choose their own providers or rely on the contractor for referral. The contractor acts as the gatekeeper.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies

Use of Collected Data
-Monitor Quality Improvement

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)

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)
-Medical record validation

ALABAMA
Partnership Hospital Program

MCO conducts data accuracy check(s) on specified data elements
-Procedure Codes

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Alabama Quality Assurance Foundation

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-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

ALABAMA
Patient 1st

CONTACT INFORMATION

State Medicaid Contact:
Kim Davis-Allen
Alabama Medicaid Agency
(334) 242-5011

State Website Address:
http://www.medicaid.state.al.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1997

Implementation Date:
January 01, 1997

Waiver Expiration Date:
December 26, 2001

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-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, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

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

Enrollment

ALABAMA
Patient 1st

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Long Term Care

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

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:

-Aging Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Patient 1st

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Enrollee Hotlines
-Provider Data

Use of Collected Data:
-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data
None

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

CONTACT INFORMATION

State Medicaid Contact:
Lynn Dunton
AHCCCS
(602)417-4447

State Website Address:
http://www.AHCCCS.state.az.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - 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, 2002

Sections of Title XIX Waived:
-1902(a)(10)((a)(ii)(V) - Hospitalized Individuals
-1902(a)(10)(B)(i) - MCO Enrollees
-1902(a)(10)(B), Supported Employment
-1902(a)(13) except 1902(a)(13)(A)
-1902(a)(14) - Copays
-1902(a)(17) - Quarterly Income
-1902(a)(23) - Freedom of Choice
-1902(a)(30)
-1902(a)(34) - Prior Quarter
-1902(a)(54) - Outpatient Drugs

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(i)
-1903(i)(10) Eligibility Expansion, Eligibility Simplification, Family Planning, IMD
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(ix)
-1903(m)(2)(A)(vi)
-1903(m)(2)(A)(viii)
-1903(m)(4)(A)&(B) HCBS

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management (DDD only), Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing (EPSDT only), Home Health, Hospice (EPSDT only), Immunization,

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Maternity, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplantation of Organs and Tissue and Related Immunosuppresant Drugs, Transportation, Vision (EPSDT only), X-Ray

-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Indian Health Service (IHS) Providers
-Physician Assistants
-Certified Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Foster Care Children
-TITLE XXI SCHIP
-Families with Dependent Children Under Age 18 (1931) and Continuing Coverage (TMA/CS)
-Pregnant Women (SOBRA)
-Federal Poverty Level Children Under Age 19 (SOBRA)
-Adults Without Minor Children Title XIX Waivers
-Adoption Subsidy Children
-Section 1931 Families with Children and Related Populations

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

Lock-In Provision:
12 month lock-in

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:
Case Management, Crisis, Detoxification, Emergency and Non-emergency Transportation, IMD Services, Individual Therapy and Counseling, Inpatient Mental Health, Inpatient Psychiatric for Persons Under 21, Inpatient Substance Abuse, Laboratory, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Opiate Treatment Programs, Outpatient Hospital Services, Outpatient Substance Abuse, Pharmacy, Residential Substance Abuse Treatment Programs, X-Ray

Allowable PCPs:
-PCP is in Medicaid Health Plan
-In Maricopa County, a psychologist, psychiatrist, physician assistant or certified psychiatric nurse

Contractor Types:
-Regional Authority Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Families with Dependent Children under age 18 (1931) and Continuing Coverage (TMA/CS)
-Pregnant Women (SOBRA)
-Federal Poverty Level Children Under Age 19 (SOBRA)
-Adults Without Minor Children Title XIX Waiver
-Adoption Subsidy Children
-Section 1931 Families with Children and Related Populations
-Title XIX Waiver Spend Down

Subpopulations Excluded from Otherwise Included Populations:
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)

Lock-In Provision:
No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AZ Physicians IPA (Family Planning Extension)
AZ Physicians IPA (HP)
CIGNA Community Choice (Family Planning Extension)
CIGNA Community Choice (HP)
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)
Family Health Plan of North Eastern Arizona (Family Planning Extension)
Family Health Plan of North Eastern Arizona (HP)
Health Choice Arizona (Family Planning Extension)
Health Choice Arizona (HP)
Lifemark Health Plans (PC)
Maricopa County Health Plan (Family Planning Extension)
Maricopa County Health Plan (HP)
Maricopa County Health Plan (PC)
Mercy Care Plan (Family Planning Extension)
Mercy Care Plan (HP)
Mercy Care Plan (PC)
Phoenix Health Plan/Community Connection (Family Planning Extension)
Phoenix Health Plan/Community Connection (HP)
Pima Health System (Family Planning Extension)
Pima Health System (HP)

ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

Pima Health System (PC)
University Family Care (Family Planning Extension)
Yavapai County Long Term Care (PC)
Pinal County Long Term Care (PC)
University Family Care (HP)

ADDITIONAL INFORMATION

A managed care system based on prepaid capitation to health plans and long term care program contractors. Never operated as a fee-for-service program. Arizona contracts with the Arizona Department of Health Services, who in turn contracts with Regional Behavioral Health Authorities (RBHAs) to provide behavioral health services to AHCCCS members.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Dentist Survey
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Physician Survey
-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

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-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 modifies/requires MCOs/PHPs 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 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. CMS 1500, UB-92, NCPDP, ADA)
-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Established guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-ADA - American Dental Association dental claim form
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved

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/PHP commercial utilization rates, comparisons to national norms,

electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term facilities

comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent Well-Care Visits
-Adults' Access to Preventitive/Ambulatory Health Services

-Alzheimers study to evaluate appropriateness of care
-Annual Dental Visits among Children (ages 3 - 20)
-Blood lead screening
-Breast Cancer Screening
-Cervical Cancer Screening
-Children's Access to Primary Care Providers
-Children's Access to Primary Care Providers - KidsCare Population
-Dental referrals
-Dental Services
-Diabetes Management (ATLCS indicator)
-Health Screenings
-Hearing Services for Individuals less than 21 years of age
-Immunization of 2 year olds
-Influenza Immunizations and Pneumococcal Vaccination Rates in the Elderly and Physically Disabled Population in Nursing Facilities and In Home Community Based Setting (ALTCS indicator)
-Initiation of Prenatal Care
-Lead Screening Rate
-Low Birth Weight Deliveries
-Number of new Perinatal cases of HIV/AIDS
-Patient Satisfaction With Care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Prenatal Care in the First Trimester
-Timeliness of Initiation of Services (ALTCS Indicator)
-Utilization of Family Planning Services (Internal Report Only)
-Vision services for individuals less than 21 years of age
-Well-child visits at 3,4,5 and 6 years of age

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care

-Alzheimer study to evaluate appropriateness of HCBS care

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

-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
-Readmission rates of MH/SA

Health Plan Stability/ Financial/Cost of
-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.)
-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
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Performance Improvement Projects

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

Clinical Topics
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Coordination of primary and behavioral health care
-Emergency Room service utilization
-HIV Status/Screening
-Hospital Discharge Planning
-Low birth-weight baby
-Medical problems of the frail elderly
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Pregnancy Prevention
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Provider education regarding cultural health care needs of members

Standards/Accreditation

MCO/PHP 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
None

Accreditation for Deeming
None

EQRO Name
-Health Services Advisory Group

ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

EQRO Organization	EQRO Activities
-Peer Review Organization PRO)	-Administration or validation of consumer or provider surveys -Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services -Review of MCO compliance with structural and operational standards established by the State -Validation of performance improvement projects -Validation of performance measures

ARKANSAS
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:
Roy Jeffus
Medicaid Agency
501-682-1671

State Website Address:
http://www.medicaid.state.ar.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
February 19, 1998

Implementation Date:
March 01, 1998

Waiver Expiration Date:
August 22, 2003

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PHP - Full 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:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

ARKANSAS
Non-Emergency Transportation

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-QMB
-Special low income beneficiaries
-Qualified individuals 1 and 2
-1115 demonstration waivers

Lock-In Provision:
No lock-in

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

-TITLE XXI SCHIP

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

The state contracts with transportation brokers on a capitation basis.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Field Audits
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-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
-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 MCO/PHP

ARKANSAS
Non-Emergency Transportation

MCO conducts data accuracy check(s) on specified data elements
-Provider ID
-Type of Service
-Medicaid Eligibility

State conducts general data completeness assessments
Yes

commercial utilization rates, comparisons to national norms, comparisons to submitted bills

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Arkansas Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys

ARKANSAS
Primary Care Physician

CONTACT INFORMATION

State Medicaid Contact:
Roy Jeffus
State Medicaid Agency
501-682-1671

State Website Address:
http://www.medicaid.state.ar.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 30, 1996

Implementation Date:
November 01, 1996

Waiver Expiration Date:
June 20, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-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, Durable Medical Equipment, EPSDT(25 counties), Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Physician, Podiatry, X-Ray

Allowable PCPs:
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Area Health Education Centers (AHECs)
-Pediatricians
-General Practitioners
-Family Practitioners

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

ARKANSAS
Primary Care Physician

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Eligibility Period that is Retroactive
-Medically Needy "Spenddown" Categories

Lock-In Provision:
6 month lock-in

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

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-1115 Demonstration Waiver (Our Kids B)

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Connect Care

ADDITIONAL INFORMATION

All included services requires PCP referral. All other services available in Medicaid FFS do not require PCP referral.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Enrollee Hotlines
-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
None

CALIFORNIA
Altamed Health Senior Buenacare

CONTACT INFORMATION

State Medicaid Contact:
Carol Freels
DHS
(916)322-4475

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - 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 28, 1998

Implementation Date:
November 01, 1998

Waiver Expiration Date:
November 24, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(f)(4)(C)
-1903(m)(A)(I)(II)

SERVICE DELIVERY

Long Term Care MCO - Full Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Physician Assistants
-Family Practitioners
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

CALIFORNIA
Altamed Health Senior Buenacare

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Special Needs Children

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Mass Mailings to Potential Enrollees
-Uses eligibility data to identify members of these

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Altamed Senior BuenaCare

ADDITIONAL INFORMATION

If the potential participant meets the eligibility requirements for enrollment into the PACE program, which is 55 years and older, lives in the plans approved service area, and is certified for nursing facility level of care and elects to enroll in the PACE program, the participant will remain enrolled in the program unless he or she chooses to voluntarily disenroll from the plan or is involuntarily disenrolled by the plan with DHS approval.

The program provides a full continuum of medical, social and long term care services to nursing home eilgibles age 55 and over in a specific geographic area.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Does not Collect Quality Data

Use of Collected Data
-Not Applicable

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

CALIFORNIA
Altamed Health Senior Buenacare

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

Participation

CALIFORNIA
Caloptima

CONTACT INFORMATION

State Medicaid Contact:
Cheri Rice
Medi-Cal Managed Care Division
(916)654-8076

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
October 01, 1995

Implementation Date:
October 01, 1995

Waiver Expiration Date:
July 29, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

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

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

Enrollment

CALIFORNIA
Caloptima

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

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

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

ADDITIONAL INFORMATION

1 of 5 County Organized Health Systems that has special waiver authority under OBRA 1985.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements 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
-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 uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some

CALIFORNIA

Caloptima

or all of the measures

-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms
None

Validation: Methods
None

MCO conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

Standards/Accreditation

CALIFORNIA
Caloptima

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Private Accreditation Organization

EQRO Activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

CALIFORNIA
Center For Elders Independence

CONTACT INFORMATION

State Medicaid Contact:
Carol Freels
DHS
(916)322-4475

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - 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:
April 04, 1995

Implementation Date:
April 01, 1995

Waiver Expiration Date:
November 15, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(a)(23)
-1903(m)(2)(A)(I)(II)

SERVICE DELIVERY

Long Term Care MCO - Full Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

CALIFORNIA
Center For Elders Independence

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Special Needs Children

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Mass Mailings to Potential Enrollees
-Uses eligibility data to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:
-None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Centers for Elders Independence

ADDITIONAL INFORMATION

If the potential participant meets the eligibility requirements for enrollment into the PACE program, which is 55 years and older, lives in the plans approved service area, and is certified for nursing facility level of care and elects to enroll in the PACE program, the participant will remain enrolled in the program unless he or she chooses to voluntarily disenroll from the plan or is involuntarily disenrolled by the plan with DHS approval.

The program provides a full continuum of medical, social and long term care services to nursing home eligibles age 55 and over who live in a specifica geographic area.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Does not Collect Quality Data

Use of Collected Data
-Not Applicable

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

CALIFORNIA
Center For Elders Independence

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

Participation

CALIFORNIA
Central Coast Alliance for Health

CONTACT INFORMATION

State Medicaid Contact:
Cheri Rice
Medi-Cal Managed Care Division
(916)654-8076

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1996

Implementation Date:
January 01, 1996

Waiver Expiration Date:
June 02, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-OBRA 1985 & 1990

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(ii)and(vi)

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

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

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

Enrollment

CALIFORNIA
Central Coast Alliance for Health

Populations Voluntarily Enrolled:
None

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

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

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

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

Central Coast Alliance for Health

ADDITIONAL INFORMATION

1 of 5 County Organized Health Systems that has special waiver authority under OBRA 1985.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements 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

-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 measures, but plans to generate SOME or ALL of the

CALIFORNIA
Central Coast Alliance for Health

HEDIS measures listed for Medicaid in the future
-State uses/requires MCOs/PHPs 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/PHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms
None

Validation: Methods
None

MCO conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

CALIFORNIA
Central Coast Alliance for Health

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Private Accreditation Organization

EQRO Activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

CALIFORNIA
Health Plan of San Mateo

CONTACT INFORMATION

State Medicaid Contact:
Cheri Rice
Medi-Cal Managed Care Division
(916)654-8076

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 30, 1987

Implementation Date:
November 30, 1987

Waiver Expiration Date:
April 03, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(5)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-OBRA 1985 & 1990-1903(m)(2)(A)(ii)and(vi)

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

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

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists or Gynecologists
-Nurse Midwives
-Indian Health Service (IHS) Providers

Enrollment

CALIFORNIA
Health Plan of San Mateo

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

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

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

Health Plan of San Mateo

ADDITIONAL INFORMATION

1 of 5 County Health Systems that has special waiver authority under OBRA 1985.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements 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

-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 measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State uses/requires MCOs/PHPs 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

CALIFORNIA
Health Plan of San Mateo

-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms
None

Validation: Methods
None

MCO conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

Standards/Accreditation

CALIFORNIA
Health Plan of San Mateo

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Private Accreditation Organization

EQRO Activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

CALIFORNIA
Hudman

CONTACT INFORMATION

State Medicaid Contact:
Benjamin C. Thomas
Medi-Cal Operations Division
(916)323-0081

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
April 24, 1992

Implementation Date:
April 24, 1992

Waiver Expiration Date:
July 15, 2003

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

The reimbursement arrangement waiver is described as: Individuals affected by this waiver include all long term care residents for Medi-Cal. This waiver is a mechanism for placement in freestanding nursing facilities rather than hospital based distinct part nursing facilities unless waiver exemptions allow residents to remain in distinct part nursing facilities.

CALIFORNIA
Managed Care Network

CONTACT INFORMATION

State Medicaid Contact:
Cheri Rice
Medi-Cal Managed Care Division
(916)654-8076

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 28, 1997

Implementation Date:
March 01, 1997

Waiver Expiration Date:
May 18, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-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, EPSDT, Family Planning, Health Education and Preventive Services, Home Health, Immunization, Laboratory, Outpatient Hospital, Physician, Transportation, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers
-Physical Medicine/Rehabilitation Physicians
-Primary Care Clinics
-Community Clinics
-Hospital Outpatient Clinics
-County Government Clinics
-Health Maintenance Organizations
-Specialty Physicians

CALIFORNIA
Managed Care Network

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

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

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

Placer County Managed Care Network

Sonoma County Managed Care Network

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-None

Use of Collected Data:
-None

Consumer Self-Report Data
None

CALIFORNIA
Medi-Cal Mental Health Care Field Test

CONTACT INFORMATION

State Medicaid Contact:
Dee Lemonds
Managed Care Implementation
(916)654-5691

State Website Address:
http://www.dmh.cahwnet.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 13, 1995

Implementation Date:
April 01, 1995

Waiver Expiration Date:
July 29, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Case Rate Funding Mechanism for All Specialty Mental Health Services - Fee-for-Service

Service Delivery

Included Services:
Inpatient Mental Health Services, Outpatient Mental Health Services, Pharmacy

Contractor Types:
-County Operated Entity (Public)

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Other(State-Only Medi-Cal and Emergency Services Only populations)
-Section 1931 (AFDC/TANF) Children and Related Populations

CALIFORNIA
Medi-Cal Mental Health Care Field Test

Subpopulations Excluded from Otherwise Included Populations:
-Not Applicable

Lock-In Provision:
No lock-in

ADDITIONAL INFORMATION

All Medicaid eligibles in San Mateo County are eligible for mental health services on an as needed basis. There is a case rate funding mechanism for all specialty mental health services except for pharmacy and related laboratory costs and therapeutic

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Does Not Collect Quality Data

Use of Collected Data:
-Not Applicable

Consumer Self-Report Data
None

CALIFORNIA
Medi-Cal Specialty Mental Health Services Consolidation

CONTACT INFORMATION

State Medicaid Contact:
Dee Lemonds
Managed Care Implementation
(916)654-5691

State Website Address:
http://www.dmh.cahwnet.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 15, 1995

Implementation Date:
March 15, 1995

Waiver Expiration Date:
November 19, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) Methods of Administration

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mechanism to allow Fee-for-Service payment for mental health services statewide.
- Fee-for-Service

Service Delivery

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

Allowable PCPs:
-Not Applicable

Contractor Types:
None

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Other (State-Only Medi-Cal and Emergency Services only

CALIFORNIA
Medi-Cal Specialty Mental Health Services Consolidation

Subpopulations Excluded from Otherwise Included Populations:
-Not Applicable

Lock-In Provision:
No lock-in

ADDITIONAL INFORMATION

All Medicaid eligibles 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. This program is not available in San Mateo and Solano counties. Although this program is, in effect, a statewide program, it has been implemented in smaller and defined geographic areas, while ensuring adequate access to quality services for all Medi-Cal beneficiaries. populations)

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Does not Collect Quality Data

Use of Collected Data:
-Not Applicable

Consumer Self-Report Data
None

CALIFORNIA
On Lok Senior Health Services

CONTACT INFORMATION

State Medicaid Contact:
Carol Freels
DHS
(916)322-4475

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - 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, 1983

Implementation Date:
November 01, 1983

Waiver Expiration Date:
November 24, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(f)(4)(C)
-1903(m)(A)(I)(II)

SERVICE DELIVERY

Long Term Care MCO - Full Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

CALIFORNIA
On Lok Senior Health Services

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Special Needs Children

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Mass Mailings to Potential Enrollees
-Uses eligibility data to identify members of these

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

On Lok

ADDITIONAL INFORMATION

If the potential participant meets the eligibility requirements for enrollment into the PACE program, which is 55 years and older, lives in the plans approved service area, and is certified for nursing facility level of care and elects to enroll in the PACE program, the participant will remain enrolled in the program unless he or she chooses to voluntarily disenroll from the plan or is involuntarily disenrolled by the plan with DHS approval.

This program provides a full continuum of medical, social and long term care services to nursing home eligibles age 55 and over who live in a specific geographic area.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Does Not Collect Quality Data

Use of Collected Data
-Not Applicable

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

CALIFORNIA
On Lok Senior Health Services

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA
Partnership Health Plan of California

CONTACT INFORMATION

State Medicaid Contact:
Cheri Rice
Medi-Cal Managed Care Division
(916)654-8076

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 01, 1994

Implementation Date:
May 01, 1994

Waiver Expiration Date:
February 10, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-OBRA 1985 & 1990

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(ii) and (vi)

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Long Term Care - Counseling and Social Support, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Pediatricians
-General Practitioners

Enrollment

CALIFORNIA
Partnership Health Plan of California

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

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

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
Partnership Health Plan

ADDITIONAL INFORMATION
1 of 5 County Organized Health Systems that has special waiver authority under OBRA 1985.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements 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
-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 uses/requires MCOs/PHPs 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

CALIFORNIA
Partnership Health Plan of California

-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms
None

Validation: Methods
None

MCO conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

CALIFORNIA
Partnership Health Plan of California

Standard/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Private Accreditation Organization

EQRO Activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

CALIFORNIA
Prepaid Health Plan Program

CONTACT INFORMATION

State Medicaid Contact:
Cheri Rice
Medi-Cal Managed Care Division
(916)654-8076

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

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:
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

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, 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:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Section 1931 (CALWORKS/TANF) Children and Related

Populations Mandatorily Enrolled:
None

CALIFORNIA
Prepaid Health Plan Program

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

Dental PHP - Full Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Dentists

Populations
-Section 1931 (CALWORKS/TANF) Adults and Related Populations

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Section 1931 (CALWORKS/TANF) Children and Related Populations
-Section 1931 (CALWORKS/TANF) Adults and Related Populations

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Populations residing outside plans service area defined by contract

Lock-In Provision:
No lock-in

CALIFORNIA
Prepaid Health Plan Program

PHP (Only for Emotional Support) - Full Capitation

Service Delivery

Included Services:
Emotional Support Services

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Disabled Children

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

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
Care 1st Health Plan-Dental PHP
Kaiser Foundation
San Francisco City & CO/Family Mosiac
UHP Healthcare-Dental
Western Dental Services
American Health Guard-Dental Plan
Foundation Dental
Maxicare Dental PHP
Tower Health Care-Dental PHP
Universal Care-Dental

ADDITIONAL INFORMATION

San Francisco City & CO/Family Mosiac under this program only provides emotional support to severely emotionally disturbed children.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Does Not Collect Quality Data

Use of Collected Data
-Not Applicable

CALIFORNIA
Prepaid Health Plan Program

Consumer Self-Report Data
-Not Applicable

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA
Primary Care Case Management Program

CONTACT INFORMATION

State Medicaid Contact:
Cheri Rice
Medi-Cal Managed Care Division
(916)654-8076

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 20, 1982

Implementation Date:
August 01, 1984

Waiver Expiration Date:
August 09, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(30)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PHP - Full Capitation

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

CALIFORNIA
Primary Care Case Management Program

-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Other (All categories of federally eligible Medi-Cal beneficiaries)
-Section 1931 (AFDC/TANF) Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-California Children Services (CCS) Program, needing renal dialysis.
-Poverty Level Pregnant Woman

Lock-In Provision:
No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Positive Healthcare/AIDS Health Care

ADDITIONAL INFORMATION

PCPs contract to provide and assume risk for primary care, specialty physician services, and selected outpatient preventive and treatment services.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Does Not Collect Quality Data

Use of Collected Data
-Not Applicable

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA
Sacramento Geographic Managed Care

CONTACT INFORMATION

State Medicaid Contact:
Cheri Rice
Medi-Cal Managed Care Division
(916)654-8076

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Health Care
Options/Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1994

Implementation Date:
April 01, 1994

Waiver Expiration Date:
August 12, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(5)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Enhanced Perinatal and Preventive Services, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Psychiatrists
-Pediatricians
-Family Practitioners
-Internists
-General Practitioners

CALIFORNIA
Sacramento Geographic Managed Care

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Adoption Assist/Medically Indigent-Child
-Foster Care/Medically Indigent-Child
-Pregnant/Medically Indigent-Adult
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (CALWORKS/TANF) Children and Related Populations
-Special Program/Percent/Children
-Section 1931 (CALWORKS/TANF) Adults and Related Populations
-Public Assistance-Family

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

Dental PHP - Full Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Dentists

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Adoption Assist/Medically indigent-Child
-Foster Care/Medically indigent-Child
-Pregnant/Medically Indigent-Adult

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Section 1931 (CALWORKS/TANF) Children and Related Populations
-Section 1931 (CALWORKS/TANF) Adults and Related Populations
-Public Assistance-Family
-Special Program/Percent/Children

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Other Insurance
-Enrolled In Another Medicaid Program

Lock-In Provision:
No lock-in

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities
-Education Agency
-Home and Community Based Care
-Local Schools
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

CALIFORNIA
Sacramento Geographic Managed Care

Groups

-Social Services Agency
-Substance Abuse Agency
-Title V

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan-Sacramento GMC
Blue Cross of California-Sacramento GMC
Delta Dental Plan
Denticare of California-Sacramento GMC
Health Net-Sacramento GMC
Kaiser Foundation-Sacramento GMC
Maxicare-Sacramento GMC
Molina Medical Centers-Sacramento GMC
Western Dental Services-Sacramento GMC
Western Health Advantage-Sacramento GMC

ADDITIONAL INFORMATION

Restricts aid code beneficiaries designated mandatory to enroll in 1 of 5 health plans and 1 of 4 dental plans.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements 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

-CAHPS
  Adult Medicaid Questionnaire
  Child Medicaid 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/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-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. CMS 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-National Drug Code assigned by the Federal Drug Administration
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Validation: Methods

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

care facilities

MCO 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

No

Performance Measures

Process Quality

-Check-ups after delivery
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Well-child care visit rates

Health Status/Outcomes Quality

None

Access/Availability of Care

None

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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
-Breathe with ease (a comprehensive multi-disciplinary health management system for children with asthma)
-CHDP documentation
-Childhood Immunization
-Improving the quality of asthma care and reduction of inappropriate use of services through patient self-management
-Pediatric preventive services

Non-Clinical Topics

-Appropriateness of specialty referral and improving access to care
-Depression pharmacy management
-Improvement of 120-Day assessment compliance
-Improving timeliness of initial health assessments
-Interventions-What to do when your child gets sick
-Member satisfaction survey

CALIFORNIA
Sacramento Geographic Managed Care

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

CALIFORNIA
San Diego Geographic Managed Care

CONTACT INFORMATION

State Medicaid Contact:
Cheri Rice
Medi-Cal Managed Care Division
(916)654-8076

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Health Care
Options/Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 17, 1998

Implementation Date:
October 17, 1998

Waiver Expiration Date:
October 10, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(5), 1902(a)(30)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Enhanced Perinatal and Preventive Services, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision,

Allowable PCPs:
-Psychiatrists
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers

CALIFORNIA
San Diego Geographic Managed Care

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
X-Ray
-Adoption Assist/Medically Indigent-Child
-Foster Care/Medically Indigent-Child
-Pregnant/Medically Indigent-Adult

Populations Mandatorily Enrolled:
-Section 1931 (CALWORKS TANF) Children and Related Populations
-Section 1931 (CALWORKS TANF) Adults and Related
-Foster Care Populations
-Public Assistance-Family
-Special Program/Percent/Children

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Other Insurance
-Enrolled in Another Medicaid Program

Lock-In Provision:
No lock-in

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

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabililties
-Education Agency
-Home and Community Based Care
-Local Schools
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Title V

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross of California-San Diego GMC
Community Health Group
Foundation Health-Dental
Health Net-San Diego GMC
Kaiser Foundation-San Diego GMC
Sharp Health Plan
UCSD Health Plan
Universal Care

ADDITIONAL INFORMATION

Restricts aid code beneficiaries designated as mandatory to enroll in 1 of 6 health plans.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement

CALIFORNIA
San Diego Geographic Managed Care

-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
-Adult and child English and Spanish
-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/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements
-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. CMS 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-National Drug Code assigned by the Federal Drug Administration
-UB-92 (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)

MCO 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
No

Performance Measures

Process Quality
-Check-ups after delivery
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Well-child care visit rates

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

CALIFORNIA
San Diego Geographic Managed Care

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

CALIFORNIA
Santa Barbara Health Initiative

CONTACT INFORMATION

State Medicaid Contact:
Cheri. Rice
Medi-Cal Managed Care Division
(916)654-8076

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
September 01, 1987

Implementation Date:
September 01, 1987

Waiver Expiration Date:
January 11, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

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

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers

Enrollment

CALIFORNIA
Santa Barbara Health Initiative

Populations Voluntarily Enrolled:
None

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

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period Less Than 3 Months

Lock-In Provision:
No lock-in

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

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

Santa Barbara Health Initiative

ADDITIONAL INFORMATION

Established under State Statute of 1982.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements 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
-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 uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for

CALIFORNIA
Santa Barbara Health Initiative

some or all of the measures
-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms
None

Validation: Methods
None

MCO conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

CALIFORNIA
Santa Barbara Health Initiative

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Private Accreditation Organization

EQRO Activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

CALIFORNIA
Selective Provider Contracting Program

CONTACT INFORMATION

State Medicaid Contact:
Benjamin C. Thomas
Medi-Cal Operations
(916)323-0081

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Initial Waiver Approval Date:
September 21, 1982

Implementation Date:
September 21, 1982

Waiver Expiration Date:
December 12, 2001

Sections of Title XIX Waived:
-1902(a)(13)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(5)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

ADDITIONAL INFORMATION

The reimbursement arrangement waiver is described as: This waiver allows CA to selectively contract with hospitals to provide acute inpatient care to all Medi-Cal beneficiaries. This waiver does not differentiate by beneficiary aid code.

CALIFORNIA
Senior Care Action Network

CONTACT INFORMATION

State Medicaid Contact:
Carol Freels
DHS
(916)322-4475

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - 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:
June 07, 1985

Implementation Date:
January 01, 1985

Waiver Expiration Date:
December 31, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(e)(2)(A)

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

SERVICE DELIVERY

Social HMO - Full Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Long Term Care, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

CALIFORNIA
Senior Care Action Network

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Special Needs Children

Lock-In Provision:
No lock-in

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

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

ADDITIONAL INFORMATION

SCAN eligibility requires the beneficiary to be dually eligible, over 65 and for long term benefits must meet the criteria for skilled or intermediate nursing care. SCAN is the only social HMO in California.

This program provides medical, social and long term care services.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Does Not Collect Quality Data

Use of Collected Data
-Not Applicable

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA
Sutter Senior Care

CONTACT INFORMATION

State Medicaid Contact:
Carol Freels
DHS
(916)322-4475

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - 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:
July 14, 1994

Implementation Date:
May 01, 1994

Waiver Expiration Date:
November 24, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(f)(4)(c)
-1903(m)(2)(A)(I)(II)

SERVICE DELIVERY

Long Term Care MCO - Full Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

CALIFORNIA
Sutter Senior Care

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Special Needs Children

Lock-In Provision:
No lock-in

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

Sutter Senior Care

ADDITIONAL INFORMATION

If the potential participant meets the eligibility requirements for enrollment into the PACE program, which is 55 years and older,lives in the plans approved service area, and is certified for nursing facility level of care and elects to enroll in the PACE program, the participant will remain enrolled in the program unless he or she chooses to voluntarily disenroll from the plan or is involuntarily disenrolled by the plan with DHS approval.

This program provides a full continuum of medical, social and long term care services to nursing home eligibles age 55 and over who live in a specific geographic area.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Does Not Collect Quality Data

Use of Collected Data
-Not Applicable

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

CALIFORNIA
Sutter Senior Care

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA
Two-Plan Model Program

CONTACT INFORMATION

State Medicaid Contact:
Cheri Rice
Medi-Cal Managed Care Division
(916)654-8076

State Website Address:
http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Health Care
Options/Maximus

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 22, 1996

Implementation Date:
January 23, 1996

Waiver Expiration Date:
November 08, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Cultural/Linguistic Services, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Preventive Health Screening, Transportation, Vision, X-Ray

Allowable PCPs:
-Internists
-Family Practitioners
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Pediatricians
-General Practitioners

Enrollment

CALIFORNIA
Two-Plan Model Program

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

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

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

Alameda Alliance for Health
Contra Costa Health Plan
Health Plan of San Joaquin
Kern Family Health Care
Molina Medical Centers-TPMP
Santa Clara Family Health Plan
Blue Cross of California-TPMP
Health Net-TPMP
Inland Empire Health Plan
LA Care Health Plan
San Francisco Health Plan

ADDITIONAL INFORMATION

Eligibles may choose to join either a local initiative plan or a commercial plan selected by the State.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-site Reviews
-Performance Improvements 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

CALIFORNIA
Two-Plan Model Program

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 uses/requires MCOs/PHPs 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/PHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-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. CMS 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-National Drug Codes assigned by the Federal Drug Administration
-UB-92 (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)

MCO 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
No

Performance Measures

Process Quality
-Check-ups after delivery
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Well-child care visit rates

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

CALIFORNIA
Two-Plan Model Program

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

COLORADO
Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:
Mary Kohl
Dept. of Health Care Policy and Financing
(303) 866-4722

State Website Address:
http://www.CHCPF.state.co.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)

Enrollment Broker:
MAXIMUS, INC.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
August 01, 1982

Implementation Date:
May 01, 1983

Waiver Expiration Date:
April 30, 2003

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-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, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Outpatient Hospital, Physician, Skilled Nursing Facility

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

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related

COLORADO
Managed Care Program

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Presumptive Eligible

Lock-In Provision:
6 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

-Foster Care Children
-Dual Eligibles

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Presumptive Eligible

Lock-In Provision:
6 month lock-in

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 provider referrals to identify members of these

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Colorado Access
Kaiser
Community Health Plan of the Rockies
Primary Care Physician Program

COLORADO
Managed Care Program

Rocky Mountain HMO
United Healthcare of Colorado

Total Long Term Care

ADDITIONAL INFORMATION

PCCM is a managed care program available statewide which provides beneficiaries the option of a fee-for-service physician who acts as a gatekeeper and refers for specialty care. 5 HMO options are available however, availability varies by county. Total Long Term Care is a PACE provider available in the Denver Metro Area only.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Accreditation for Deeming (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements 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

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/PHPs 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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, 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
-Not Applicable

MCO conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care

Health Status/Outcomes Quality
-Patient satisfaction with care

COLORADO
Managed Care Program

-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Immunizations for two year olds
-Initiation of prenatal care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Well-child care visit rates

Access/Availability of Care
-Average wait time for an appointment with PCP

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
-NCQA (National Committee for Quality Assurance)

EQRO Name
-First Peer Review of Colorado

EQRO Organization
-Peer Review Organization (PRO)
-PRO-like Entity

EQRO Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct performance improvement projects
-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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Focused Studies

Use of Collected Data:
-Monitor Quality Improvement
-Provider Profiling

COLORADO
Managed Care Program

-Ombudsman
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Track Health Service provision

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

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Smoking prevention and cessation
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

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

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Provider Characteristics
None

Beneficiary Characteristics
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Childhood Immunization
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

COLORADO
Mental Health Capitation Program

CONTACT INFORMATION

State Medicaid Contact:
Bill Bush
Mental Health Services
(303) 866-7411

State Website Address:
http://www.CHCPF.state.co.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
October 04, 1993

Implementation Date:
July 01, 1995

Waiver Expiration Date:
April 09, 2003

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PHP - Full Capitation

Service Delivery

Included Services:
Crisis, IMD Services, Inpatient Mental Health Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support

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

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Blind/Disabled Children and Related Populations

COLORADO
Mental Health Capitation Program

-Foster Care Children

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

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Behavioral Care
Behavioral Healthcare, Inc.
Jefferson Center for Mental Health
Mental Health Center of Boulder
North Range Behavioral
Northeast Behavioral Health
Pikes Peak-Options Colorado Health Networks
SyCare-Options Colorado Health Networks
West Slope-Options Colorado Health Networks

ADDITIONAL INFORMATION

Due to the nature of the waiver which is for a limited segment of services, the program does not designate a primary care provider. Individuals choose their own providers or rely on the contractor (Mental Health and Service Agency (MHASA)) for referral. The contractor acts as the gatekeeper.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-Contract Standard Compliance
-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
-Mental Health Statistics Improvement Program (MHSIP)

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

COLORADO
Mental Health Capitation Program

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

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)
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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
None

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average wait time for an appointment with PCP

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Number of PCP visits per beneficiary

Health Plan Stability/ Financial/Cost of
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

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

COLORADO
Mental Health Capitation Program

EQRO Organization
-Not Applicable

EQRO Activities
-Validation of performance improvement projects

CONNECTICUT
Husky A

CONTACT INFORMATION

State Medicaid Contact:
Julie Bisi
Department of Social Services
(860) 424-5133

State Website Address:
http://www.huskyhealth.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
Benova

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
July 20, 1995

Implementation Date:
October 01, 1995

Waiver Expiration Date:
May 31, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Clinics, Dental, Durable Medical Equipment, EPSDT, Family Planning, Federally Qualified Health Centers, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Intermediate Care Facilities, Laboratory, Nurse Practitioners, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Outreach, Pediatrics, Pharmacy, Physical Therapy, Physician, Podiatry, Pre-natal, Rural Health Clinics, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants

Enrollment

CONNECTICUT
Husky A

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program
-Children in Targeted Case Management under Department of Mental Health and Addiction Services
-Children in Targeted Case Management under Department of Mental Retardation
-Children in Katie Beckett Waiver

Lock-In Provision:
12 months lock-in

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 the Balanced Budget Act group.

Agencies with which Medicaid Coordinates the Operation of the Program:
-Child Welfare Agency
-Education Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem Blue Care Family Plan
First Choice Health Plan - Preferred One
Community Health Network of Connecticut
Health Net - Healthy Options

ADDITIONAL INFORMATION

12 month Continuous Eligibility period is guaranteed for children under age 19, once they are deemed eligible for Medicaid. State decides which guaranteed eligibility is applicable based upon whether the enrollee is an adult or child.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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

CONNECTICUT
Husky A

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 modifies/requires MCOs/PHPs 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, definitons, 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)
-Medical record validation
-State conducts multiple critical edits to ensure data accuracy

MCO 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
-25 Pages of critical edits

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Depression management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care

Health Status/Outcomes Quality
None

CONNECTICUT
Husky A

-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care
-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
-Emergency room visits/1,000 beneficiary
-EPSDT Visit Rates
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Percent of beneficiaries using any MH or SA service

Health Plan Stability/ Financial/Cost of
-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 Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency. (For instance: regional projects)

Clinical Topics
-Asthma management
-Child/Adolescent Dental Screening and Services

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Qualidigm

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-On-site operations reviews
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities

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

DELAWARE
Diamond State Health Plan

CONTACT INFORMATION

State Medicaid Contact:
Kay Holmes
Delaware Social Services
(302)577-4903

State Website Address:
DSS.State.De.Us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
EDS, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
July 27, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
March 15, 2004

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B)
-1902(a)(13)(E)
-1902(a)(23) Freedom of Choice
-1902(a)(30)(A)
-1902(a)(34)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(ii)(vi)
-1903(m)(2)(A)(vi) Eligibility Expansion, Family Planning, IMD

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Other Delaware Medicaid Services, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Skilled Nursing Facility,

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

DELAWARE
Diamond State Health Plan

Enrollment

Populations Voluntarily Enrolled:
None

Vision, X-Ray

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Aged and Related Populations
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-CHAMPUS

Lock-In Provision:
12 month lock-in

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
-Enrollment Broker Contacts
-State developed advocacy group (Delaweans with Special Needs
-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:
-Easter Seals
-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

Coventry/DelawareCare

First State Health Plan

ADDITIONAL INFORMATION

This program offers very limited mental health and substance abuse benefits. Most of the mental health and substance abuse services are fee-for-service. Skilled nursing facility is covered for the first 30 days only. Private Duty Nursing is covered for 28 hours per week. This program covers emergency transportation only.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-CAHPS- Partially
-Consumer Self-Report Data (see below for details)

Use of Collected Data
-Contract Standard Compliance
-Fraud and Abuse

DELAWARE
Diamond State Health Plan

-Encounter Data (see below for details)
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-Performance Improvements Projects (see below for details)
-On-Site Reviews
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation

Consumer Self-Report Data

-CAHPS
Adult Medicaid AFDC Questionnaire (partially)
Child Medicaid AFDC Questionnaire (partially)

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
-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. CMS 1500, UB-92, NCPDP, ADA)

Collection: Standardized Forms

-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Validation: Methods

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

MCO conducts data accuracy check(s) on specified data elements

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

State conducts general data completeness assessments

Yes

Performance Improvement Projects

Project Requirements

-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Otitis Media management
-Sickle cell anemia management

Non-Clinical Topics

-Availability of language interpretation services
-Children's access to primary care practitioners

DELAWARE
Diamond State Health Plan

Standards/Accreditation

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Delmarva Foundation/Mercer

EQRO Organization
-PRO-like Entity

EQRO Activities
-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
-Validation of performance improvement projects

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:
Maude Holt
Department of Health, Medical Assisstance
(202) 442-9074

State Website Address:
http://www.dchealth.dc.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Benova, Incorporated

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 1993

Implementation Date:
April 01, 1994

Waiver Expiration Date:
September 23, 2003

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Adult day treatment (MR only), Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Nurse mid-wife services, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Transportation, Vision, X-Ray

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

Enrollment

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

Populations Voluntarily Enrolled:
-TANF HIV Patients:Pregnant >26 Weeks

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver

Lock-In Provision:
1 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Advantage Health, Incorporated
Capital Community Health Plan
Health Right, Incorporated
Americaid Community Care
DC Chartered Health Plan, Incorporated

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-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
-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 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/PHPs 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
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
None

Collection: Standardized Forms
None

Validation: Methods
None

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

MCO conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Adolescent immunization rate
-Check-ups after delivery
-Dental services
-Diabetes management
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality
-Percentage of low birth weight infants

Access/Availability of Care
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Delmarva Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

EQRO 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
-Review of MCO compliance with structural and operational standards established by the State
-Validation of client level data, such as claims and encounters
-Validation of performance measures

DISTRICT OF COLUMBIA
Health Services for Children with Special Needs

CONTACT INFORMATION

State Medicaid Contact:
Maude Holt
Dept. of Health, Medical Assistance Administrator
202-442-9074

State Website Address:
http://www.dchealth.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
Benova, Incorporated

For All Areas Phased-In:
Yes

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 PHP (non-risk, comprehensive) - Partial 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 Abuse, Laboratory, Most Medicaid Services, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

DISTRICT OF COLUMBIA
Health Services for Children with Special Needs

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver

Lock-In Provision:
1 month lock-in

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:
-Maternal and Child Health Agency
-Mental Health Agency
-Social Services Agencies
-Transportation Agencies

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. Skilled Nursing Facility for first 30 days. Program provides Emergency Transportation only.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-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
-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 DOES NOT generate from encounter data any of the

DISTRICT OF COLUMBIA
Health Services for Children with Special Needs

HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs/PHPs 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)
-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data

Collections: Submission Specifications
None

Collection: Standardized Forms
None

Validation: Methods
None

MCO conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Check-ups after delivery
-Dental services
-Diabetes management
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality
-Percentage of low birth weight infants

Access/Availability of Care
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation
None

DISTRICT OF COLUMBIA
Health Services for Children with Special Needs

Accreditation for Deeming
None

EQRO Name
-Delmarva Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

EQRO 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
-Review of MCO compliance with structural and operational standards established by the State
-Validation of client level data, such as claims and encounters
-Validation of performance measures

FLORIDA
Managed Health Care

CONTACT INFORMATION

State Medicaid Contact:
Pamela Thomas
Agency for Health Care Administration (AHCA)
(850)922-6830

State Website Address:
http://www.fdhc.state.fl.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Benova

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
October 01, 1992

Implementation Date:
October 01, 1992

Waiver Expiration Date:
December 28, 2001

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-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:
Advanced Registered Nurse Practitioner, Ambulatory Surgical Center, Chiropractic (limited direct access), County Health Department, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Outpatient Hospital, Physician, Podiatric (limited direct access), Therapy, X-Ray

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

FLORIDA
Managed Health Care

Enrollment

Populations Voluntarily Enrolled:
None

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

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Hospice
-Share of cost (Medically needy)

Lock-In Provision:
12 month lock-in

FLORIDA
Managed Health Care

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Community Mental Health Services in Area 6 only, Dental, Durable Medical Equipment, EPSDT, Family Planning, Freestanding Dialysis Centers, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Mental Health Targeted Case Management in specific area only, Outpatient Hospital, Pharmacy, Physician, Therapy Services, Transportation, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-AIDs HCBS Waiver Enrollees
-Assisted Living HCBS Waiver Enrollees
-Prescribed Pediatric Extended Care Center Residents
-Qualified Medicare Beneficiaries - QMBs
-Medically Complex Children in CMS Program
-Enrolled in Another Managed Care Program
-Hospice
-Reside in Nursing Facility or ICF/MR
-State Hospital Services
-Eligibles in Residential Group Care
-Adult Day Health
-Medically Needy
-Medicaid Eligibles in Residential Committment Facilities
-Children in Residential Treatment Facilities
-Residents in ADM Residential Treatment Facilities

Lock-In Provision:
12 month lock-in

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 criteria for special codes
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agencies

FLORIDA
Managed Health Care

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Beacon Health Plan
Florida 1st Health Plan
Healthease
Humana Family Health Plan
Medipass
Physicians Healthcare Plans
Provider Service Network
Staywell Health Plan
Discovery Health Plan
Foundation Health
Healthy Palm Beaches
JMH Health Plan
Neighborhood Health Partnership, Inc.
Preferred Medical Plan
St. Augustine Health Care
United Healthcare Plans of Florida

ADDITIONAL INFORMATION

PCCM enrollees in six counties receive mental health services through a capitated arrangement. Enrollees are allowed to choose either the fee-for-service or a capitated health plan. If the enrollee fails to make a choice, they are mandatory enrolled into a capitated health plan.

Dental and Transportation services are provided at the option of the Plan and the Agency.

The Provider Service Network(PSN) plan is associated with this program and is structured as a fee-for-service model, it is another managed care option that links recipients to a provider network rather than just a primary care case provider. PSN is available to managed care eligibles who reside in Broward and Dade counties.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-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
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements 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
-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
-Disenrollment Survey
-MCO Member Satisfaction Surveys

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/PHPs 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

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, 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. CMS 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission

Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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 conducts data accuracy check(s) on specified data elements

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Adolescent Well-care visits
-Asthma care
-Beta Blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Diabetes 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
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

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 mental health providers to number of beneficiaries

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 home health visits per benificiary
-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
-Claims payable and IBNR by line of business
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient,

Health Plan/ Provider Characteristics

None

ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Expenses by line of business
-Medical and Hospital expenses
-Medical loss ratio
-Net income
-Net worth
-Revenue by line of business
-State minimum reserve requirements
-Total assets
-Total liabilities
-Total revenue

Beneficiary Characteristics

-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

-MCOs/PHPs are required to conduct a project(s) of their own choosing
-Ratio of PCPs to beneficiaries Asthma management
are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-All MCOs/PHPs participating in the managed care program -
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Breast cancer treatment
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment
-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
-Coronary artery disease treatment
-Depression management
-Diabetes management
-Domestic violence
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment
-Hypertension management
-Lead toxicity
-Pharmacy management
-Pre-natal care
-Pregnancy Prevention
-Primary and behavioral health care coordination
-Sexually transmitted disease screening
-Sexually transmitted disease treatment
-Sickle cell anemia management
-Treatment of myocardial infraction
-Tuberculosis screening and treatment
-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/PHP 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
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation

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

Accreditation for Deeming

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

EQRO Name

Keystone Peer Review Organization, Inc.

EQRO Organization

-Private Accreditation Organization

EQRO Activities

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

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
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-Disenrollment Survey
-State-developed Survey

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care
-Cervical cancer screening rate
-Check-ups after delivery
-CHF Management
-Diabetes management
-ESRD Management
-Hemophilia Management
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care
-Pregnancy Prevention
-Well-child care visit rates

Health Status/Outcomes Quality

-Patient satisfaction with 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

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiary

Manager
-Ratio of primary care case managers to beneficiaries
-Inpatient and outpatient / 1,000 beneficiaries
-Number of primary care case manager visits per beneficiary

Provider Characteristics
-Board Certification
-Provider turnover
-Languages spoken (other than English)

Beneficiary Characteristics
-Disenrollment rate
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-CHF Management
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management
-ESRD Management
-Hemophilia Management
-Hepatitis B screening and treatment
-HIV/AIDS Prevention and/or Management
-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

FLORIDA
Prepaid Mental Health Plan

CONTACT INFORMATION

State Medicaid Contact:
Mary Herkert
Agency for Health Care Administration
(813) 871-7600

State Website Address:
http://www.fdhc.state.fl.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 31, 1996

Implementation Date:
March 01, 1996

Waiver Expiration Date:
December 31, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PHP - Full Capitation

Service Delivery

Included Services:
Crisis, IMD Services, Inpatient Mental Health Services, Mental Health Outpatient, Mental Health Outpatient Hospital, Mental Health Rehabilitation, Mental Health Support, Mental Health Targeted Case Management

Allowable PCPs:
-Psychiatrists
-Licensed Psychologists
-Licensed Mental Health Practitioner

Contractor Types:
-Partnership between private managed care and local community MH inc.

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-SOBRA CHILDREN
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

FLORIDA
Prepaid Mental Health Plan

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Reside in Nursing Facility or ICF/MR
-Poverty Level Pregnant Woman
-Medically Needed

Lock-In Provision:
12 month lock-in

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 provider referrals to identify members of these

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Agencies with which Medicaid Coordinates the Operation of the Program:

-Community-based care providers
-Department of Juvenile Justice
-Family Safety Program
-Forensic/Corrections System
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Florida Health Partners, Inc.

ADDITIONAL INFORMATION

Medicaid recipients who do not voluntarily choose a managed care plan are mandatorily assigned. In five counties, recipients who choose or are mandatorily assigned to Medipass are automatically enrolled in the Prepaid Mental Health Plan. Children who are admitted to residential facilities designated by the Department of Juvenile Justice or the Child Welfare system are disenrolled from the Prepaid Mental Health Plan upon admission and then re-enrolled upon returning to the community.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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
-Program Modification, Expansion, or Renewal
-Track Health Service provision

FLORIDA
Prepaid Mental Health Plan

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 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, definitons, 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 MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation

MCO 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

Process Quality
-Coordination of mental health care with primary care
-Follow-up after hospitalization for mental illness
-Percentage of beneficiaries who are satisfied with their ability to obtain care

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

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

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
-Board Certification
-Credentials and numbers of professional staff
-Languages Spoken (other than English)

FLORIDA
Prepaid Mental Health Plan

Beneficiary Characteristics
None

Performance Improvement Projects

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

Clinical Topics
-Coordination of primary and behavioral health care
-Coordination of Substance Abuse and Mental Health Care
-Deprssion management

Non-Clinical Topics
-Availability and access to specialty therapies
Care -Availability of language interpretation services

Standards/Accreditation

MCO/PHP 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
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

Accreditation for Deeming
None

EQRO Name
-University of South Florida

EQRO Organization
-State
-University

EQRO 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
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance measures

FLORIDA
Sub-Acute Inpatient Psychiatric Program

CONTACT INFORMATION

State Medicaid Contact:
Catharine Nelson
Agency for Health Care Administration
(850) 922-7343

State Website Address:
http://www.fdhc.state.fl.us

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 23, 1998

Implementation Date:
April 01, 1999

Waiver Expiration Date:
December 31, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-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:
Alternative or Step-down for inpatient psychiatric for children and adolescents, Case Management, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Pharmacy, Transportation, Vision, X-Ray

Allowable PCPs:
-Psychiatrists
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
None

FLORIDA
Sub-Acute Inpatient Psychiatric Program

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period Less Than 3 Months
-Medically needed
-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes
-SOBRA Children

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

-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
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Daniel Memorial

ADDITIONAL INFORMATION

PCCM enrollees in fourteen counties can receive an alternative to inpatient behavioral health care that is less costly with a longer expected length of stay, when it is determined to be medically necessary and appropriate.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

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

Consumer Self-Report Data
-Independent evaluation contractor has developed a survey
-Provider-developed survey

Performance Measures

Process Quality
-Changes in level of functioning
-Depression management
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality
-Patient satisfaction with care

FLORIDA
Sub-Acute Inpatient Psychiatric Program

Access/Availability of Care
-Average distance to primary care case manager
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Family therapy and involvement
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Re-admission rates of MH/SA

Provider Characteristics
-Board Certification
-Languages spoken (other than English)

Beneficiary Characteristics
-Complaints or grievances
-Consumer or family satisfaction
-Current medications prescribed
-Information on diagnosis

GEORGIA
Georgia Better Health Care

CONTACT INFORMATION

State Medicaid Contact:
Kathrine Driggers
Department of Community Health/Division of Medical
(404)657-7793

State Website Address:
http://www.dch.state.ga.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 14, 1993

Implementation Date:
October 01, 1993

Waiver Expiration Date:
December 14, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-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:
Durable Medical Equipment, EPSDT, Home Health, Immunization, In-home Nursing, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

GEORGIA
Georgia Better Health Care

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Poverty Level Pregnant Woman
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-SOBRA Eligible Pregnant Women
-Special Needs Children

Lock-In Provision:
No lock-in

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:
-Blind/Disabled Adults and Related Populations

-Blind/Disabled Children and Related Populations
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Georgia Better Health Care

ADDITIONAL INFORMATION

Special needs children include children with severe illnesses.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

Use of Collected Data:
-Program Evaluation

Consumer Self-Report Data
-State-developed Survey

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with 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
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of primary care case manager visits per beneficiary

GEORGIA
Georgia Better Health Care

-Number of specialist visits per beneficiary

Provider Characteristics

-Board Certification
-Languages spoken (other than English)

Beneficiary Characteristics

-Percentage of beneficiaries who are auto-assigned to PCCM

GEORGIA
Non-Emergency Transportation Broker Program

CONTACT INFORMATION

State Medicaid Contact:
Butch Beaty
Department of Community Health/Division of Medical
(404) 657-7793

State Website Address:
http://www.dch.state.ga.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 08, 1999

Implementation Date:
October 01, 1997

Waiver Expiration Date:
September 07, 2001

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PHP - Full Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

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

GEORGIA
Non-Emergency Transportation Broker Program

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 enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Social Services Agency
-Transportation Agency

-Aged and Related Populations

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

State contracts with a single broker in each of the states 5 non-emergency transportation regions to coordinate and provide non-emergency transportation services statewide.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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 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

Collections: Submission Specifications

-Guidelines for frequency of encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

None

Validation: Methods

-Accuracy Audits

GEORGIA
Non-Emergency Transportation Broker Program

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Type of Service

State conducts general data completeness assessments
No

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Record Audits

Use of Services/Utilization
-Utilization by Type

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

GEORGIA
Preadmission Screening and Annual Resident Review (PASARR)

CONTACT INFORMATION

State Medicaid Contact:
Wanda Patterson
Department of Community Health/Division of Medical
(404)651-7884

State Website Address:
http://www.dch.state.ga.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
April 01, 1994

Implementation Date:
November 01, 1994

Waiver Expiration Date:
April 08, 2003

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PHP - Full Capitation

Service Delivery

Included Services:
Mental Health/Mental Retardation Rehabilitation Services

Allowable PCPs:
-Psychiatrists
-Other Specialists Approved on a Case-by-Case Basis
-Psychologists
-Clinical Social Workers

Contractor Types:
-Private

Enrollment

Populations Voluntarily Enrolled:
None

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

GEORGIA
Preadmission Screening and Annual Resident Review (PASARR)

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Women
-Reside in ICF/MR
-Enrolled in another managed care program
-QMB
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Special Needs Children

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

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:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Preadmission Screening and Annual Resident Review (PASARR)

ADDITIONAL INFORMATION

One contractor provides services to this population statewide. Special needs children include children with severe illnesses.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Focused Studies
-Ombudsman
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data
-Program Evaluation
-Program Modification, Expansion, or Renewal

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
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
None

GEORGIA
Preadmission Screening and Annual Resident Review (PASARR)

Collection: Standardized Forms
None

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

MCO 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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-OASYS

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

HAWAII
Hawaii QUEST

CONTACT INFORMATION

State Medicaid Contact:
Aileen Hiramatsu
Hawaii Department of Human Services, Med-QUEST
(808) 692-8050

State Website Address:
http://www.state.hi.us/dhs/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
July 16, 1993

Implementation Date:
August 01, 1994

Waiver Expiration Date:
March 31, 2002

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(A)(i)(I),(III)-(VII)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(C)(ii)
-1902(a)(13)
-1902(a)(13)(E)
-1902(a)(14)
-1902(a)(17)(D)
-1902(a)(23) Freedom of Choice
-1902(a)(25)(G)
-1902(a)(30)
-1902(a)(34)
-1902(a)(4)
-1902(a)(51)(B)
-1902(a)(52)
-1902(a)(58)
-1902(e)(1)(A)
-1902(e)(4)-(7)

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Eligibility Expansion
-1903(m)(a)(A)(i)
-1903(m)(I)(A)

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

HAWAII
Hawaii QUEST

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

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Psychiatrists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-General Assistance (GA) Program

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Special Needs Children

Lock-In Provision:
12 month lock-in

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:
Crisis, Detoxification, IMD Services, Inpatient Mental Health Services, Inpatient Substance Abuse Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Abuse Services, Pharmacy, Residential Substance Abuse Treatment

Allowable PCPs:
-Psychiatrists
-Psychologists

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Special Needs Children
-Participate in HCBS Waiver
-All children are excluded

Lock-In Provision:
No lock-in

HAWAII
Hawaii QUEST

Dental PHP - Full Capitation

Service Delivery

Included Services:
Dental

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-General Assistance (GA) Program

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Special Needs Children (State defined)
-Children who satisfy the disability criteria under State law

Lock-In Provision:
12 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aloha Care
Aloha Care-Dental
Child & Adolescent Mental Health Division, Department of Health
Denticare
Early Intervention Programs, Department of Health
HMSA-Behavioral Health for SMI
HMSA-Dental
HMSA-Medical
Kaiser Permanente
Kapiolani HealthHawaii
Queens Hawaii Care
Straub

ADDITIONAL INFORMATION

This program provides medical, dental, and behavioral health services through competitive managed care delivery system. Aged, Blind/disabled populations have the option to enroll in either a fee-for-service or a managed care programs for mental health services. Quest-Net Program was implemented on April 1, 1996 as a component of the 1115(a) Hawaii Quest primarily to serve as a safety net for persons who became ineligible for Hawaii Quest or Medicaid Fee-For-Service (FFS) because their assets or income exceeded the allowable retention limits. Individuals with medical coverage including Medicare or military coverage are not eligible for Quest-Net. Adults are provided with limited basic health coverage. Children who are not blind or disabled are provided the same Quest standard benefits: similarly, benefits provided under the Medicaid FFS program are provided for children who are blind and disabled. The person reserve standard for Quest-Net is $5000 for a single person and $7000 for a family of two. Add $500 for each additional family member. Income can not exceed 300% of the current Federal Poverty Level for Hawaii. Special needs children include children who satisfy the disability criteria under State law.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

HAWAII
Hawaii QUEST

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

Use of Collected Data
-Beneficiary Plan Selection
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-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 generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PHPs 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)
-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-Established requirements for data validation
-Established standards to ensure 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, definitons, 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. CMS 1500, UB-92, 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
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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 MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-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

HAWAII
Hawaii QUEST

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-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

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

Access/Availability of Care
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient discharges for MH/SA conditions/1,000 beneficiaries
-Inpatient discharges/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Expenditures by medical category of service
-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

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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
-Childhood Immunization
-Pharmacy management
-Prescription drug abuse
-Well Child Care/EPSDT

Non-Clinical Topics
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

HAWAII
Hawaii QUEST

Accreditation for Deeming
None

EQRO Name
-Mountain-Pacific Quality Health Foundation

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of MCO compliance with structural and operational standards established by the State
-Validation of client level data, such as claims and encounters
-Validation of performance measures

IDAHO
Healthy Connections

CONTACT INFORMATION

State Medicaid Contact:
Patty Rustad
Medicaid Research & Statistics
(208) 364-1893

State Website Address:
http://www2.state.id.us/dhw/hwgd_www/medicaid/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
October 01, 1993

Implementation Date:
October 01, 1993

Waiver Expiration Date:
February 09, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-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, Childhood Immunizations through District Health Services, Chiropractic, Dental, Durable Medical Equipment, EPSDT, Family Planning, Flu shots, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Podiatry, Standard/HIV Testing and Treatment, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-Pulmonologists
-Cardiologists
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-General Surgeon
-Oncologist
-Public Health Departments
-Urgent Care Facilities

IDAHO
Healthy Connections

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-If tracel > 30 Minutes or 30 Miles
-Have Existing Relationship With a Non-participating PCP
-QMB-only or SLMB-only
-Live in a Non-participating County
-Retro-Eligibility Only

Lock-In Provision:
No lock-in

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Connections

ADDITIONAL INFORMATION

Case management fee per member per month; two mandatory counties.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Disenrollment Surveys
-Enrollee Hotlines
-Enrollee Satisfaction Surveys
-Focused Studies
-Focuses Clinical Studies
-Grievance and Complaints
-Ombudsman

Use of Collected Data:
-Program Evaluation

-Required Board Certification of Providers

Consumer Self-Report Data

-State-developed Survey

ILLINOIS
Voluntary Managed Care

CONTACT INFORMATION

State Medicaid Contact:
Matt Powers
Illinois Department of Public Aid
(217)782-2570

State Website Address:
http://www.state.il.us/dpa

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

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:
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) - Full Capitation

Service Delivery

Included Services:
Blood and Blood Components, Chiropractic, Clinic, Durable Medical Equipment, Emergency Medical, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Medical Appliances, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physical Therapies and Related Services for Enrollees Aged 21 and Over, Physician, Podiatric, Skilled Nursing Facility, Transportation, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Populations Mandatorily Enrolled:
None

ILLINOIS
Voluntary Managed Care

-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Spenddown Eligibles
-Department of Children and Family Services Wards
-Non-citizens only receiving emergency services
-Healthy Start Eligibles
-Medicare Dual Eligible
-Other Insurance

Lock-In Provision:
No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Americaid Community Care
Harmony Health Plan
United HealthCare of Illinois
Family Health Network
Humana Health Plan

ADDITIONAL INFORMATION

Nursing facility services are provided up to 90 days annually.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Performance Improvements 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
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Modified CAHPS 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/PHPs 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, definitons, 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. CMS 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

ILLINOIS
Voluntary Managed Care

-Standards to ensure complete, accurate, timely encounter data submission

-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-IDPA - approved electronic flat file for transmitting pharmacy encounters
-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 (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

-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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

-Behavioral health utilization statistics
-Follow-up after hospitalization for mental illness
-Follow-up after hospitalization for substance abuse
-Frequency of on-going prenatal care
-Health history/physicals
-Hearing screenings for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Vision screenings for individuals less than 21 years of age

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care

-Average wait time for an appointment with PCP
-Network adequacy of specialists, pharmacies, hospitals and other ancillary providers
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Average number of visits to MH/SA providers per beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of

-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
-Provider license number
-Specialty of providers

ILLINOIS
Voluntary Managed Care

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate

-Well-child care visit rates

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

Care EQRO Name
-CIMRO

EQRO Organization
-PRO-like Entity

EQRO Activities
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities

INDIANA
Hoosier Healthwise

CONTACT INFORMATION

State Medicaid Contact:
Ginger Brophy
Indiana Family and Social Services Administration
(317)233-4697

State Website Address:
http://www.ai.org/fssa/html/programs/2d.html

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Lifemark Corporation

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
September 13, 1993

Implementation Date:
July 01, 1994

Waiver Expiration Date:
April 23, 2003

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-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, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Podiatry, Transportation, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

INDIANA
Hoosier Healthwise

Subpopulations Excluded from Otherwise Included Populations:
-Spend Down
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program
-Illegal Aliens
-Refugees

Lock-In Provision:
12 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Illegal Aliens
-Refugees
-Spend Down
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver

Lock-In Provision:
12 month lock-in

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 combined enrollment form at certain locations to identify members of the group.

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Harmony Health Plans of Indiana

Managed Health Services (MHS)

INDIANA
Hoosier Healthwise

MDwise PCCM (PrimeStep)

ADDITIONAL INFORMATION

Inpatient psychiatric hospital and outpatient pyschiatric services are generally carved-out. However, where these services are provided by an acute care hospital or a PCP, they are included. The same coverage condition applies to inpatient and outpatient substance abuse services. Studies are conducted on a rotating basis for Process Quality under the PCCM section.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data
-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 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/PHPs 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 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, definitons, 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. CMS 1500, UB-92, 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
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-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 (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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Specification/source code review, such as a programming language used to create an encounter data file for submission

INDIANA
Hoosier Healthwise

MCO 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

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs 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
-Childhood Immunization
-Low birth-weight baby
-Pre-natal care
-Smoking prevention and cessation
-Well Child Care/EPSDT

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

Standards/Accreditation

MCO/PHP Standards
-NCQA recommended, not required.

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Tucker Alan, Incorporated

INDIANA
Hoosier Healthwise

EQRO Organization
-PRO-like Entity

EQRO Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of MCO compliance with structural and operational standards established by the State

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)

-Performance Measures (see below for details)

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data
-State-developed Survey

Performance Measures

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-NOTE: Studies are conducted on a rotating basis
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-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 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of primary care case manager visits per beneficiary

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Cervical cancer treatment
-Childhood Immunization
-Low birth-weight baby
-Pre-natal care
-Well Child Care/EPSDT

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

IOWA
Iowa Medicaid Managed Health Care

CONTACT INFORMATION

State Medicaid Contact:
Dann Stevens
Department of Human Services
(515) 281-7269

State Website Address:
http://www.dhs.state.ia.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
ACS/Consultec

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 2001

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) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment (MCO Option), EPSDT, Family Planning, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

IOWA
Iowa Medicaid Managed Health Care

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)

Lock-In Provision:
6 month lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, X-Ray

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

-Section 1931 (AFDC/TANF) Adults and Related Populations

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)

Lock-In Provision:
6 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coventry Health Care
John Deere Health Plan, Inc.
United Health Care of the Midlands
Iowa Health Solutions
Medipass

ADDITIONAL INFORMATION

Effective April 1, 2001 program was converted from a 1915(b) to a 1932(a).

Coventry Health Care and United Health Care of the Midlands have both included the optional services of Chiropractic and Durable Medical Equipment in addition to the basic contract services. Iowa Health Solutions has included the optional service of Durable Medical Equipment in addition to the basic contract services.

Special needs children include blind/disabled children and related populations; eligible under section 1902(e)(3)of the SSA; Foster care, receiving foster care or adoption assistance.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

IOWA
Iowa Medicaid Managed Health Care

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

Use of Collected Data
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-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/PHPs 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, definitons, 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)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

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

State conducts general data completeness assessments
Yes

Performance Measures

IOWA
Iowa Medicaid Managed Health Care

Process Quality
-Adolescent immunization rate
-Asthma care
-Cervical cancer screening rate
-Follow-up after hospitalization for mental illness
-Immunizations for two year olds
-Influenza vaccines for high risk enrollees
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

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
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
-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
-Provider turnover

None

Performance Improvement Projects

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

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-NAIC (National Association of Insurance Commissioners) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

Accreditation for Deeming
None

EQRO Name
-Iowa Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

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

IOWA
Iowa Medicaid Managed Health Care

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Focused Studies
-Performance Improvements Projects (see below for details)

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

Consumer Self-Report Data
None

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with 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
-Inpatient admissions/1,000 beneficiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics
-Board Certification
-Provider turnover

Beneficiary Characteristics
-Disenrollment rate
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Childhood Immunization
-Well Child Care/EPSDT

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

IOWA
Iowa Plan For Behavioral Health

CONTACT INFORMATION

State Medicaid Contact:
Jane Gaskill
Department of Human Services
(515)281-5755

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)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 01, 1999

Implementation Date:
January 01, 1999

Waiver Expiration Date:
February 28, 2003

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:
Ambulance, Clinic, Detoxification, Enhanced Services, Home Health, Inpatient Mental Health Services, Inpatient Substance Abuse Services, Laboratory and X-Ray, Mental Health Outpatient, Outpatient Substance Abuse Services

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

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

IOWA
Iowa Plan For Behavioral Health

Subpopulations Excluded from Otherwise Included Populations:
-Medically Needy with cash spenddown
-Reside in State Hospital-School
-Eligible for Limited Benefit Package
-Age 65 or older

Lock-In Provision:
No lock-in

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

Agencies with which Medicaid Coordinates the Operation of the Program:
-Dual Eligibles-Medicaid and Medicare
-Foster Care Children
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Iowa Plan For Behavioral Health

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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)
-Focused Studies
-On-Site Reviews
-Performance Improvements 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
-Program Evaluation

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 modifies/requires MCOs/PHPs 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

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

IOWA
Iowa Plan For Behavioral Health

-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely 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)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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
-Follow-up after hospitalization for mental illness
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

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

Clinical Topics
-Dual diagnosis MH/SA

IOWA
Iowa Plan For Behavioral Health

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
None

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

Accreditation for Deeming
None

EQRO Name
-Iowa Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

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

KANSAS
KMMC: HealthConnect Kansas

CONTACT INFORMATION

State Medicaid Contact:
Janelle Garrison
Health Care Policy/Medical Policy
(785) 368-6293

State Website Address:
http://www.srskansas.org/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Blue Cross/Blue Shield of Kansas (until Oct. 1, 2001)
MAXIMUS, Inc. (as of Oct. 1, 2001)

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months continous eligibility for children

Initial Waiver Approval Date:
January 01, 1984

Implementation Date:
January 01, 1984

Waiver Expiration Date:
October 04, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-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:
Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Nursing Facility, Obstetrical, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Personal Care, Pharmacy, Physician, Therapies, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Indian Health Service (IHS) Providers
-Nurse Midwives
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Osteopaths
-Local Health Departments (LHDs)

KANSAS
KMMC: HealthConnect Kansas

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Spenddown Eligible
-Participate in HCBS Waiver
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Reside in Juvenile Justice Facility or other State Institution
-Medically Needy-eligible
-Foster Care Children
-Receive Adoption Support

Lock-In Provision:
12 month lock-in

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 information from Title V agency to identify

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HealthConnect Kansas

ADDITIONAL INFORMATION

Blue Cross/Blue Shield of Kansas - Enrollment Broker until October 1, 2001. Thereafter, MAXIMUS, Inc. will be the new Enrollment Broker.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews

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

KANSAS
KMMC: HealthConnect Kansas

-Performance Measures (see below for details)
-Provider Data
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Performance Measures

Process Quality

-Adolescent immunization rate
-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

Health Status/Outcomes Quality

-Patient satisfaction with 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

-Board Certification
-Languages spoken (other than English)

Beneficiary Characteristics

None

KANSAS
KMMC: PrimeCare Kansas

CONTACT INFORMATION

State Medicaid Contact:
Debra Bachmann
Health Care Policy/Medical Policy
(785) 296-3667

State Website Address:
http://www.srskansas.org/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Blue Cross/Blue Shield
of Kansas

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months continous eligibility for children

Initial Waiver Approval Date:
December 28, 1994

Implementation Date:
December 01, 1995

Waiver Expiration Date:
October 04, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Emergency, EPSDT, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Newborn, Nutrition, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Prenatal Health Promotion, Speech Therapy, Transfusions, Transplants, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Indian Health Service (IHS) Providers
-Nurse Practitioners
-Nurse Midwives

Enrollment

KANSAS
KMMC: PrimeCare Kansas

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Reside in State Hospitals
-Receive Services through Health Insurance Premium Payment System (HIPPS)

Lock-In Provision:
12 month lock-in

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 information from the Title V agency to identify

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

FirstGuard Health Plan Kansas, Inc.

ADDITIONAL INFORMATION

Blue Cross/Blue Shield of Kansas - Enrollment Broker until October 1, 2001. Thereafter, MAXIMUS, Inc. will be the new Enrollment Broker.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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

KANSAS
KMMC: PrimeCare Kansas

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/PHPs 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, definitons, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, 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
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-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 (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)
-Medical record validation

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Dental services
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

KANSAS
KMMC: PrimeCare Kansas

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
None

Health Plan Stability/ Financial/Cost of
-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
None

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Kansas Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

KENTUCKY
Human Service Transportation

CONTACT INFORMATION

State Medicaid Contact:
Neville Wise
KY Department for Medicaid Services
(502) 564-8196

State Website Address:
http://chs.state.ky.us/dms/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
February 01, 1996

Implementation Date:
June 01, 1998

Waiver Expiration Date:
October 30, 2002

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PHP - Full Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

KENTUCKY
Human Service Transportation

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

Lock-In Provision:
No lock-in

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 Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Human Service Transportation

ADDITIONAL INFORMATION
Human Service Transportation covers 5/6th of the state with plans for statewide coverage.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of MCO/PHP Standards
-Ombudsman

Use of Collected Data
-Contract Standard Compliance
-Fraud and Abuse
-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

Encounter Data

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

Collections: Submission Specifications
None

KENTUCKY
Human Service Transportation

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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Comparsion to plan claims payment data
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-N/A

EQRO Organization
-None

EQRO Activities
-Arranges for transportation related to EPSDT special services and organ transplantation

KENTUCKY
Kentucky Health Care Partnership Program

CONTACT INFORMATION

State Medicaid Contact:
Mike Robinson
Kentucky Department for Medicaid Services
(502) 564-4321

State Website Address:
http://chs.state.ky.us

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1115 - 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:
November 01, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10) Payment of FQHC
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(E)
-1902(a)(23) Freedom of Choice
-1902(c)(34) Retroactive eligibility

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(ii)(vi)
-1903(m)(2)(A)(vi) Guaranteed Eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full 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, Transportation, Vision,

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

KENTUCKY
Kentucky Health Care Partnership Program

Populations Voluntarily Enrolled:
None

X-Ray

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Most Medicaid Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Psychiatric Residential Treatment Facility PRTF
-Eligibility for Spend down
-Residents of Institutions for Mental Disease

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

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Passport Health Plan

ADDITIONAL INFORMATION

As of June 30, 2000 only one managed care region operational.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

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

-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

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/PHPs 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, definitons, 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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Comparsion to plan claims payment data
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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

KENTUCKY
Kentucky Health Care Partnership Program

Process Quality
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit

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 benificiary
-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
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP 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

Accreditation Required for Participation
-Plan required to obtain MCO accreditation by NCQA or other accrediting body

Accreditation for Deeming
None

EQRO Name
-Health Care Review Corporation

EQRO Organization
-Federally Designated PRO-like Entity

EQRO Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of high cost services and procedures
-Review of MCO compliance with structural and operational standards established by the State

-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects

KENTUCKY
Kentucky Patient Access and Care (KENPAC) Program

CONTACT INFORMATION

State Medicaid Contact:
Lynn Chapple
KY Department for Medicaid Services
(502) 564-7940

State Website Address:
http://chs.state.ky.us/

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1932 - State Plan Option to Use Managed Care

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:
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,

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

KENTUCKY
Kentucky Patient Access and Care (KENPAC) Program

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
X-Ray -Special Needs Children
-Spenddown
-American Indian/Alaskan Native

Lock-In Provision:
No lock-in

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:
-Commission for Children with Special Health Care Needs
-Maternal and Child Health Agency
-TITLE XXI SCHIP -Public Health Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Kentucky Patient Access and Care (KenPAC)

ADDITIONAL INFORMATION
Beginning in April 2000 the KenPAC Program was implemented under a state plan ammendment in all counties in Kentucky excluding region 3. For the following Included services- EPDST, Dental, Pharmacy, Transportation, Vision, and Hearing services , beneficiary may go to any participating provider for these services without a referral. receiving comprehensive case managment services through Title V, Commission for Children with Special Health Care Needs

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Surveys
-Enrollee Hotlines
-Ombudsman
-Provider Data

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
None

LOUISIANA
Community Care

CONTACT INFORMATION

State Medicaid Contact:
Madeline Darcey
Department of Health and Hospitals
225 342-1304

State Website Address:
http://www.dhh.state.la.us

PROGRAM DATA

Program Service Area:
Parish

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
June 01, 1992

Implementation Date:
June 01, 1992

Waiver Expiration Date:
March 25, 2003

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

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

LOUISIANA
Community Care

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period Less Than 3 Months
-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

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:
-Education Agency
-Maternal and Child Health Agency
-TITLE XXI SCHIP
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care Program

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data
-State-developed Survey

MAINE
Maine PrimeCare

CONTACT INFORMATION

State Medicaid Contact:
Brenda McCormick
Bureau of Medical Services
(207) 287-1774

State Website Address:
HTTP://www.state.me.us/bms/bmshome.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - 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 Services, Certain Family Planning Services, Chiropractic Services, Clinic Services (FQHC & RHC), Developmental & Behavioral Evaluation Clinic Services, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Physical Therapy Services, Physician, Podiatric Services, Speech/Language Pathology Services, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Physician Assistants
-Nurse Midwives
-Ambulatory Care Clinic or Hospital Based Outpatient Clinic

Enrollment

MAINE
Maine PrimeCare

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Individuals on Medicaid recipient restriction program
-Individuals eligible for SSI
-Individuals under 19 with special health care needs
-Katie Beckett Eligibles
-Special Needs Children (State defined)

Lock-In Provision:
12 months lock-in

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Maine PrimeCare

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.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Beneficiary Provider Selection
-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
-Disenrollment Survey
-State-developed Survey

MAINE
Maine PrimeCare

Performance Measures

Process Quality
-Adolescent immunization rate
-Provider Data -Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Diabetes management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care
-Lead screening rate
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Provider Characteristics
-Languages spoken (other than English)

Beneficiary Characteristics
-Beneficiary need for interpreter
-Disenrollment rate
-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 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
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-Lead toxicity
-Medical prblems of the frail elderly
-Otitis Media management
-Pharmacy management
-Pre-natal care
-Presciption drug abuse
-Prevention of Influenza
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services
-Children's access to primary care practitioners

MARYLAND
HealthChoice

CONTACT INFORMATION

State Medicaid Contact:
Rosalie Koslof
Department of Health and Mental Hygiene
(410) 767-1482

State Website Address:
http://www.dhmh.state.md.us/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Benova

Initial Waiver Approval Date:
October 30, 1996

Implementation Date:
June 02, 1997

Waiver Expiration Date:
June 01, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(E)
-1902(a)(23) Freedom of Choice
-1902(a)(4)(A)
-1902(a)(47)
-1902(a)(5)
-1903(u)

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Guaranteed Eligibility, IMD

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

MARYLAND
HealthChoice

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Family Planning Waiver Program
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Institutionalized more than 30 days
-Eligibility for Less Than 6 Months
-If enrolled in Model Waiver for Fragile Children
-If determined Medically Needy Under a Spend Down

Lock-In Provision:
12 month lock-in

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

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

AMERIGROUP Maryland Inc.
JAI Medical System
Priority Partner MCO
Helix Family Choice
Maryland Physicians Care
United Health Care

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research

MARYLAND
HealthChoice

-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-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 measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs/PHPs 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)
-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-Established standards to ensure 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

-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Required use of Medicaid Identification Number for

Collection: Standardized Forms

-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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

MARYLAND
HealthChoice

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Diabetes management
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Inpatient admissions/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-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.)
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs 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
-Childhood Immunization
-Diabetes management
-Lead toxicity
-Prevention of Influenza
-Well Child Care/EPSDT

Non-Clinical Topics
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
None

Accreditation for Deeming
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Delmarva Foundation for Medical Care, Inc.

MARYLAND
HealthChoice

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of performance improvement projects
-Validation of performance measures

MASSACHUSETTS
Mass Health

CONTACT INFORMATION

State Medicaid Contact:
Phyllis Peters
Division of Medical Assistance
(617) 210-5720

State Website Address:
http://www.state.ma.us/dma/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

Initial Waiver Approval Date:
April 15, 1995

Implementation Date:
July 01, 1997

Waiver Expiration Date:
June 30, 2002

Sections of Title XIX Waived:
-1902(a)(10)(A)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(C)
-1902(a)(13)(C)
-1902(a)(17)
-1902(a)(17)(D)
-1902(a)(23) Freedom of Choice
-1902(a)(30)(A)
-1902(a)(32)
-1902(a)(34)
-1902(a)(4)(A)

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Disenrollment
-Eligibility Expansion
-Inst. For Mental Disease
-Insurance Reimbursement

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray

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

MASSACHUSETTS
Mass Health

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Over 65 years old

Lock-In Provision:
No lock-in

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:
Crisis, Detoxification, IMD Services, Inpatient Mental Health Services, Inpatient Substance Abuse Services, Mental Health Outpatient, Mental Health Residential, Mental Health Support, Opiate Treatment Programs, Outpatient Day Programs, Outpatient Substance Abuse Services, Residential Substance Abuse Treatment Programs

Allowable PCPs:
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Addictionologists

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

MASSACHUSETTS
Mass Health

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Chiropractic Services, Durable Medical Equipment, Emergency Transportation, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Podiatry, Skilled Nursing Facility, Therapy Services, Vision,

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Over 65 years old

Lock-In Provision:
No lock-in

ADDITIONAL INFORMATION

Mass Health has a behavioral carve-out for PCCM enrolles and for children in the care or custody of the Commonwealth.

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-Housing Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Boston Medical Center HealthNet Plan
MA Behavioral Health Partnership
Network Health
Fallon Community Health Plan
Neighborhood Health Plan
Primary Care Clinician Plan

MASSACHUSETTS
Mass Health

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO/PHP Standards (see below for details)
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data
-Beneficiary Plan Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire (modified)
Adult Medicaid SSI Questionnaire (modified)
Child Medicaid AFDC Questionnaire (modified)
Child Medicaid SSI Questionnaire (modified)

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/PHPs 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)
-Established requirements for data validation
-Established standards to ensure 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
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 MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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

MASSACHUSETTS
Mass Health
Performance Measures

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average wait time for an appointment with PCP

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
-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
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Coordination of primary and behavioral health care
-Pharmacy management
-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
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

MASSACHUSETTS
Mass Health

Accreditation for Deeming
None

EQRO Name
-MassPro

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

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

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire (modified)
  Adult Medicaid SSI Questionnaire (modified)
  Child Medicaid AFDC Questionnaire (modified)
  Child Medicaid SSI Questionnaire (modified)

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Inpatient admission for MH/SA conditions/1,000 beneficiaries

Provider Characteristics
None

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 Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization

Non-Clinical Topics
None

MASSACHUSETTS
Mass Health

-Diabetes management
-Performance Measures (see below for details) -Emergency Room service utilization
-Inpatient maternity care and discharge planning
-Pharmacy management
-Post-natal Care

MICHIGAN
Childrens Special Health Care Services

CONTACT INFORMATION

State Medicaid Contact:
Jane Finn
Michigan Department of Community Health
(517) 241-7186

State Website Address:
http://www.mdch.state.mi.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
Michigan Enrolls

For All Areas Phased-In:
No

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
12 months guaranteed eligibility for children

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Additional Continuity of Care Requirement, Care Coordination, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Individualized Care Planning, Inpatient Hospital, Laboratory, Maternal and Infant Support Services, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Most Pediatric Sub Specialists
-Some General Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

MICHIGAN
Childrens Special Health Care Services

-Blind/Disabled Children and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-When Medically Eligible

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Other Insurance
-Medicare Dual Eligibles excluded as of 10/1/2000
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Beneficiaries are already identified as special needs as eligibility in the program

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Childrens Choice of Michigan

Kids Care of Michigan

ADDITIONAL INFORMATION

The Children Special Health Services Program serves children who have qualifying conditions under CSHCS. The special needs are the focal point of services versus primary care. The operating authority for this program is Title V of the SSA pa 368 of 1978. Under this program, the State prior authorizes managed care services and providers for these children under two service delivery options either FFS or enrollment in one of two special health plans. The two special health plans that provide services under this program are incorporated, but not licensed in MI and therefore do not provide services to the commercial population.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data
-Collected data will be used for assurance of appropriate care and to identify trends

Consumer Self-Report Data
-CAHPS
add-on sruvey for special needs
-Consumer/Beneficiary Focus Groups
-Satisfaction survey for SHP enrollees
-Survey for new enrollees and follow-up at 6 months
-Survey for people who have lost coverage

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

MICHIGAN
Childrens Special Health Care Services

Performance Measures

Process Quality
-Site reviews with SHPs to evaluate IHCPs

Health Status/Outcomes Quality
None

Access/Availability of Care
-Extensive network specialists

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-State minimum reserve requirements

Health Plan/ Provider Characteristics
-Board Certification
-Experience with pediatric care of special needs population
-Languages Spoken (other than English)

Beneficiary Characteristics
None

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Michigan Peer Review Organization

EQRO Organization
-Planning underway with MPRO

EQRO Activities
-Planning for MPRO to review general population, asthma, and CP population

MICHIGAN
Comprehensive Health Plan

CONTACT INFORMATION

State Medicaid Contact:
Judith Kloko
Michigan Department of Community Health
(517) 241-5714

State Website Address:
http://www.mdch.state.mi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Michigan Enrolls

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 30, 1997

Implementation Date:
July 01, 1997

Waiver Expiration Date:
March 27, 2002

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

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Maternal and Infant Support Services, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

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

Enrollment

MICHIGAN
Comprehensive Health Plan

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Other Insurance
-Participate in HCBS Waiver
-Medicare Dual Eligibles excluded as of 10/1/2000
-Enrolled in Another Managed Care Program
-Spenddown
-Court Wards
-Kosovo Refugees
-Residents of Correctional Facilities- cannot be medicaid eligible

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Monthly enrollment file flags SSI and adoptive kids indicators to health plans

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Botsford Health Plan
Cape Health Plan
Care Choices
Community Care Plan
Community Choice Michigan
Great Lakes Health Plan
Health Plan of Michigan
HealthPlus of Michigan
M-Care HMO
McLaren Health Plan
Midwest Health Plan
Molina Healthcare of Michigan
Omnicare Health Plan
Physicians Health Plan of Mid-Michigan
Physicians Health Plan of Southwest Michigan
Priority Health
Total Health Care
Upper Penninsula Health Plan
Wellness Plan

ADDITIONAL INFORMATION

The enrollment basis for included populations will depend if they fall under the Special needs population. Michigan Special Needs Children include children who have one of 2700 different qualifying physical diagnoses, if the condition has the necessary level of severity and chronicity to qualify.

MICHIGAN
Comprehensive Health Plan

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Accreditation for Deeming (see below for details)
-Accreditation for participation, member or applied for membership
-Complaint and Grievance Monitoring
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Choice Monitoring
-Provider Data
-Provider Selection Monitoring
-Timely and Compliant Claims Reporting
-Timely Provider File Submissions

Use of Collected Data
-Beneficiary Plan Selection
-Contract Standard Compliance
-Monitor quality improvement efforts
-Monitor service provision
-Program Evaluation

Consumer Self-Report Data
-CAHPS
Adult Medicaid Questionaire
Child Medicaid Questionaire

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/PHPs 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, definitons, 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)

MCO 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
-county
-zip code

State conducts general data completeness assessments
Yes

MICHIGAN
Comprehensive Health Plan

Performance Measures

Process Quality
-Immunizations for two year olds
-Initiation of prenatal care
-Percentage of beneficiaries with at least one dental visit
-Well-child care for 0-15 months
-Well-child care for 3-6 years

Health Status/Outcomes Quality
None

Access/Availability of Care
-Well-child visits for 0-15 mos.
-Well-child visits for 3-6 years

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

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

Accreditation Required for
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-Plan is required to have applied or be accredited

Accreditation for Deeming
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name
-CAHPS survey vendor
-Market Facts - (conducts consumer surveys)

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct studies on quality and access that focus on a particular aspect of clinical or non-clinical services
-Medstat (collects and validates encounter data)
-Review of MCO compliance with structural and operational standards established by the State
-Validation of client level data, such as claims and encounters

MICHIGAN
Specialty Community Mental Health Services Programs

CONTACT INFORMATION

State Medicaid Contact:
Judy Webb
MDCH, Mental Health and Substance Abuse Services
(517) 335-4419

State Website Address:
http://www.mdch.state.mi.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
June 26, 1998

Implementation Date:
October 01, 1998

Waiver Expiration Date:
March 13, 2003

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Developmentally Disabled, Mental Health and Substance Abuse PHP - Full Capitation

Service Delivery

Included Services:
Crisis, Durable Medical Equipment, Emergency Specialty DD, MH and SA Services, Home Health, Inpatient Mental Health, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, MH Clinic Services, Outpatient Mental Health (Partial Hospitalization), Outpatient Substance Abuse, Personal Care, Residential Substance Abuse Rehabilitation, Specialty Services and Supports for persons with DD, Targetted Case Management,

Allowable PCPs:
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Addictionologists
-Other Specialists Approved on a Case-by-Case Basis

Contractor Types:
-County Community Mental Health Services

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

MICHIGAN
Specialty Community Mental Health Services Programs

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:

Transportation
-Residing in ICF/MR
-Children Enrolled in Childrens Waiver (Section 1915(c))

Lock-In Provision:

No lock-in

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
-Education Agency
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Specialty Employment Agency (Supported Employment)
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Allegan County CMH
Antrim Kalkaska CMH
AuSable Valley CMH
Barry County CMH
Bay Arenac CMH
Berrien County CMH
Central Michigan CMH
Clinton-Eaton-Ingham CMH
Copper Country CMH
Detroit-Wayne CMH
Genesee County CMH
Gogebic County CMH
Gratiot County CMH
Great Lakes CMH
Hiawatha
Huron Behavioral Health
Ionia County CMH
Kalamazoo County CMH
Kent County CMH
Lapeer County CMH
Lenawee County CMH
Lifeways
Livingston County CMH
Macomb County CMH
Manistee-Benzie CMH
Midland-Gladwin CMH
Monroe County CMH
Montcalm Center
Muskegon County CMH
Newaygo County CMH
North Central CMH
Northeast CMH
Northern Michigan CMH
Northpointe Behavioral Health
Oakland County CMH
Ottawa County CMH
Pathways
Pines Behavioral Health
Saginaw County CMH Authority
Sanilac County CMH
Shiawassee County CMH
St. Clair County CMH

MICHIGAN
Specialty Community Mental Health Services Programs

St. Joseph County CMH
Tuscola County CMH
Washtenaw County CMH
Woodland Behavioral Health
Summit Pointe
Van Buren County CMH
Western Michigan CMH

ADDITIONAL INFORMATION

Michigan remains one of the very few, if not the only, state to have incorporated services to persons with Developmental Disabilities into a 1915(b) Freedom of Choice "managed care" waiver. Also, all persons adjudicated Medicaid eligible are deemed enrolled in this Specialty Community Mental Health Services and Supports managed care program.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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)
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Measures (see below for details)

Use of Collected Data
-Actuarial analysis
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal and State Reporting
-Track Health Service provision

Consumer Self-Report Data
-MHSIP Consumer 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/PHPs 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, definitons, 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 electronic file formats
-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)

MCO conducts data accuracy check(s) on specified data elements
-Provider ID
-Type of Service
-Medicaid Eligibility
-Diagnosis Codes

State conducts general data completeness assessments
Yes

-Age-appropriate diagnosis/procedure
-age
-gender
-race/ethnicity
-social security

Performance Measures

Process Quality
-Follow-up after hospitalization for mental illness
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality
-Adults living in homes of their own
-Adults working in supported employment
-Children living with family
-Patient satisfaction with care
-Rates of rights complaints
-Rates of sentinel events/1000 served
-Rates of suicide/1000 served

Access/Availability of Care
-Average wait time for an appointment with PCP
-Penetration rates for special populations
-Percent of denials of service
-Percent of persons in NH's who met OBRA criteria, served

Use of Services/Utilization
-Cost per case by population
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Standards/Accreditation

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for
-CARF
-COA
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-The Council

Accreditation for Deeming
None

EQRO Name
-Michigan Peer Review Organization

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Clinical Record Review
-Validation of performance measures

MINNESOTA
Consolidated Chemical Dependency Treatment Fund (CCDTF)

CONTACT INFORMATION

State Medicaid Contact:
Mary Kennedy
Minnesota Department of Human Services
(651)282-9921

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)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1988

Implementation Date:
January 01, 1988

Waiver Expiration Date:
March 23, 2003

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(30) Utilization Review

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

County Case Manager - Fee-for-Service

Service Delivery

Included Services:
Case Management, EPSDT, Extended Rehabilitation (Consolidated Care), Inpatient Hospital Services, Inpatient Substance Abuse Services, Outpatient Hospital Services, Outpatient Substance Abuse Services, Residential Substance Abuse Treatment Programs, Transitional Rehabilitation (Halfway House)

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

MINNESOTA
Consolidated Chemical Dependency Treatment Fund (CCDTF)

-Blind/Disabled Children and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Aged and Related Populations
-All Medicaid Recipients Are Eligible For The CCDTF Program.

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program that covers CD services

Lock-In Provision:
No lock-in

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 enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Mental Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Consolidated Chemical Dependency Treatment Fund (CCDTF)

ADDITIONAL INFORMATION

The CCDTF program is only for chemical dependency services and does not designate types of primary care providers. Providers are reimbursed on a Fee-For-Service basis. County and tribal chemical dependency Assessors assess the level of care and make appropriate placements or necessary referrals based on statewide placement criteria. Recipients are locked in for the period of the chemical dependency placement which can vary in length.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

Use of Collected Data:
-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
-State-developed Survey

Performance Measures

MINNESOTA
Consolidated Chemical Dependency Treatment Fund (CCDTF)

Process Quality
-HIV/AIDS care
-Track # of placements by beneficiary characteristics
-Track # of placements by type of service

Health Status/Outcomes Quality
-Drug/alcohol use at admision and 6-months after
-Treatment completion rates

Access/Availability of Care
-Average wait time before admission to treatment

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Re-admission rates of MH/SA

Provider Characteristics
-Licensing for provider/entity and its staff

Beneficiary Characteristics
-Age
-County of residence
-Disenrollment rate
-Household size
-Information of beneficiary ethnicity/race
-Marital status
-Percentage of beneficiaries who are auto-assigned to PCCM
-Housing status

Performance Improvement Projects

Clinical Topics
-Adolescent Well Care/EPSDT
-Coordination of primary and behavioral health care
-HIV Status/Screening
-HIV/AIDS Prevention and/or Management
-Post-natal Care
-Pre-natal care
-Presciption drug abuse
-Primary and behavioral health care coordination
-Tuberculosis screening and treatment
-Well Child Care/EPSDT

Non-Clinical Topics
-Case management
-Special population projects for cultural/ethnic minorities

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

CONTACT INFORMATION

State Medicaid Contact:
Mary Kennedy
Minnesota Department of Human Services
(651)282-9921

State Website Address:
http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

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:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Medicare Services Under Parts A & B, Case Management, Dental, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Nursing Facility Services Are Covered for 180 Days, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Services Available Under The Home And Community-Based Waiver (Elderly Waiver), Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Age 65 Or Older And Dually Eligible For Medicare And Medicaid

Populations Mandatorily Enrolled:
None

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

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

Lock-In Provision:
No lock-in

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

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medica
Metropolitan Health Plan
UCARE

ADDITIONAL INFORMATION

Contractors are not required to identify PCPs. PCP provider types are designated by HMOs rather than State; county staff perform enrollment functions. Health plans have been encouraged to develop networks with professionals with geriatric experience. MSHO provides one month rolling eligibility to provide coverage for enrollees who do not return a scheduled income or redetermination report on a timely basis. Children Participating In the Minnesota Department Of Health Administered Program For Children With Special Health Needs Under Title V Of The Social Security Act.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data
-Beneficiary Plan Selection
-Health Services Research
-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
-Disenrollment Survey
-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/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

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, definitons, 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. CMS 1500, UB-92, 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
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-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 (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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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

Process Quality
-Cervical cancer screening rate
-Cholesterol screening and management
-Depression management
-Diabetes management
-Influenza Vaccination Rate

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA 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 benificiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Medical loss ratio

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

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

-Net income
-State minimum reserve requirements
-Total revenue
-Provider turnover

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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
-Prevention of Influenza

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-FMAS (PRO-Like)
-MetaStar (PRO)
-NCQA (Accreditation)
-PRS (PRO)
-Stratis Health (PRO)

EQRO Organization
-Peer Review Organization (PRO)
-Private Accreditation Organization
-PRO-like Entity

EQRO Activities
-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
-Validation of performance improvement projects
-Validation of performance measures

MINNESOTA
MinnesotaCare Program For Families And Children

CONTACT INFORMATION

State Medicaid Contact:
Mary Kennedy
Minnesota Department of Human Services
(651)282-9921

State Website Address:
http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility

Initial Waiver Approval Date:
April 27, 1995

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30) Utilization Review
-1902(a)(4) Contract-Specific Upper Payment
-1902(a)(4)(A) MEQC

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Eligibility Expansion, Eligibility Simplification, Medical Education Trust Fund

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All other MA Benefits Covered Except NF, ICF/MR and Home And Community Based Waiver Services, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable

Enrollment

MINNESOTA

MinnesotaCare Program For Families And Children

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Pregnant Women And Children Whose Income Is At Or Below 275% FPG
-Parents and other relative caretakers whose household

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Pregnant Women Up to 275 of FPG With Other Insurance
-Enrolled in Another Managed Care Program
-Individuals with household income above 150% of poverty with other health insurance
-Individuals with health insurance available through employment if subsidized at 50% or greater

Lock-In Provision:
12 month lock-in

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:
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Altru
First Plan
Itasca Medical Care
Metropolitan Health Plan
Blue Plus
Health Partners
Medica
UCARE

ADDITIONAL INFORMATION

Contractors are not required to identify PCPs. PCP provider types are designated by HMOs rather than State.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data
-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

MINNESOTA
MinnesotaCare Program For Families And Children

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Disenrollment Survey
-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/PHPs 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, definitons, 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. CMS 1500, UB-92, 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
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-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 (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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Cervical cancer screening rate
-Cholesterol screening and management
-Depression management
-Diabetes management
-Immunizations for two year olds
-Influenza vaccination rate
-Lead screening rate

Health Status/Outcomes Quality
-Patient satisfaction with care

MINNESOTA
MinnesotaCare Program For Families And Children

-Well-child care visit rates

Access/Availability of Care
-Average distance to PCP

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

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Medical loss ratio
-Net income
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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
-Childhood Immunization
-Prevention of Influenza
-Well Child Care/EPSDT

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-FMAS (PRO-Like)
-MetaStar (PRO)
-MPQRO (PRO)
-NCQA (Accreditation)
-PRS (PRO)
-Stratis Health (PRO)

EQRO Organization
-Peer Review Organization (PRO)
-Private Accreditation Organization
-PRO-like Entity

EQRO Activities
-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
-Validation of performance improvement projects
-Validation of performance measures

MINNESOTA
Prepaid Medical Assistance Program

CONTACT INFORMATION

State Medicaid Contact:
Mary Kennedy
Minnesota Department of Human Services
(651)282-9921

State Website Address:
http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - 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:
July 01, 1985

Implementation Date:
July 01, 1985

Waiver Expiration Date:
June 30, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30) Utilization Review
-1902(a)(4) Contract-Specific Upper Payment
-1902(a)(4)(A) MEQC

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Medical Education Trust Fund, El

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Other MA Benefits Covered Except Nursing Facility Per Diem, ICF/MR And Home And Community Based, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable

Enrollment

MINNESOTA
Prepaid Medical Assistance Program

Populations Voluntarily Enrolled:

-Children with SED
-Enrolled in another managed care program

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:

-Recipients with terminal or communicable disease at time of enrollment
-Those With Private Coverage With An HMO Not Participating In Medicaid
-Refugee Assistance Program Recipients
-Recipients Residing In State Institutions
-Non-Institutionalized Recipients Who Are Eligible On A Spenddown Basis
-Blind And Disabled Under Age 65
-Non-documented Alien Recipients Who Only Receive Emergency MA Under Minn. Stat. 256B.06(4)
-QMBs And SLMBs Who Are Not Otherwise Receiving MA

Lock-In Provision:

12 month lock-in

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

Altru
First Plan
Itasca Medical Care
Metropolitan Health Plan
Blue Plus
Health Partners
Medica
UCARE

ADDITIONAL INFORMATION

Contractors are not required to identify PCPs. PCP provider types are designated by HMOs rather than State; county staff perform enrollment functions. PMAP provides one month rolling eligibility to provide coverage for enrollees who do not return a scheduled income or redetermination report on a timely basis.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies

Use of Collected Data

-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Regulatory Compliance/Federal Reporting

MINNESOTA
Prepaid Medical Assistance Program

-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Track Health Service provision

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Disenrollment Survey
-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/PHPs 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, definitons, 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. CMS 1500, UB-92, 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
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-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 (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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

MINNESOTA
Prepaid Medical Assistance Program

Process Quality
-Adolescent immunization rate
-Cervical cancer screening rate
-Cholesterol screening and management
-Depression management
-Diabetes management
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP

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

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Medical loss ratio
-Net income
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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
-Childhood Immunization
-Prevention of Influenza
-Well Child Care/EPSDT

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-FMAS (PRO-Like)
-MetaStar (PRO)
-NCQA (Accreditation)
-PRS (PRO)
-Stratis Health (PRO)

EQRO Organization
-Peer Review Organization (PRO)
-Private Accreditation Organization
-PRO-like Entity

EQRO Activities
-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
-Validation of performance improvement projects
-Validation of performance measures

MISSISSIPPI
HealthMACS

CONTACT INFORMATION

State Medicaid Contact:
Vicky Donaho
Division of Medicaid
601-359-6133

State Website Address:
http:\\www.dom.state.ms.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
EDS-fiscal agent

For All Areas Phased-In:
Yes

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
June 28, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

Guaranteed Eligibility:
12 months guaranteed eligibility for children

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Outpatient Hospital, Physician

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

MISSISSIPPI
HealthMACS

-Section 1931 (AFDC/TANF) Adults and Related Populations
-Certain Title XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Special Needs Children

Lock-In Provision:
1 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HEALTHMACS

ADDITIONAL INFORMATION

No longer have capitated managed care programs with HMO plans as they have been taken over by the Department of Insurance for financial reasons. Certain XXI SCHIP is listed as an Included Population. This refers to those children in CHIP Phase 1who are up to age 19 are enrolled in regular Medicaid and are included in HEALTHMACS program. Children receiving services from the State Department of Health through the Childrens Medical Program, Title V.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews

Use of Collected Data:
-Contract Standard Compliance
-Program Evaluation
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data
None

MISSOURI
MC+ Managed Care/1115

CONTACT INFORMATION

State Medicaid Contact:
Darlene Bleich
Department of Social Services, Division of Medical
(573)751-5178

State Website Address:
http://www.medicaid.state.mo.us

PROGRAM DATA

Program Service Area:
City
County

Initial Waiver Approval Date:
April 29, 1998

Operating Authority:
1115 - Demonstration Waiver Program

Implementation Date:
September 01, 1998

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
December 03, 2003

Enrollment Broker:
First Health Services
Corporation

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1916(a)(1)
-1916(a)(2)(A)
-1916(a)(3)
-1916(c)(3)
-1916(e)

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(u) Eligibility Expansion
-Expenditures to provide Medicaid coverage to individuals with incomes at or below 300 percent of FPL
-Special Programs/CHCCDP

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental - for 1115 Adults, Trauma or Disease only, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation - Emergency only except for Parents Fairshare Recipients receive both emergency and n, Vision - Trauma or Disease only for Adults

Allowable PCPs:
-Internists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-PCP Teams
-Obstetricians/Gynecologists or Gynecologists (Health Plans can choose to designate OB/GYNs for PCPs
-PCP Clinics - which can include FQHCs/RHCs
-Pediatricians
-General Practitioners

MISSOURI
MC+ Managed Care/1115

- Includes one pair of glasses following cataract surgery, X-Ray
-Family Practitioners

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-TITLE XXI SCHIP
-Uninsured Parents - ME Code 76 - 80

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Aid to the Blind and Blind Pension individuals
-General Relief Program participants
-AIDS Waiver program participants
-Permanently and Totally Disabled Individuals
-Presumptive Eligibility Program pregnant women eligibles
-Children enrolled in Developmental Disabilities Program
-Mentally Retarded Developmental Disabled (MRDD) Waiver
-American Indian/Alaskan Native

Lock-In Provision:
9 month lock-in

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 Assessments
-Helpline
-MCOs monitor Drug Usage
-MCOs use Hospital Admissions
-MCOs use Hospital Encounters
-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:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Other State Agencies as necessary
-Public Health Agency
-Social Security Administration

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Advantage+ Plus
Community Care Plus
FirstGuard
HealthNet
Missouri Care
Care Partners
Family Health Partners
HealthCare USA
Mercy

MISSOURI
MC+ Managed Care/1115

ADDITIONAL INFORMATION

Implementation Date: 09/01/1998 - Services began for MC+ For Kids. On 02/01/1999, services began for Uninsured Parents.

Medicaid eligibles in the included populations who are receiving Supplemental Security Income (SSI) or who meet the SSI medical disability definition may choose not to enroll or voluntarily disenroll from MC+ at any time.

Inpatient and Outpatient Mental Health and Substance Abuse - 30 inpatient/20 outpatient limitation.

Transportation: 1115 Adults and Children receive emergency transportation only except for 1115 Parents Fairshare recipients.

EPSDT: Uninsured Parents Age 19 and above do not receive EPDST services.

HealthCare USA participates in both Eastern and Central Regions.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman (Western and Eastern Region only)
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement EPSDT
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
Adult Medicaid AFDC Questionnaire
Children with Special Needs, MC+ Managed Care Version, version 7/99, Rev. 1/00

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/PHPs 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)
-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-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

-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Established guidelines for initial encounter data submission
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Required use of "home grown" forms
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

MISSOURI
MC+ Managed Care/1115

MCO 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
-Gender-appropriate diagnosis/procedure
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-C-Section Rates
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-Dental services
-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
-Mental Health Utilization
-Outcomes of Pregnancy
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Preventable Hospitalization under age 18
-Smoking during Pregnancy
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

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

Access/Availability of Care
-Average distance to PCP

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care
-Missouri Department of Insurance monitors and tracks Health Plan stability/financial/cost of care

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

Beneficiary Characteristics
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for

women giving birth during the reporting period

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Missouri Patient Care Review Foundation

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-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

MISSOURI
MC+ Managed Care/1915b

CONTACT INFORMATION

State Medicaid Contact:
Darlene Bleich
Department of Social Services, Division of Medical
(573)751-5178

State Website Address:
http://www.medicaid.state.mo.us

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
First Health Services
Corporation

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:
March 14, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-PCP Teams
-PCP Clinics - which can include FQHCs/RHCs

MISSOURI
MC+ Managed Care/1915b

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program
-General Relief Participants
-AIDS Waiver program participants
-Permanently and totally disabled individuals
-Presumptive and Eligibility Program Pregnant Women Eligibles
-Aid to the Blind and Blind Pension Individuals
-Special Needs Children
-American Indian/Alaskan Native
-Children with Developmental Disabilities Program
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
9 month lock-in

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
-MCOs use Drug Usage
-MCOs use hospital admissions
-MCOs use Hospital Encounters
-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:
-Department of Mental Health
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Other State Agencies as necessary
-Public Health Agency
-Social Security Administration

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Advantage+ Plus
Community Care Plus
FirstGuard
HealthNet
Missouri Care
Care Partners
Family Health Partners
HealthCare USA
Mercy

MISSOURI
MC+ Managed Care/1915b
ADDITIONAL INFORMATION

HealthCare USA participates in Eastern and Central Regions

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 enroll or voluntarily disenroll from MC+ at any time. Special Needs Children enrollment is mandatory but individuals may request to opt out.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman (Western and Eastern Regions only)
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

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

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
Children with Special 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 use/requires MCOs/PHPs 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)
-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-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
-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Established guidelines for initial encounter data submission
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Required use of "home grown" forms
-Required 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 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

MISSOURI
MC+ Managed Care/1915b

-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-C-Section Rates
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-Dental services
-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
-Mental Health Utilization
-Outcomes of pregnancy
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Preventable Hospitalization under age 18
-Smoking during pregnancy
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

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

Access/Availability of Care
-Average distance to PCP

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care
-Missouri Department of Insurance monitors and tracks Health Plan stability/financial/cost of care

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

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

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

MISSOURI
MC+ Managed Care/1915b

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Missouri Patient Care Review Foundation

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-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

MONTANA
Passport To Health

CONTACT INFORMATION

State Medicaid Contact:
Mary Angela Collins
Montana Department of Public Health and Human
(406)444-4146

State Website Address:
http://www.dphhs.state.mt.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
No

Guaranteed Eligibility:
1 month guaranteed eligibility

Initial Waiver Approval Date:
August 31, 1993

Implementation Date:
January 01, 1993

Waiver Expiration Date:
October 26, 2001

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-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, Dental, Dialysis, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home and Community Based Waiver, Home Health, Home Health Care, Home Infusion Therapy, Home Personal Attendant, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Nursing Homes, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplants, Transportation,

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

MONTANA
Passport To Health

Enrollment

Populations Voluntarily Enrolled:
None

Vision, X-Ray

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Medically Needy
-Restricted Card Program
-Area Without Managed Care
-Subsidized Adoption
-Only Retroactive Eligibility
-Home and Community Waiver

Lock-In Provision:
No lock-in

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
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Nurses
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Passport to Health

ADDITIONAL INFORMATION

Program includes a $3.00 case management fee.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)
-Provider Data
-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
-Regulatory Compliance/Federal Reporting

MONTANA
Passport To Health

-Track Health Service provision

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
-State-developed Survey

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Diabetes management
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with 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
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics
-Board Certification

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

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Diabetes management
-Emergency Room service utilization
-Lead toxicity
-Low birth-weight baby
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Native American

NEBRASKA
Nebraska Health Connection - Medical/Surgical Component

CONTACT INFORMATION

State Medicaid Contact:
David Cygan
Nebraska Medicaid
(402)471-9050

State Website Address:
http://www.hhss.state.ne

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Nebraska Health Connection/Access Medicaid

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months continous eligibility for children

Initial Waiver Approval Date:
June 06, 1995

Implementation Date:
July 01, 1995

Waiver Expiration Date:
December 23, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-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, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Transportation, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

NEBRASKA

Nebraska Health Connection - Medical/Surgical Component

-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Clients Eligible During the Period of Presumptive Eligilbility
-Transplant Recipients
-Clients Who Have Received a Disenrollment/Waiver of Enrollment
-Clients Residing Outside the Designated Coverage Area
-Special Needs Children (BBA defined)

Lock-In Provision:
1 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Participate in HCBS Waiver
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Clients Eligible During the Period of Presumptive Eligibility
-Transplant Recipients
-Clients Who Have Received a Disenrollment/Waiver of Enrollment
-Clients Residing Outside the Desinated Coverage Area
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)

Lock-In Provision:
1 month lock-in

NEBRASKA
Nebraska Health Connection - Medical/Surgical Component

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Primary Care Plus
The Wellness Option
Share Advantage

ADDITIONAL INFORMATION

Children Participating in the Katie Beckett Program

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

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
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-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 use/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-Established standards to ensure 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, definitons, sets of acceptable values, standards for data processing and editing
-Established deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)

NEBRASKA
Nebraska Health Connection - Medical/Surgical Component

-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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

Performance Measures

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Pregnancy Prevention
-Well-child care visit rates

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

Access/Availability of Care
-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 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 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 of beneficiary ethnicity/race

NEBRASKA
Nebraska Health Connection - Medical/Surgical Component

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

Performance Improvement Projects

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

Clinical Topics
-Diabetes management

Non-Clinical Topics
-Complaint-Tracking
-Telephone Response Rates

Standards/Accreditation Care

MCO/PHP Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

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

Accreditation for Deeming
None

EQRO Name
-Iowa Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

EQRO 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
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of performance improvement projects

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-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
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-State-developed Survey

NEBRASKA
Nebraska Health Connection - Medical/Surgical Component

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Diabetes management
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Smoking prevention and cessation
-Well-child care visit rates

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
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of primary care case manager visits per beneficiary

Provider Characteristics
-Board Certification
-Languages spoken (other than English)

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
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

NEBRASKA
Nebraska Health Connection - Mental Health/Substance Abuse

CONTACT INFORMATION

State Medicaid Contact:
David Cygan
Nebraska Medicaid
(402)471-9050

State Website Address:
http://www.hhss.state.ne.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
June 05, 1995

Implementation Date:
July 17, 1995

Waiver Expiration Date:
July 31, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:
Case Management, Client Assistance Program, Crisis, EPSDT, IMD Services, Inpatient Hospital, Inpatient Mental Health Services, Inpatient Substance Abuse Services, Laboratory, Mental Health Outpatient, Mental Health Residential, Opiate Treatment Programs, Outpatient Hospital, Outpatient Substance Abuse Services, Physician Services, Residential Substance Abuse Treatment Programs, Transportation, X-ray

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

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

NEBRASKA

Nebraska Health Connection - Mental Health/Substance Abuse

Populations Voluntarily Enrolled:
None

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

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Special Needs Children (BBA defined)

Lock-In Provision:
1 month lock-in

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ValueOptions

ADDITIONAL INFORMATION

Due to the nature of the waiver which is a limited carve-out for a segment of Substance Abuse/Mental Health Services, the program does not designate a primary care provider. Individuals choose their own providers or rely on the contractor for referral. The contractor acts as the gatekeeper. Children Participating in the Katie Beckett Program

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

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
-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

NEBRASKA

Nebraska Health Connection - Mental Health/Substance Abuse

HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-Established standards to ensure 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

-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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 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

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

-Patient satisfaction with care

Access/Availability of Care

-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization

-Average number of visits to MH/SA providers per beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of

-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

Health Plan/ Provider Characteristics

None

-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

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

Performance Improvement Projects

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

Clinical Topics
-Attention Deficit/Hyperactivity Disorder

Non-Clinical Topics
-Complaint-Tracking

Standards/Accreditation

MCO/PHP Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

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

Accreditation for Deeming
None

EQRO Name
-Iowa Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

EQRO 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
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of performance improvement projects

NEVADA
Mandatory Health Maintenance Program

CONTACT INFORMATION

State Medicaid Contact:
Mary Pennington
Division of Health Care Financing and Policy
(775) 684-3698

State Website Address:
http://www.state.nv.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

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:
December 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

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Ambulatory Surgery Center, Case Management, Certified Registered Nurse Practioner, Chiropactor, Disposable Medical Supplies, Durable Medical Equipment, Emergency Transportation, 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 Services, Noninvasive Diagnostic Centers, Nurse Anesthetist, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Physician Assistants, Podiatrist, Prosthetics, Pyschologist, Respiratory Therapy, Rural Health Clinics, Skilled Nursing Facility, Special Clinics, Speech Therapy, Transitional Rehabilitative Center, Vision, X-Ray

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

Enrollment

NEVADA
Mandatory Health Maintenance Program

Populations Voluntarily Enrolled:
-Severely Emotionally Disabled Children
-Seriously Mentally Ill Adults
-Children with Special Health Care Needs
-American Indian

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Children - Inpatients at Residential Treatment Facility
-Medicare Dual Eligible
-Other Insurance

Lock-In Provision:
12 month lock-in

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:
-Maternal and Child Health Agency
-Mental Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Plan of Nevada
NevadaCare DBA Nevada Health Solutions
United Healthcare of Nevada

ADDITIONAL INFORMATION

For the Mandatory Program, Temporary Assistance for Needy Families/Child Health Assurance 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.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

NEVADA
Mandatory Health Maintenance Program

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 modifies/requires MCOs/PHPs 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)
-Established requirements for data validation
-Established standards to ensure 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, definitons, 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. CMS 1500, UB-92, 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
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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
-Dental services
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care

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

NEVADA
Mandatory Health Maintenance Program

-Well-child care visit rates

Access/Availability of Care
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility

Health Plan Stability/ Financial/Cost of
-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
-Board Certification

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP 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

Accreditation Required for
None

Accreditation for Deeming
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance measures

NEVADA
Voluntary Health Maintenance Program

CONTACT INFORMATION

State Medicaid Contact:
Mary Pennington
Division of Health Care Financing & Policy
(775)684-3698

State Website Address:
http://www.state.nv.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

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:
April 01, 1997

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) - Full Capitation

Service Delivery

Included Services:
Ambulatory Surgery Center, Case Management, Certified Registered Nurse Practioner, Chiropractor, Disposable Medical Supplies, Durable Medical Equipment, Emergency Transportation, 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 Service, Noninvasive Diagnostic Center, Nurse Anesthetist, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Physician Assistant, Podiatrist, Prosthetics, Psychologist, Respiratory Therapy, Rural Health Clinic, Skilled Nursing Facility, Special Clinics, Speech Therapy, Transitional Rehabilitative Center, Vision, X-Ray

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

Enrollment

NEVADA
Voluntary Health Maintenance Program

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

-Severely Emotionally Disturbed Children
-Seriously Mentally Ill Adults

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Inpatients in Residential Treatment Facilities
-Residents in Nursing Facilities beyond 45 Days

Lock-In Provision:
12 month lock-in

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 provider referrals to identify members of these

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

NevadaCare DBA Nevada Health Solutions

ADDITIONAL INFORMATION

This program only includes beneficiaries in Washoe county.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for

NEVADA
Voluntary Health Maintenance Program

Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire
Child with Special Needs Questionnaire

Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs/PHPs 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)
-Established requirements for data validation
-Established standards to ensure 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, definitons, 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. CMS 1500, UB-92, 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
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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
-Dental services
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates

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

NEVADA
Voluntary Health Maintenance Program

Access/Availability of Care
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility

Health Plan Stability/ Financial/Cost of Care
-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 ration
-Net Worth
-Total revenue

Health Plan/ Provider Characteristics
-Board Certification

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP 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

Accreditation Required for
None

Accreditation for Deeming
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of performance measures

NEW HAMPSHIRE
New Hampshire Voluntary Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:
Diane Kemp
State of New Hampshire Medicaid Agency
603-271-4365

State Website Address:
http://www.dhhs.state.nh.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 02, 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) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Organ Transplant, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Skilled Nursing Facility, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

NEW HAMPSHIRE
New Hampshire Voluntary Managed Care Program

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

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 enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Employment Agency
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Anthem Blue Cross/Blue Shield

ADDITIONAL INFORMATION
The SCHIP children aged 0-1 are enrolled voluntary.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Enrollee Hotlines
-Focused Studies
-Performance Improvements 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 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/PHPs to modify some or all NCQA specifications in ways other than continous enrollment

Performance Measures

NEW HAMPSHIRE
New Hampshire Voluntary Managed Care Program

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-# readmissions,same patients,same diagnosis within 7 days
-After-hours visits
-Emergency room visits/1,000 beneficiary
-Hospital Days/ 1000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Northeast Quality Healthcare Foundation

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

NEW JERSEY
New Jersey Care 2000+ (1915 {b})

CONTACT INFORMATION

State Medicaid Contact:
Susan Welsh
Office of Quality Assurance
(609)588-7379

State Website Address:
http://www.state.nj.us/humanservices

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)

Enrollment Broker:
MAXIMUS

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:
September 30, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Chiropractor, Dental, Durable Medical Equipment, Emergency Services, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient and Outpatient Mental Health & Substance Abuse Services for Clients of the DDD, Inpatient Hospital, Inpatient Rehabilitative Services, Laboratory, Medical Supplies, Optical Appliances, Optometrist Services, Organ Transplants, Outpatient Hospital, Pharmacy, Physician, Podiatrist Services, Preventive Health Care and Counseling and Promotion, Prosthetics and Orthotics, Transportation Services, Vision, X-Ray

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

Enrollment

NEW JERSEY
New Jersey Care 2000+ (1915 {b})

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Non duals DDD/CCW children
-Non dual Blind and Disabled Children and Related

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program Without Department of Human Services Contract
-Participate in HCBS Waiver (except DDD/CCW non-duals)

Lock-In Provision:
No lock-in

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 provider referrals to identify members of these

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
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna US Healthcare
AMERIGROUP New Jersey, Inc.
Physicians Health Services of New Jersey, Inc.
AmeriChoice of New Jersey, Inc.
Horizon Mercy
University Health Plans, Inc.

ADDITIONAL INFORMATION

1915(b) Waiver program was approved in April 2000, however, the program was not effective until 10/01/2000. Please note benefits listed are those that were in effect prior to 10/01/2000.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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 MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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

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

NEW JERSEY
New Jersey Care 2000+ (1915 {b})

HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State modifies/requires MCOs/PHPs 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)
-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-Established 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, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Electronic format is a modified Fee-For-Service MMIS based on CMS 1500, UB-92 and Home Gown Forms
-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 to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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
-Comparison of reported changes to reasonable and customary fees.

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes management
-Frequency of on-going prenatal care
-HIV/AIDS care

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

NEW JERSEY

New Jersey Care 2000+ (1915 {b})

-Immunizations for two year olds
-Initiation of prenatal care
-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

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

-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

-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 ration
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

-All MCOs/PHPs 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
-Breast cancer screening (Mammography)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management
-Lead toxicity
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics

-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

NEW JERSEY
New Jersey Care 2000+ (1915 {b})

Accreditation for Deeming
None

EQRO Name
-The Peer Review Organization of New Jersey, Inc.

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Calculation of performance measures
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Medical Record review
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of performance improvement projects
-Validation of performance measures

NEW JERSEY
New Jersey Care 2000+ (1932)

CONTACT INFORMATION

State Medicaid Contact:
Susan Welsh
Office of Quality Assurance
(609)588-7379

State Website Address:
http://www.state.nj.us/humanservices

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
Yes

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) - Full Capitation

Service Delivery

Included Services:
Chiropractor, Dental, Durable Medical Equipment, Emergency Medical Care, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient and Outpatient Mental Health and Substance Abuse Services for Clients of the Division of D, Inpatient Hospital, Inpatient Rehabilitation, Laboratory, Medical Supplies, Optical Appliances, Organ Transplants, Outpatient Hospital, Pharmacy, Physician, Podiatrist, Preventive Health Care, Prosthetics and Orthotics, Transportation, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Medicare Dual Eligible

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Adults and Related Populations

NEW JERSEY
New Jersey Care 2000+ (1932)

-Non Dually Eligible Aged, Blind and Disabled Adults and Related Populations
-Non dual DDD/CCW

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program Without Department of Human Services Contract
-Special Needs Children and all Aged, Blind and Disabled were excluded from mandatory enrollment
-American Indian/Alaskan Native
-Participate in HCBS Waiver except DDD/CCW non-duals

Lock-In Provision:
12 month lock-in

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 provider referrals to identify members of these

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
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna US Healthcare
AMERIGROUP New Jersey, Inc.
Physicians Health Services of New Jersey, Inc.
AmeriChoice of New Jersey, Inc.
Horizon Mercy
University Health Plans, Inc.

ADDITIONAL INFORMATION

Initially a 1915(b) converted to a SPA effective 1/1/1999. Effective 4/1/00, 1932(a) program was amended to include SSI, Aged, Blind, Disabled, and Division of Developmental Disabilities Community Care Waiver (DDD/CCW) population. Contract to provide services to newly mandated population was not effective until 10/1/00. Phased-in Enrollment for the Aged, Blind,Disabled and DDD/CCW Population effective 10/01/2000. Lock-in Period: 12-month lock in is for AFDC/TANF and Title XXI population. There is no lock-in for SSI, Aged, Blind, Disabled and DDD and DFYS populations. Children with special Health Care Needs and those children who have or are at increased risk for chronic physical, developmental, or emotional conditions and who also require health

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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 MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)

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

NEW JERSEY

New Jersey Care 2000+ (1932)

-Performance Measures (see below for details)
-Provider Data
-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 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/PHPs 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, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Electronic format is a modified Fee-For-Service MMIS based on CMS 1500, UB-92 and Home Grown Forms
-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 to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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
-Comparison of reported changes to reasonable and customary fees.

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes 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
-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

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
-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 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
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs 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
-Breast cancer screening (Mammography)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management
-Lead toxicity
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

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

NEW JERSEY
New Jersey Care 2000+ (1932)

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-The Peer Review Organization of New Jersey, Inc.

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Calculation of performance measures
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Medical Record review
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of performance improvement projects
-Validation of performance measures

NEW MEXICO
SALUD!

CONTACT INFORMATION

State Medicaid Contact:
Carol Shisler
HSD-Medical Assistance Division
(505) 827-1311

State Website Address:
http;//www.state.nm.us/hsd/mad/salud.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
May 13, 1997

Implementation Date:
July 01, 1997

Waiver Expiration Date:
July 01, 2001

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full 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 Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

NEW MEXICO
SALUD!

-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Home and Community Based Waiver

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Poverty Level Pregnant Woman
-Native Americans

Lock-In Provision:
12 month lock-in

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 fee for service claims data
-Uses history of prior authorization of special services

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Cimarron
Lovelace
Presbyterian Salud

ADDITIONAL INFORMATION

HMOs designate PCPS.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Accreditation for Deeming (see below for details)
-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
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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
-CAHPS
Adult Medicaid AFDC Questionnaire

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid

NEW MEXICO
SALUD!

-State-developed Survey

-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs/PHPs 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, definitons, 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. CMS 1500, UB-92, 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
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-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 (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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-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
-Percentage of beneficiaries with at least one dental visit

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income

Health Plan/ Provider Characteristics
-Provider turnover

-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Performance Improvement Projects

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

Clinical Topics
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

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

Accreditation for Deeming
-NCQA (National Committee for Quality Assurance)

EQRO Name
-IPRO

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

NEW YORK
New York State Mandatory Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:
Elizabeth McFarlane
Office of Managed Care, New York State Department
(518)473-0122

State Website Address:
http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

Initial Waiver Approval Date:
July 15, 1997

Implementation Date:
October 01, 1997

Waiver Expiration Date:
March 31, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(C)
-1902(a)(23) Freedom of Choice
-1902(a)(25)
-1902(a)(30)
-1902(a)(34)

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Eligibility Expansion, Guarantee
-1903(u) Special Program (Community Health Care Conversion Demonstration Program)

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental (MCO Option), Durable Medical Equipment, EPSDT, Family Planning (MCO Option), Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Skilled Nursing Facility, Transportation (Optional), Vision, X-Ray

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

NEW YORK
New York State Mandatory Managed Care Program

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Reside in Nursing Facility or ICF/MR
-Partcipation in LTC Demonstration Program
-Other Insurance
-Eligible less than 6 Months
-Spend downs
-Reside in State Operated Psychiatric facility
-Enrolled in the Restricted Recipient Program
-Admitted to hospice at the time of enrollment
-Foster children in direct care
-Eligible only for TB related services
-Reside in residential treatment facility for children and youth
-Infants weighing less than 1200 grams or infants who meet SSI criteria
-Special Needs Children (BBA defined)

Lock-In Provision:
12 month lock-in

NEW YORK
New York State Mandatory Managed Care Program

PCCM Provider - Fee-for-Service

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:
-Nurse Practitioners
-Pediatricians
-Internists
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Aged and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Admitted to hospice at the time of enrollment
-Foster children in direct care
-Eligible only for TB related services
-Participants in LTC Demonstration Program
-Reside in Nursing Facility or ICF/MR
-Infants weighing less than 1200 grams or other infants who met criteria for SSI
-Enrolled in Another Managed Care Program
-Eligible less than 6 months
-Special Needs Children (BBA defined)
-Spend downs
-Reside in State Operated Psychiatric Facility
-Reside in residential treatment facility for children and youth
-Enrolled in the Restricted Recipient Program

Lock-In Provision:
12 month lock-in

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

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ABC Health Plan

NEW YORK

New York State Mandatory Managed Care Program

Bronx Health Plan
Buffalo Community Health
CarePlus Health Plan
Community Choice Health Plan
Excellus
Health First
HIP Combined
LMC/Health Care Plus
MetroPlus Health Plan
NY Hospital Community PHSP
Preferred Care
Syracuse PHSP/Total Care
United Healthcare of Upstate
Wellcare
Americhoice
Broome County MC
Capital District Physicians Health Plan
Catholic Services Health Plan/Fidelis
Community Premier Plus
Genesis Health Plan
Health Now
Independent Health/Hudson Valley&WNY
Manhattan PHSP/Centercare
Neighborhood Health Providers
Physician Case Management Program
St. Barnabas/Partners in Health
United Healthcare of NY
Vytra
Westchester PHSP

ADDITIONAL INFORMATION

This program has an enrollment broker in NYC and may also come on board in Long Island. The Physician Case Management Program is a partially capitated PCCM. This provider receives a monthly premium for primary and preventive care and coordinating, locating and monitoring other necessary medical services.

Foster Care Children may be enrolled at the option of the county.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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 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/PHPs 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

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, 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

-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely 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.)
-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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-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
-Alcohol and Substance abuse use screening
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Depression management
-Diabetes management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead Screening
-Lead Screening rate
-Smoking prevention and cessation
-Well-child care visit rates

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

Access/Availability of Care
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary

NEW YORK

New York State Mandatory Managed Care Program

-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)
-Provider turnover

Beneficiary Characteristics

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

Performance Improvement Projects

Project Requirements

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

Clinical Topics

-Inpatient maternity care and discharge planning
-Low birth-weight baby
-Newborn screening for heritable diseases
-Post-natal Care
-Pre-natal care

Non-Clinical Topics

-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards

-State-Developed/Specified Standards

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-Island Peer Review Organization

EQRO Organization

-Peer Review Organization (PRO)

EQRO 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
-Validation of performance improvement projects
-Validation of performance measures

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-Focused Studies
-On-Site Reviews

Use of Collected Data:

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement

NEW YORK

New York State Mandatory Managed Care Program

-Performance Measures (see below for details)
-Provider Data

-Program Evaluation

-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-Provider developed survey

Performance Measures

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Immunizations for two year olds
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics
-Board Certification
-Languages spoken (other than English)

Beneficiary Characteristics
-Disenrollment rate
-Percentage of beneficiaries who are auto-assigned to PCCM

NEW YORK
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:
Tim Perry-Coon
Office of Medicaid Management, NY State Dept
(518)474-9266

State Website Address:
http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 16, 1996

Implementation Date:
July 01, 1996

Waiver Expiration Date:
December 20, 2001

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

Transportation PHP - Full Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

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

NEW YORK
Non-Emergency Transportation

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

Lock-In Provision:
No lock-in

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

Agencies with which Medicaid Coordinates the Operation of the Program:
-Transportation Agency
-All Medicaid Beneficiaries

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

None

ADDITIONAL INFORMATION

The reimbursement arrangement waiver is described as: Selective contracting for non-emergency transportation.

NEW YORK
Office of Mental Health/Partial Capitation Program

CONTACT INFORMATION

State Medicaid Contact:
Mike Kohler
New York State Office of Mental Health
(518)474-7720

State Website Address:
http://www.omh.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 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

Mental Health (MH) PHP - Partial Capitation

Service Delivery

Included Services:
Mental Health Continuion Day Treatment, Mental Health Intensive Psychiatric Rehabilitation Treatment, Mental Health Outpatient

Allowable PCPs:
-Mental Health PHP
-Personal Services Coordinator

Contractor Types:
-New York State Office of Mental Health Hospital

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Admitted to an outpatient psychiatric center program
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Receiving outpatient (Clinic, CDT, IPRT)

Populations Mandatorily Enrolled:
None

NEW YORK
Office of Mental Health/Partial Capitation Program

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 6 Months
-Participation in HCBS Waiver
-Special Needs Children (BBA defined)

Lock-In Provision:
No lock-in

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 provider referrals to identify members of these groups

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

OMH/Partial Capitation

ADDITIONAL INFORMATION

The patients are referred by their hospitals or outpatient programs for mental health services. Due to the nature of the program which is for a limited segment of services, the program does not designate a medical primary care provider. Individuals choose their own providers or rely on the contractor for referral. The contractor acts as the gatekeeper.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-MCO/PHP Standards (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
-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

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

NEW YORK
Office of Mental Health/Partial Capitation Program

Access/Availability of Care
-Number of encounters per provider

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Use of acute sector hospitalization

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable
-Private Accreditation Organization

EQRO Activities
-Not Applicable

NEW YORK
The New York State Voluntary Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:
Elizabeth McFarlane
New York State Department of Health
(518)473-0122

State Website Address:
http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1987

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 - Partial Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

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

Populations Mandatorily Enrolled:
None

NEW YORK
The New York State Voluntary Managed Care Program

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period Less than 6 months
-Spend downs
-Reside in State Operated Psychiatric facility
-Reside in residential treatment facility for children and youth
-Infants weighing less than 1200 grams or other infants who meet criteria for SSI
-Enrolled in the Restricted Recipient Program
-Admitted to hospice at the time of enrollment
-Foster children in direct care
-Eligible only for TB related services
-Special Needs Children (BBA defined)

Lock-In Provision:
12 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

-Foster Care Children

Service Delivery

Included Services:
Case Management, Dental (MCO Option), Durable Medical Equipment, EPSDT, Family Planning (MCO Option), Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Transportation (Optional), Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Medicare Dual Eligible
-Eligibility Period Less than 6 months
-Other Insurance
-Spend downs
-Reside in State Operated Psychiatric Facility
-Reside in residential treatment facility for children and youth
-Infants weighing less than 1200 grams or other infants who meet criteria for SSI
-Enrolled in the Restricted Recipient Program
-Admitted to hospice at the time of enrollment
-Foster children in direct care
-Eligibility only for TB related services
-Special Needs Children (BBA defined)

Lock-In Provision:
12 month lock-in

NEW YORK
The New York State Voluntary Managed Care 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
-Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ABC Health Plan
Bronx Health Plan
CarePlus Health Plan
Community Choice Health Plan
Excellus
Health Choice
Health Now
Independent Health/Hudson Valley&WNY
Manhattan PHSP/Centercare
Neighborhood Health Providers
Preferred Care
Southern Tier Pediatrics
Suffolk Health Plan
United Healthcare of NY
Vytra
Americhoice
Capital District Physicians Health Plan
Catholic Services Health Plan/Fidelis
Community Premier Plus
Genesis Health Plan
Health First
HIP Combined
LMC/Health Care Plus
MetroPlus Health Plan
NY Hospital Community PHSP
Primary Health
St. Barnabas/Partners in Health
Twin Tier/ Southern Tier Priority
United Healthcare of Upstate
Wellcare

ADDITIONAL INFORMATION

The enrollment of foster care children is a county option. BBA defined Monthly premium for primary and preventive services. All other services reimbursed through MMIS.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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

NEW YORK
The New York State Voluntary Managed Care Program

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 measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs/PHPs 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, definitons, 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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-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
-Alcohol and substance abuse screening
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Depression management

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

-Diabetes management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Smoking prevention and cessation
-Well-child care visit rates

Access/Availability of Care
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA 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.)
-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
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Performance Improvement Projects

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

Clinical Topics
-Inpatient maternity care and discharge planning
-Low birth-weight baby
-Newborn screening for heritable diseases
-Post-natal Care
-Pre-natal care

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

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Island Peer Review Organization

NEW YORK
The New York State Voluntary Managed Care Program

EQRO Organization
-Peer Review Organization (PRO)

EQRO 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
-Validation of performance improvement projects
-Validation of performance measures

NORTH CAROLINA
Access II 1915b

CONTACT INFORMATION

State Medicaid Contact:
Deborah Bowen
Division of Medical Assistance
(919)857-4246

State Website Address:
http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 01, 1998

Implementation Date:
July 01, 1998

Waiver Expiration Date:
November 08, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-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:
Chiropractor, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Outpatient Hospital, Physician

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants
-Health Departments

Enrollment

NORTH CAROLINA
Access II 1915b

Populations Voluntarily Enrolled:
-Adoption Subsidy Children
-Foster Care Children
-Medicaid Pregnant Women
-Medicare Dual Eligibles
-American Indians

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibillity Period that is only Retroactive

Lock-In Provision:
No lock-in

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 ACCESS II Health assessment form
-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
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access II

ADDITIONAL INFORMATION

An Administrative Entity is paid an additional PCCM case management fee of $2.50 per recipient participating in Access II to monitor care and implement disease management initiatives and target preventive services. ACCESS II manages the highest risk Medicaid enrollees to improve coordination and continuity of care.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan & Provide Education
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling

NORTH CAROLINA
Access II 1915b

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

-Quality Improvement Activities
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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
-Compliant Monitoring
-Ratio of primary care case managers to beneficiaries
-Satisfaction Survey

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per benificiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics
-Languages spoken (other than English)
-Patient/family satisfaction and understanding services
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-Complaints and Satisfaction Survey
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Diabetes management
-Emergency Room service utilization
-Gastroenteritis
-High risk pregnancy
-Lead toxicity
-Otitis Media management
-Pre-natal care
-Pregnancy Prevention
-Prevention of Influenza
-Smoking prevention and cessation
-Tuberculosis screening and treatment
-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
-Community Communication and Collaboration with High-Risk Clients
-Utilization of Rap-Around Services

NORTH CAROLINA
Access II 1932(a)

CONTACT INFORMATION

State Medicaid Contact:
Deborah Bowen
Division of Medical Assistance
(919)857-4246

State Website Address:
http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - 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, 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:
Chiropractic, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Outpatient Hospital, Physician

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants
-Health Departments
-Hospital Outpatient Clinics
-Community Health Centers

Enrollment

NORTH CAROLINA
Access II 1932(a)

Populations Voluntarily Enrolled:
-Pregnant Women
-Aged and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligible
-Eligibillity Period that is only Retroactive
-Refugees
-QMB

Lock-In Provision:
No lock-in

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 ACCESS II Health assessment form
-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
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access II

ADDITIONAL INFORMATION

An Administrative Entity is paid an additional PCCM case management fee of $2.50 per recipient participating in Access II to monitor care and implement disease management initiatives and target preventive studies. ACCESS II manages the highest risk Medicaid enrollees to improve coordination and continuity of care.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan and Provide Education
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Quality Improvement Activities

NORTH CAROLINA
Access II 1932(a)

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

-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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
-Complaint Monitering
-Ratio of primary care case managers to beneficiaries
-Satisfaction Survey

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per benificiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics
-Languages spoken (other than English)
-Patient/family satisfaction and understanding services
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-Complaints and Satisfaction Survey
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Diabetes management
-Emergency Room service utilization
-Gastroenteritis
-High-risk pregnancy
-Lead toxicity
-Otitis Media management
-Pre-natal care
-Pregnancy Prevention
-Prevention of Influenza
-Smoking prevention and cessation
-Tuberculosis screening and treatment
-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
-Community Communication and Collaboration with High-Risk Clients
-Utilization of Rap-around Services

NORTH CAROLINA
Carolina ACCESS 1915 (b)

CONTACT INFORMATION

State Medicaid Contact:
Deborah Bowen
Division of Medical Assistance
(919)857-4246

State Website Address:
http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Public Consulting
Group

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 1991

Implementation Date:
April 01, 1991

Waiver Expiration Date:
November 08, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Ambulance and Coordination of Non-Emergency Transportation, Case Management (Excludes HIV Case Management and At-Risk Case Management), Chiropractic, Durable Medical Equipment, EPSDT, Hearing And Hearing Aids, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

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

Enrollment

NORTH CAROLINA
Carolina ACCESS 1915 (b)

Populations Voluntarily Enrolled:
-Foster Care Children
-Adoption Subsidy Child
-Pregnant Women
-Medicare Dual Eligibles
-American Indians

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-American Indian/Alaskan Native
-Eligibility Period that is only Retroactive
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Medicaid Pregnant Women
-Medicare Dual Eligibles
-American Indians who have Indian Health Services Identification

Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Supplemental Security Income and SSI-related
-Section 1931 (AFDC/TANF) Children and Related

Subpopulations Excluded from Otherwise Included Populations:
-Native Americans choosing to be exempt
-Terminally Ill
-Non MPW pregnant women
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period that is Retroactive

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

NORTH CAROLINA
Carolina ACCESS 1915 (b)

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 memebers of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carolina Access

United HealthCare

ADDITIONAL INFORMATION

Beneficiaries in 4 counties have an option to either enroll in an MCO or PCCM.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
  Child with Special Needs Questionnaire
-Child Medicaid HMO 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/PHPs 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 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, definitons, 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. CMS 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

NORTH CAROLINA
Carolina ACCESS 1915 (b)

Collection: Standardized Forms
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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
-Units of Service

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Complaints and Grievances

Health Status/Outcomes Quality
-initiation of prenatal care
-Patient satisfaction with care
-Use of appropriate medication for children with asthma

Access/Availability of Care
-After hours survey
-Average distance to PCP
-Average wait time for an appointment with PCP
-Disenrollment
-Non-authorized visits
-Ratio of PCPs to beneficiaries
-Referral denials

Use of Services/Utilization
-Adolescent Immunization
-Ambulatory Care
-Childhood Immunization
-Family planning services
-Health Check Screens/referrals
-Inpatient Utilization
-Lead Screening

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
-Languages Spoken (other than English)
-Provider satisfaction survey
-Provider turnover

Beneficiary Characteristics
-Enrollment by payer
-Total enrollment
-Unduplicated count of Medicaid members

Performance Improvement Projects

NORTH CAROLINA
Carolina ACCESS 1915 (b)

Project Requirements
-All MCOs/PHPs 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
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-QARI (Quality Assurance Reform Initiative)
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Medical Review of North Carolina
-Myers and Stauffer

EQRO Organization
-Peer Review Organization (PRO)
-PRO-like Entity

EQRO Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of MCO compliance with structural and operational standards established by the State
-Validation of client level data, such as claims and encounters

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements 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
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire
  Child with Special Needs Questionnaire

Performance Measures

Process Quality
-After hours availability study
-Complaints/Grievances

Health Status/Outcomes Quality
-Adolescent Immunization rates
-Childhood Immunization Rates
-Prenatal care in first trimester

NORTH CAROLINA
Carolina ACCESS 1915 (b)

Access/Availability of Care
-After hours availability Study
-Children's access to primary care providers
-Ratio of primary care case managers to beneficiaries

-Provider Data

Use of Services/Utilization
-Ambulatory Care measures
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization/1000 beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Provider Characteristics
-Languages spoken (other than English)
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-Disenrollment rate
-Information of beneficiary ethnicity/race

Performance Improvement Projects

Clinical Topics
-Asthma management
-Childhood Immunization
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services
-Children's access to primary care practitioners

NORTH CAROLINA
Carolina ACCESS 1932

CONTACT INFORMATION

State Medicaid Contact:
Deborah Bowen
Division of Medical Assistance
(919)857-4246

State Website Address:
http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

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, 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

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Ambulance and Coordination of Non-ER Transportation, Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Hearing and Hearing Aids, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

NORTH CAROLINA
Carolina ACCESS 1932

-Aged and Related Populations
-Medicaid Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-American Indian/Alaskan Native
-Medicare Dual Eligible
-Participate in HCBS Waiver
-Eligibility Period that is only Retroactive
-Terminally Ill Who Sees Multiple Specialists
-A Recipient Who Has Chronic, Complex Medical Problems And Sees Multiple Specialists Who Do not Participate in the Program
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles
-Medicaid for Pregnant Women
-American Indians who have an Indian Health Services Identification

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Supplemental Security Income and SSI Related

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period that is Retroactive
-Native Americans Choosing to be Exempt
-Terminally Ill
-Private Insurance and PCP not willing to participate
-Non-MPW Pregnant Women
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

NORTH CAROLINA
Carolina ACCESS 1932

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
-Maternal and Child Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carolina Access
United HealthCare

ADDITIONAL INFORMATION

The recipient must choose and enroll with or be assigned to a primary case provider who is paid a monthly case management fee of $3.00 for each enrollee in addition to regular fee for service payments. For PCCM, the program does not have a Phased-in Enrollment nor an Enrollment Broker.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-Adult Medicaid HMO 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/PHPs 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 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, definitons, 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. CMS 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier 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.)

NORTH CAROLINA
Carolina ACCESS 1932

-UB-92 (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

-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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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
-Units of Service

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Complaints and Grievances

Health Status/Outcomes Quality

-Breast cancer screenings
-Cervical Cancer Screenings
-Initiation of prenatal care
-Patient satisfaction with care
-Use of appropriate medication for people with asthma
-Use of comprehensive Diabetes care

Access/Availability of Care

-After Hours Survey
-Average distance to PCP
-Average wait time for an appointment with PCP
-Non-authotised visits
-PCP Referral Denials
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Ambulatory care
-Family planning services
-Health Check screenings/referrals
-Inpatient Utilization

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

-Languages Spoken (other than English)
-Provider Satisfaction Survey
-Provider turnover

Beneficiary Characteristics

-Enrollment by Payer
-Unduplicated count of Medicaid members

Performance Improvement Projects

Project Requirements

-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement

Clinical Topics

-Diabetes management
-Pre-natal care

project(s) prescribed by State Medicaid agency

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-QARI (Quality Assurance Reform initiative)
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Medical Review of North Carolina
-Myers and Stauffer

EQRO Organization
-Peer Review Organization (PRO)
-PRO-like Entity

EQRO Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of MCO compliance with structural and operational standards established by the State
-Validation of client level data, such as claims and encounters

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Provider Data
-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
None

Performance Measures

Process Quality
-After Hours Availability Study
-Complaints and Grievances

Health Status/Outcomes Quality
-Breast Cancer Screening
-Cervical Cancer Screening
-Diabetic Retinal Exams
-Prenatal Care in the first trimester

Access/Availability of Care
-After Hours Avaialability Study
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Ambulatory care Measures
-Average number of visits to MH/SA providers per 1000 beneficiaries
-Drug Utilization/1000 beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of primary care case manager visits per 1000 beneficiary

NORTH CAROLINA
Carolina ACCESS 1932

-Number of specialist visits per 1000 beneficiaries

Provider Characteristics
-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

Performance Improvement Projects

Clinical Topics
-Congestive Heart Failure Management
-Diabetes management
-Smoking prevention and cessation

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services

NORTH CAROLINA
Health Care Connection (1915)b

CONTACT INFORMATION

State Medicaid Contact:
Deborah Bowen
Division of Medical Assistance
(919)857-4246

State Website Address:
http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Public Consulting
Group

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 1991

Implementation Date:
July 01, 1996

Waiver Expiration Date:
November 08, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Ambulance And Coordination of Non-ER Transportation, Case Management (Excludes HIV Case Management And At-Risk Case Management), Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Hearing And Hearing Aids, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Preventive Therapies, Vision, X-Ray

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

Enrollment

NORTH CAROLINA
Health Care Connection (1915)b

Populations Voluntarily Enrolled:
-Foster Care Children
-Adoption Subsidy Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Pregnant Women
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-American Indian/Alaskan Native
-Medicare Dual Eligible
-Participate in HCBS Waiver
-Eligibility Period That Is Only Retro-active
-Terminally Ill Who Sees Multiple Specialists
-A Recipient Who Has Chronic, Complex Medical Problems And Sees Multiple Specialists Who Do Not Participate in the Program

Lock-In Provision:
No lock-in

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:

-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

IPA of North Carolina DBA Southcare
United HealthCare
Metrolina (FQHC)
Wellness Plan of North Carolina

ADDITIONAL INFORMATION

Although Health Care Connection is capitated, the Metrolina (FQHC) plan reimburses on a FFS basis.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)

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

NORTH CAROLINA
Health Care Connection (1915)b

-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data
-CAHPS
  Child Medicaid HMO Questionnaire
  Child with Special Needs 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/PHPs 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 MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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
-Units of Service

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Complaints and Grievances

Health Status/Outcomes Quality
-Initiation of prenatal care
-Patient satisfaction with care

NORTH CAROLINA
Health Care Connection (1915)b

-Use of appropriate medication for children with asthma

Access/Availability of Care
-After hours survey
-Average distance to PCP
-Average wait time for an appointment with PCP
-Disenrollment
-Non-authorized visits
-Ratio of PCPs to beneficiaries
-Referral denials

Use of Services/Utilization
-Adolescent Immunizations
-Ambulatory Care
-Childhood Immunization
-Family planning services
-Health Check screens/referrals
-Inpatient Utilization
-Lead Screening

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
-Languages Spoken (other than English)
-Provider satisfaction survey
-Provider turnover

Beneficiary Characteristics
-Enrollment by payer
-Total enrollment
-Unduplicated count of Medicaid members

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs 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
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-QARI (Quality Assurance Reform Initiative)
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Medical Review of North Carolina
-Myers and Stauffers

EQRO Organization
-Peer Review Organization (PRO)
-PRO-like Entity

EQRO Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of MCO compliance with structural and operational standards established by the State
-Validation of client level data, such as claims and encounters

NORTH CAROLINA
Health Care Connection (1932)a

CONTACT INFORMATION

State Medicaid Contact:
Deborah Bowen
Division of Medical Assistance
(919)857-4246

State Website Address:
http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Public Consulting
Group

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 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) - Full Capitation

Service Delivery

Included Services:
Ambulance And Co-ordination Of Non-ER Transportation, Case Management (Excludes HIV Case Management And At-Risk Case Management), Chiropractic, Durable Medical Equipment, EPSDT, Hearing and Hearing Aids, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

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

Enrollment

NORTH CAROLINA
Health Care Connection (1932)a

Populations Voluntarily Enrolled:
-Aged and Related Populations

Populations Mandatorily Enrolled:
-Pregnant Women
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Age 65 or older, Family Planning Waiver Recipients
-American Indian/Alaskan Native

Lock-In Provision:
No lock-in

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:

-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

IPA of North Carolina DBA Southcare
United HealthCare
Metrolina (FQHC)
Wellness Plan of North Carolina

ADDITIONAL INFORMATION

Although Health Care Connection is capitated, the Metrolina (FQHC) plan reimburses on a FFS basis.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data
-Adult Medicaid HMO 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/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

NORTH CAROLINA
Health Care Connection (1932)a

Encounter Data

Collection: Requirements
-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, definitons, 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. CMS 1500, UB-92, NCPDP, ADA)
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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
-Units of Service

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Complaints and Grievances

Health Status/Outcomes Quality
-Breast cancer Screenings
-Cervical cancer Screenings
-Initiation of prenatal care
-Patient satisfaction with care
-Use of appropriate medication for people with asthma
-Use of comprehensive Diabetes care

Access/Availability of Care
-After Hours Survey
-Average distance to PCP
-Average wait time for an appointment with PCP
-Non-authorized visits
-PCP Referral Denials
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Ambulatory care
-Family Planning services
-Health Check screening/referrals
-Inpatient Utilization

NORTH CAROLINA
Health Care Connection (1932)a

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
-Languages Spoken (other than English)
-Provider Satisfaction Survey
-Provider turnover

Beneficiary Characteristics
-Enrollment by Payer
-Total Enrollment
-Unduplicated Count of Medicaid members

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs 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
None

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-QARI (quality Assurance Reform Initiative)
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Medical Review of North Carolina
-Myers and Stauffers

EQRO Organization
-Peer Review Organization (PRO)
-PRO-like Entity

EQRO Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of MCO compliance with structural and operational standards established by the State
-Validation of client level data, such as claims and encounters

NORTH DAKOTA
North Dakota Access and Care Program

CONTACT INFORMATION

State Medicaid Contact:
Tom Solberg
Department of Human Services, Medical Assistance
(701)328-1884

State Website Address:
http://www.state.nd.us/hms/dhs.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
June 23, 1993

Implementation Date:
January 01, 1994

Waiver Expiration Date:
June 30, 2001

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-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, Durable Medical Equipment, Emergency Services, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Mid-level Practitioner, Non-Emergency Transportation, Nutritional, Occupational, Physical, and Speech Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Podiatry, Private Duty Nursing, Public Health Unit, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

NORTH DAKOTA
North Dakota Access and Care Program

-Section 1931 (AFDC/TANF) Adults and Related Populations
-Optional Categorically Needy
-Medically Needy
-Poverty Level

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Foster Care
-Refugee Assistance
-Adoption Assistance
-Eligiblity Period that is only Retroactive

Lock-In Provision:
6 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Mid-Level Practitioner, Non-Emergency Transportation, Nutritional, Occupational, Physical, and Speech Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Podiatry, Public Health Unit, Transportation, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Physician Assistants
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Poverty Level
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Optional Categorically Needy

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medically Needy
-Foster Care
-Refugee Assistance
-Adoption Assistance
-Eligibility Period that is only Retroactive

Lock-In Provision:
6 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Altru Health Plan

North Dakota Access and Care Program

ADDITIONAL INFORMATION

NORTH DAKOTA
North Dakota Access and Care Program

Altru Health Plan is only offered in Grand Forks county.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO/PHP Standards (see below for details)
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected 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
-Health Plan Developed Survey with State Approval

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/PHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-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
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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 MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Well-child care visit rates

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

NORTH DAKOTA
North Dakota Access and Care Program

Access/Availability of Care
-Average wait time for an appointment with PCP

Use of Services/Utilization
-Emergency room visits/1,000 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.)
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
-Number and Type of Services Provided

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-Lead toxicity
-Low birth-weight baby
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-North Dakota Health Care Review

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Yet To Be Determined

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-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

NORTH DAKOTA
North Dakota Access and Care Program

Consumer Self-Report Data
-State-developed Survey

Performance Measures

Process Quality
-Breast Cancer screening rate
-Cervical cancer screening rate
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with 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
None

Provider Characteristics
None

Beneficiary Characteristics
None

OHIO
Ohio 1115 (TANF & TANF-Related)

CONTACT INFORMATION

State Medicaid Contact:
Cynthia Burnell
Bureau of Managed Health Care
(614) 466-4693

State Website Address:
http://www.state.oh.us/odjfs/index.stm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health
Systems

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 17, 1995

Implementation Date:
July 01, 1996

Waiver Expiration Date:
June 30, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(A)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(a)
-1902(a)(17)(D)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(34)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Disenrollment
-1903(m)(I)(A)

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All other Ohio Medicaid services, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Vision, X-Ray

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

OHIO
Ohio 1115 (TANF & TANF-Related)

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-All except TANF and TANF-Related Medicaid eligibles

Lock-In Provision:
12 month lock-in

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 enrollment forms to identify members of these groups

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

CareSource
Genesis
Paramount Health Care
Renaissance
Supermed HMO
Family Health Plan
HMO Health Ohio
Qualchoice Health Plan
Summacare

ADDITIONAL INFORMATION

Multiple enrollment basis for included population is because enrollment is mandatory in counties designated as such and voluntary in counties designated as such. In selected counties enrollment is voluntary; in others mandatory.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

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

-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-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/PHPs 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 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, definitons, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, 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

-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-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 (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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Manual analysis of encounter data submision to help determine data completeness
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements

-Date of Service
-Provider ID
-Type of Service
-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

-Asthma care
-Check-ups after delivery
-Dental services
-Depression management
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

-Initiation of prenatal care
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates

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
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA 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
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-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
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs 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
-Low birth-weight baby
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

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

Standards/Accreditation

MCO/PHP Standards
-JCHAO (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
None

OHIO
Ohio 1115 (TANF & TANF-Related)

Accreditation for Deeming
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Delmarva Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance measures

OKLAHOMA
SoonerCare

CONTACT INFORMATION

State Medicaid Contact:
Rebecca Pasternik-Ikard
Oklahoma Health Care Authority
(405)522-7200

State Website Address:
http://www.ohca.state.ok.us

PROGRAM DATA

Program Service Area:
County
Region

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
FirstHealth

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
October 12, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Guranteed Eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full 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 Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

OKLAHOMA

SoonerCare

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Children in permanent custody
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
12 month lock-in

PCCM Provider - Partial Capitation

Service Delivery

Included Services:
Case Management, EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Children In State Custody
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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
-Surveys medical needs of enrollee 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

OKLAHOMA
SoonerCare

-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Communitycare
Prime Advantage
UNICARE
Heartland
SoonerCare PCCM

ADDITIONAL INFORMATION

Beneficiaries are auto assigned to either PCCM or MCO models depending on where they live.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-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
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Reimbursement
-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
-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/PHPs 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
-Required data quality improvement plans
-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, definitons, 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. CMS 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of 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
-CMS 1500 - the CMS approved electronic file format for

Validation: Methods

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

OKLAHOMA
SoonerCare

transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-92 (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

MCO 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

-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Dental services
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates

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 mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 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 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 of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

OKLAHOMA
SoonerCare

-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

-All MCOs/PHPs 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
-Coordination of care for persons with physical disabilities
-Deprssion management
-Emergency Room service utilization
-Newborn screening for heritable diseases
-Pre-natal care
-Presciption drug abuse
-Prevention of Influenza
-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/PHP 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

-State recognizes accreditation but it is not required.

Accreditation for Deeming

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name

-Oklahoma Foundation for Medical Quality

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

-Administration or validation of consumer or provider surveys
-Conduct performance improvement projects
-Conducts QISMC Reviews of MCOs and PCCM program
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects

OREGON
Oregon Health Plan

CONTACT INFORMATION

State Medicaid Contact:
Joan Kapowich
Office of Medical Assistance Programs
(503) 945-6500

State Website Address:
http://www.omap.hr.state.or.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - 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:
January 31, 2002

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(A)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(C)
-1902(a)(13)(e)
-1902(a)(17)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(43)(A)
-1905(a)(13)

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(4)
-1903(m)(1)(A)
-1903(m)(2)(A)
-1903(m)(2)(A)(vi) Eligibility Expansion, Guarantee

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:
Crisis, IMD Services, Inpatient Mental Health Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Outpatient Substance Abuse Services

Allowable PCPs:
-Does not apply

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

OREGON
Oregon Health Plan

-County Operated Entity (Public)
-Regional Authority Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

Lock-In Provision:
6 month lock-in

PCCM Provider - Partial Capitation

Service Delivery

Included Services:
Case Management

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

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Aged and Related Populations
-TITLE XXI SCHIP
-Pregnant Women and Optional Children
-Medicare Dual Eligible

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

Lock-In Provision:
No lock-in

OREGON
Oregon Health Plan

Dental PHP - Full Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-DOES NOT APPLY

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Medicare Dual Eligible
-American Indian/Alaskan Native
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

Lock-In Provision:
6 month lock-in

OREGON
Oregon Health Plan

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Pregnant Women and Optional Children
-Medicare Dual Eligible
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

Lock-In Provision:
6 month lock-in

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
-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
-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

OREGON
Oregon Health Plan

Accountable Behavioral Health
Care Oregon
Central Oregon Independent Health Services
Deschutes County CDO
Douglas County IPA
FamilyCare Health Plans
Hayden Family Dentistry
Jefferson Behavioral Health
Lane Care MHO
Managed Dental Care of Oregon
Mid Valley Behavioral Care Network
Multicare Dental
Northwest Dental Services
Oregon Dental Service
PCCM
Providence Health Plan
Tuality Health Care
Capitol Dental Care Inc.
Cascade Comprehensive Care
Clackamas County Mental Health
Doctors of the Oregon Coast South
FamilyCare (Mental Health)
Greater Oregon Behavioral Health, Inc.
Inter-Community Health Network
Kaiser Permanente
Lane Individual Practice Association
Marion Polk Community Health Plan
Mid-Rogue Independent Practice Assoc.
Multnomah County Verity
ODS Health Plan
Oregon Health Management Service
Providence Behavioral
Tuality Health Alliance (Mental Health)
Willamette Dental

ADDITIONAL INFORMATION

1902(a)(1) Statewideness was waived under the uniformity section.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-On-Site Reviews
-Performance Improvements 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
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
"Core" Adult/Child Survey w/selected Medicaid and Special Needs Questions

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/PHPs 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

-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
-Specifications for the submission of encounter data to the

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, 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. CMS 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

OREGON
Oregon Health Plan

Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Use of "home grown" forms
-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.)
-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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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
-Breast Cancer screening rate
-Dental services
-Depression management
-Diabetes management
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Preventive Care Services
-Smoking prevention and cessation
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care
-Patient self reporting health status
-Percentage of low birth weight infants

Access/Availability of Care
-Adult access to ambulatory and preventive care
-Average wait time for an appointment with PCP
-Child Access to PCP's
-Percentage of eligibles enrolled in a FCHP or PCCM
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Percentage of beneficiaries with at least one dental visit

OREGON
Oregon Health Plan

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)

Beneficiary Characteristics
-Beneficiary need for information in an alternate format
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs 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
-Childhood Immunization
-Depression management
-Early childhood cavities prevention
-Primary and behavioral health care coordination
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Permedion

EQRO Organization
-PRO-like Entity Permedion

EQRO Activities
-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

OREGON
Transportation Program

CONTACT INFORMATION

State Medicaid Contact:
Larry Daimler
Office of Medical Assistance Programs
(503) 945-6493

State Website Address:
http://www.omap.hr.state.or.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 01, 1994

Implementation Date:
September 01, 1994

Waiver Expiration Date:
July 25, 2003

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

The reimbursement arrangement waiver is described as: The State contracts with brokers on a per ride fee-for-service basis. The brokers subcontract with providers on a per ride fee-for-service basis who provide non-emergency transportation services.

PENNSYLVANIA
Family Care Network

CONTACT INFORMATION

State Medicaid Contact:
Sherry Gritman
Pennsylvania Department of Welfare
(717) 772-6112

State Website Address:
www.dpw.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 14, 1993

Implementation Date:
February 01, 1994

Waiver Expiration Date:
October 26, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-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, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Psychiatrists
-Other Specialists Approved on a Case-by-Case Basis
-Specialist Who Meets Special Needs of Client

Enrollment

PENNSYLVANIA
Family Care Network

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Section 1931 (AFDC/TANF) Children and Related

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Restricted Beneficiaries
-State Blind Pension Recipients

Lock-In Provision:
No lock-in

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

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

Family Care Network

ADDITIONAL INFORMATION

Enrollment focuses on Medicaid recipients under age 21. There is a monthly patient fee of $3.00.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

Use of Collected Data:
-Contract Standard Compliance
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
-State-developed Survey

Performance Measures

PENNSYLVANIA
Family Care Network

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Performance Measures (see below for details)
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Average distance to primary care case manager None

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
None

Non-Clinical Topics
-Availability of language interpretation services

PENNSYLVANIA
HealthChoices

CONTACT INFORMATION

State Medicaid Contact:
Mike Jacobs
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)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Benova

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 18, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30) Upper Payment Limit

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Emergency Ambulance Transportation, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility for First 30 Days, Vision, X-Ray

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

PENNSYLVANIA
HealthChoices

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-State Only Categorically and Medically Needy

Subpopulations Excluded from Otherwise Included Populations:
-State Blind Pension Recipients
-Monthly Spend Downs
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Mental Health (MH) PHP - Full Capitation

Service Delivery

Included Services:
Case Management, EPSDT, Inpatient Mental Health Services, Inpatient Substance Abuse, Laboratory, Mental Health Outpatient, Outpatient Substance Abuse, Physician

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-No PCPs are designated

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-State Only Categorically and Medically Needy

Subpopulations Excluded from Otherwise Included Populations:
-State Blind Pension Recipients
-Monthly Spend Downs
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

PENNSYLVANIA
HealthChoices

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

AmeriChoice of Pennsylvania
County of Allegheny - Community Care Behavioral
County of Armstrong - Value Behavioral Health of PA
County of Beaver - Value Behavioral Health of PA
County of Bucks - Magellan Behavioral Health
County of Butler - Value Behavioral Health of PA
County of Chester - Magellan Behavioral Health
County of Delaware - Magellan Behavioral Health
County of Fayette - Value Behavioral Health of PA
County of Indiana - Value Behavioral Health of PA
County of Lawrence - Value Behavioral Health of PA
County of Montgomery - Magellan Choice Behavioral
County of Philadelphia - Community Behavioral
County of Washington - Value Behavioral Health of PA
County of Westmoreland - Value Behavioral Health of PA
Gateway Health Plan, Inc.
Health Partners of Philadelphia
HRM HealthPlans/OakTree Health Plan
Keystone Mercy Health Plan
Three Rivers Health Plans, Inc. / MedPLUS
UPMC Health Plan, Inc. / Best Health Care of Western PA
Value Behavioral Health of PA (Greene County)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

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
  2.0H adult and children
-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/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

PENNSYLVANIA
HealthChoices

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, definitons, 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)
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes 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
-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

Health Status/Outcomes Quality
-Patient satisfaction with care

PENNSYLVANIA
HealthChoices

Access/Availability of Care
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-All use of services in HEDIS measure
-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
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-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/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-Multiple, but not all, MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency. (For instance: regional projects)

Clinical Topics
None

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-IPRO
-KeyPro

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-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

PENNSYLVANIA
Lancaster Community Health Plan

CONTACT INFORMATION

State Medicaid Contact:
Sherry Gritman
Pennsylvania Department of Welfare
(717)772-6112

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)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 10, 1994

Implementation Date:
May 01, 1995

Waiver Expiration Date:
April 18, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-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, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

PENNSYLVANIA
Lancaster Community Health Plan

-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-State Only Categorically and Medically Needy

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Restricted Beneficiaries
-State Blind Pension Recipients

Lock-In Provision:
No lock-in

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

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
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Lancaster Community Health Plan

ADDITIONAL INFORMATION

PCCM program sponsors by consortium of hospitals and State Medical Society.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (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

Performance Measures

PENNSYLVANIA
Lancaster Community Health Plan

Process Quality
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management
-Frequency of on-going prenatal care
-Performance Measures (see below for details) -Initiation of prenatal care
-Pregnancy Prevention

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
-Number of primary care case manager visits per beneficiary

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
None

Non-Clinical Topics
-Availability of language interpretation services
-Children and adults access to dental care

PENNSYLVANIA
Voluntary HMO Contracts

CONTACT INFORMATION

State Medicaid Contact:
Mike Jacobs
Pennsylvania Department of Welfare
(717) 772-6300

State Website Address:
http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

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, 1972

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) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Emergency Ambulance Transportation, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility for First 30 Days, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Populations Mandatorily Enrolled:
None

PENNSYLVANIA
Voluntary HMO Contracts

Subpopulations Excluded from Otherwise Included Populations:
-State Blind Pension Recipients
-Monthly Spend Downs
-Reside in Nursing Facility or ICF/MR
-Special Needs Children

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-State Only Categorically Needy
-State Only Medically Needy
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups
-Asks advocacy groups 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
-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 VOL
Gateway Health Plan, Inc. -VOL
HRM/ HealthMATE - VOL
Three Rivers Health Plans, Inc./MedPlus - VOL
UPMC Health Plan, Inc./Best Health Care - VOL

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

PENNSYLVANIA
Voluntary HMO Contracts

Consumer Self-Report Data
-CAHPS
  2.0H Adult and Children
-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/PHPs 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
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes 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
-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

Health Status/Outcomes Quality
-Patient satisfaction with care

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
-All use of services - Hedis measure
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per benificiary
-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
-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/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-Multiple, but not all, MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency. (For instance: regional projects)

Clinical Topics
None

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-IPRO
-KeyPro

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

PUERTO RICO
Puerto Rico Health Care Reform

CONTACT INFORMATION

State Medicaid Contact:
Orlando Gonzalez
Puerto Rico Health Insurance Administration
(787)725-9427

State Website Address:
None

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
Voluntary - No Authority

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:
February 01, 1994

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) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

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

Populations Mandatorily Enrolled:
None

PUERTO RICO

-Foster Care Children
-TITLE XXI SCHIP
-Individual/families up to 200% of the Puerto Rico poverty line. Police

Puerto Rico Health Care Reform

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

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

Humana Health Plans of Puerto Rico, Inc.
MCS Health Management Options, Inc.
La Cruz Azul de Puerto Rico
Triple-S, Inc.

ADDITIONAL INFORMATION

The Puerto Rico Health Insurance Administration (PRHIA) is a public corporation of the government of Puerto Rico established under Act number 72 of September 7, 1993. PRHIA main duty is to obtain health insurance coverage for the medically indigent. Transportation services only include emergency ambulance services. Vision and hearing services only include physician services and other ancillary services. It does not include vision or hearing equipment.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-On-Site Reviews

Use of Collected Data
-Program Evaluation

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

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Established guidelines for frequency of encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing

PUERTO RICO
Puerto Rico Health Care Reform

Collection: Standardized Forms
None

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

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Type of Service
-Diagnosis Codes
-Procedure Codes

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-QIPRO

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Validation of client level data, such as claims and encounters

RHODE ISLAND
Rite Care

CONTACT INFORMATION

State Medicaid Contact:
Sharon Penkala
Center for Child & Family Health
(401) 462-2187

State Website Address:
http://www.state.ri.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
November 01, 1993

Implementation Date:
August 01, 1994

Waiver Expiration Date:
July 31, 2002

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(A)(ii)(I)(II)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(E)
-1902(a)(14)
-1902(a)(17)(b)
-1902(a)(23) Freedom of Choice
-1902(a)(34)

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(1)(A)
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Eligibility Expansion, Family Planning, IMD

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full 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 Abuse, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

RHODE ISLAND
Rite Care

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-Participate in HCBS Waiver
-Medicare Dual Eligible
-American Indian/Alaskan Native

Lock-In Provision:
12 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coordinated Health Partners
Neighborhood Health Plan of RI
United HealthCare of NE

ADDITIONAL INFORMATION

Effective May 1, 1997, eligibility was expanded to include children in families with income up to 250% federal poverty level to age 18. Program has a one month open enrollment period every 12 months. Enrollees are "locked in" from the date of enrollment. As of 7/1/99, 18 year olds are eligible regardless of school status. Also, as of 11/1/98, parents of eligible children may be found eligible at family incomes up to 185% FPL under the States implementation of Section 1931. The Rhode Island SCHIP program operates as a part of Rite Care.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

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
-Consumer Advisory Committee
-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 modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

RHODE ISLAND
Rite Care

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, definitons, 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 "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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Monitoring submision processes from providers to health plans to assure complete and timely submissions
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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
-Cervical cancer screening rate
-Check-ups after delivery
-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
-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

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

RHODE ISLAND
Rite Care

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Complaint Resolution Statistics
-Patient/Member Satisfaction with Access to Care
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA 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
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SA

Process Quality
-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 Status/Outcomes Quality
-Board Certification
-Languages Spoken (other than English)

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

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

RHODE ISLAND
Rite Care

Standards/Accreditation

MCO/PHP Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Birch & Davis Health Management Corp.

EQRO Organization
-PRO-like Entity

EQRO 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
-Review of MCO compliance with structural and operational standards established by the State
-Validation of client level data, such as claims and encounters
-Validation of performance measures

SOUTH CAROLINA
Health Maintenance Organization (HMO)

CONTACT INFORMATION

State Medicaid Contact:
Linda E. Price
Division of Family Services
(803) 898-2565

State Website Address:
http://www.dhhs.state.sc.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

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:
December 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

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

SOUTH CAROLINA
Health Maintenance Organization (HMO)

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Age 65 Or Older
-Hospice Recipients
-Enrolled In An HMO Through Third Party Coverage

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Blind/Disabled Children and Related Populations

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT identify members of these groups -Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Select Health of South Carolina, Incorporated

ADDITIONAL INFORMATION

The State does not require the MCO to have accreditation for deeming. However, Select Health the MCO that State is contracted with has NCQA accreditation. Program provides ambulatory transportation only.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Performance Improvements 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
-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/PHPs 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

SOUTH CAROLINA
Health Maintenance Organization (HMO)

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-Established requirements for data validation
-Established standards to ensure 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
-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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 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
-Drug Quantity Units not greater than zero
-Invalid Drug Unit Type
-Prescribing Provider Number Not on File
-Submitting Provider Not on File

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Asthma care
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates

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

SOUTH CAROLINA
Health Maintenance Organization (HMO)

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-State minimum reserve requirements

Health Plan/ Provider Characteristics
-Board Certification
-Provider turnover

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

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Carolina Medical Review

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Calculation of performance measures
-Conduct performance improvement projects
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

SOUTH CAROLINA
High Risk Channeling Project (HRCP)

CONTACT INFORMATION

State Medicaid Contact:
Leslie Martins, RN
Department of Health and Human Services
803-898-2565

State Website Address:
http://www.dhhs.state.sc.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 1986

Implementation Date:
April 01, 1986

Waiver Expiration Date:
August 11, 2001

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medicaid Fee-For-Service Program - Fee-for-Service

Service Delivery

Included Services:
Ancillary Services based on Individual Circumstances, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Hospice, IE Social Work, Immunization, Inpatient Hospital, Laboratory, Nutrition, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

SOUTH CAROLINA
High Risk Channeling Project (HRCP)

-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-All high-risk pregnant women

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

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Pregnancy/Newborn Risk Assessment

Agencies with which Medicaid Coordinates the Operation of the Program:
-Department of Health and Environmental Control

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

High Risk Channeling Project (HCRP)

ADDITIONAL INFORMATION

This program will be terminated on August 11, 2001. Program does not collect quality data.

SOUTH CAROLINA
Physicians Enhanced Program (PEP)

CONTACT INFORMATION

State Medicaid Contact:
Jonathan Tapley
Department of Physician Services
(803)898-2660

State Website Address:
http://www.dhhs.state.sc.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

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:
May 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 PHP (risk, non-comprehensive) - Partial Capitation

Service Delivery

Included Services:
EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Populations Mandatorily Enrolled:
None

SOUTH CAROLINA
Physicians Enhanced Program (PEP)

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

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
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Physicians Enhanced Program (PEP)

ADDITIONAL INFORMATION

Only physician services are partially capitated for this program. All other services are fee-for-service.

SOUTH DAKOTA
Dental Program

CONTACT INFORMATION

State Medicaid Contact:
Scott Beshara
Office of Medical Services
(605) 773-3495

State Website Address:
http://www.state.sd.us/social/medicaid

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 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

Dental PHP - Full Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

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

SOUTH DAKOTA
Dental Program

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Delta Dental

ADDITIONAL INFORMATION

Most of the Medicaid eligibles are automatically included in the program except beneficiaries with limited benefits.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Focused Studies
-Performance Improvements 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
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/PHPs 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
-State established standards to ensure complete, accurate, timely encounter data submission

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)

MCO 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
-Patient satisfaction with care

SOUTH DAKOTA
Dental Program

Access/Availability of Care
-Availability of Dental Providers

Use of Services/Utilization
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

SOUTH DAKOTA
PRIME

CONTACT INFORMATION

State Medicaid Contact:
Scott Beshara
Office of Medical Services
(605) 773-3495

State Website Address:
http://www.state.sd.us/Social/Medicaid/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
June 30, 1993

Implementation Date:
September 01, 1993

Waiver Expiration Date:
September 28, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-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, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Laboratory, Opthalmology, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Residential Treatment Centers, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

SOUTH DAKOTA
PRIME

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-TITLE XXI SCHIP
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver

Lock-In Provision:
12 month lock-in

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

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Focused Studies
-Performance Improvements Projects (see below for details)
-Provider Data
-Performance Measures (see below for details)

Use of Collected Data:
-Beneficiary Provider Selection
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling

Consumer Self-Report Data
-State-developed Survey

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

SOUTH DAKOTA
PRIME

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 manager to beneficiaries

Use of Services/Utilization
None

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Low birth-weight baby
-Well Child Care/EPSDT

Non-Clinical Topics
None

TENNESSEE
TennCare

CONTACT INFORMATION

State Medicaid Contact:
Mark Reynolds
TennCare
(615)741-0213

State Website Address:
http://www.state.tn.us/tenncare

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
November 18, 1993

Implementation Date:
January 01, 1994

Waiver Expiration Date:
December 31, 2001

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(A)
-1902(a)(13)(C)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(34)
-1902(a)(54)

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(1)(A)
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Eligibility Expansion, IMD

Guaranteed Eligibility:
12 months guaranteed eligibility for children

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Title XIX Medicaid services are covered except Long Term Care and Medicare crossovers., 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:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists or Gynecologists
-Rural Health Centers (RHCs)
-Public Health Departments and Clinics
-Internists
-Federally Qualified Health Centers (FQHCs)
-Nurse Midwives
-Indian Health Service (IHS) Providers

TENNESSEE
TennCare

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Medically Needy
-Uninsured
-Uninsurable

Subpopulations Excluded from Otherwise Included Populations:
-Individuals not qualifying under traditional Medicaid criteria and have access to private insurance

Lock-In Provision:
12 month lock-in

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:
Crisis, Detoxification, Inpatient Mental Health Services, Inpatient Substance Abuse Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Abuse Services, Residential Substance Abuse Treatment Programs

Allowable PCPs:
-Public Health Departments and Clinics
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Pediatricians
-General Practitioners
-Family Practitioners

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Medically needy
-Uninsured
-Uninsurable

Subpopulations Excluded from Otherwise Included Populations:
-Individuals not qualifying under traditional Medicaid criteria and have access to private insurance

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

TENNESSEE
TennCare

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

John Deere/Heritage National Health Plan
Omnicare Health Plan
Premier Behavioral Systems of TN
TN Managed Care Network (ACCESS MED PLUS)
VUMC Care (VHP Community Care)
Memphis Managed Care Corp. (TLC)
Preferred Health Partnership/PHP
Tennessee Behavioral Health, Inc.
Volunteer State Health Plan (Bluecare)
Xantus Health Care

ADDITIONAL INFORMATION

All medically necessary services are provided through the managed care organizations. All mental health and substance abuse services are provided through behavioral health organizations.The State has carved out pharmacy services from the capitation rate from these individuals who are both TennCare enrollees and eligible for Medicare.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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
-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 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 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

-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Established guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Required use of Medicaid Identification Number for beneficiaries

TENNESSEE
TennCare

Collection: Standardized Forms
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-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 (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)
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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 as completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-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
-Lead screening rate
-Pregnancy Prevention
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

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

Access/Availability of Care
-Average distance to 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/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-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
-Re-admission rates of MH/SA

TENNESSEE
TennCare

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
-Provider turnover

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Performance Improvement Projects

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

Clinical Topics
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-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
-Diabetes management
-Emergency Room service utilization
-Hospital Discharge Planning
-Lead toxicity
-Low birth-weight baby
-Newborn screening for heritable diseases
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Presciption drug abuse
-Sickle cell anemia management
-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/PHP Standards
-NCQA(National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-First Health

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys
-Conduct performance improvement projects

TENNESSEE

TennCare

-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting
-Validation of client level data, such as claims and encounters

TEXAS

Lonestar Select I

CONTACT INFORMATION

State Medicaid Contact:

Doug Odle
Texas Health & Human Services Commission
(512)794-5167

State Website Address:

http://www.tdh.texas.gov/hcf/medicaid.htm

PROGRAM DATA

Program Service Area:
Metropolitan Statistical Areas

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 01, 1994

Implementation Date:
September 01, 1994

Waiver Expiration Date:
September 03, 2002

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

The reimbursement arrangement waiver is described as: LoneSTAR Select I is the program that enables the State of Texas to selectively contract with general acute care hospitals including childrens hospitals for inpatient services.Under selective contracting arrangements, providers must bid a discount from their Medicaid reimbursement rates.Then, the State of Texas accepts or negotiates those bids so that qualified providers may serve the Medicaid population for a period of three years.

TEXAS
Lonestar Select II

CONTACT INFORMATION

State Medicaid Contact:
Doug Odle
Texas Health & Human Services Commission
(512) 794-5167

State Website Address:
http://www.tdh.state.tx.us/hcf/medicaid.htm

PROGRAM DATA

Program Service Area:
Metropolitan Statistical Areas

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
March 10, 1995

Implementation Date:
March 10, 1995

Waiver Expiration Date:
March 18, 2002

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

The reimbursement arrangement waiver is described as: Lonestar Select II is a program that enables the State of Texas to selectively contract with freestanding psychiatric facilities for inpatients services to children. Under Lonestar Select II, providers must bid all inclusive per diem rates for Medicaid reimbursement. The State of Texas then either accepts or negotiates those rates so that providers may serve the under 21 Medicaid population for a period of three years.

TEXAS
NorthSTAR

CONTACT INFORMATION

State Medicaid Contact:
Linda Wertz
Health and Human Services Commision
(512) 424-6500

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)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Maximus Incorporated

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
November 01, 1999

Implementation Date:
November 01, 1999

Waiver Expiration Date:
October 31, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:
Assertive Community Treatment Team Services, Crisis, Detoxification, Dual Diagnosis Services, Inpatient Mental Health Services, Inpatient Substance Abuse Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Abuse Services, Residential Substance Abuse Treatment Programs, Targeted Case Management

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

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

TEXAS
NorthSTAR

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Children in Protective Foster Care
-Individuals Residing Outside of the Service Region
-Individuals Eligible as Medically Needy
-Individuals Receiving Inpatient Medicaid IMD Services
-Qualified Medicare Beneficiaries
-Other Insurance

Lock-In Provision:
No lock-in

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:
-Mental Health Agency
-Protective and Regulatory Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ValueOptions

ADDITIONAL INFORMATION

NorthSTAR originally contracted with both ValueOptions and Magellan Behavioral Health Inc. to provide services to NorthSTAR enrollees. Magellan withdrew from the program as of 9/30/00. Although the State attempted to reprocure a replacement for Magellan, no proposals were forthcoming in response to the State Request for Proposals.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (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

TEXAS
NorthSTAR

Consumer Self-Report Data
-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 MCOs/PHPs 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 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, definitons, 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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills

MCO 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
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Number and types of providers

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

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
-Behavioral Health Specialty Network
-Languages Spoken (other than English)
-Provider turnover

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

Beneficiary Characteristics
None

Performance Improvement Projects

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

Clinical Topics
-Attention Deficit Hyperactivity Disorder
-Primary and behavioral health care coordination
-Substance Abuse and Pregnancy

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Texas Health Quality Alliance

EQRO Organization
-PRO-like Entity

EQRO 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
-Receive, analyze and aggregate data across all statewide Medicaid Managed Care Contracts. Will allow comparative analysis of services across service delivery areas.
-Review of MCO compliance with structural and operational standards established by the State

TEXAS
STAR

CONTACT INFORMATION

State Medicaid Contact:
Alison Smith
Texas Health and Human Services Commission
(512)794-6859

State Website Address:
http://www.tdh.texas.gov/hcf/medicaid.htm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

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:
August 31, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-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:
Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Vision, X-Ray

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

TEXAS
STAR

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

TEXAS
STAR

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmCare
Community First
El Paso First Health

HMO Blue - STAR
JPS Star
Parkland Community Health Plan
Superior Health Plan

Americaid - STAR
Community Health Choice
First Care

Humana - STAR
Methodist Care
Seton Health Plan
Texas Health Network - Birch & Davis (STAR)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI 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/PHPs 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
-MCO to submit encounter data to the External Quality Review Organization.
-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, definitons, 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. CMS 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

TEXAS
STAR

Collection: Standardized Forms

-ADA - American Dental Association dental claim form
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-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 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing

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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across

MCO 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

No

Performance Measures

Process Quality

-Adolescent immunization rate
-Check-ups after delivery
-Depression management
-Diabetes management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates

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 mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Average number of visits to MH/SA providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per benificiary
-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/SA facility
-Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of Care

-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

Health Plan/ Provider Characteristics

-Provider turnover

-Net income
-Total revenue

Beneficiary Characteristics

-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

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

Clinical Topics

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Childhood Immunization
-Coordination of primary and behavioral health care
-Deprssion management
-Diabetes management
-Emergency Room service utilization
-Pre-natal care
-Primary and behavioral health care coordination
-Well Child Care/EPSDT

Non-Clinical Topics

-Availability of language interpretation services

Standards/Accreditation

MCO/PHP Standards

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-Texas Health Quality Alliance

EQRO Organization

-PRO-like Entity

EQRO 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
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

TEXAS
STAR

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

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-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
-State-developed Survey

Performance Measures

Process Quality
-Check-ups after delivery
-Depression management
-Diabetes management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with 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 mental health providers to number of beneficiaries
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Number of home health visits per benificiary
-Number of OB/GYN visits per adult female beneficiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary
-Re-admission rates of MH/SA

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

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Childhood Immunization
-Diabetes management
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services
-Children's access to primary care practitioners

TEXAS
STAR Plus

CONTACT INFORMATION

State Medicaid Contact:
Pam Coleman
Texas Department of Human Services
(512)438-5067

State Website Address:
http://www.hhsc.state.tx.us/starplus/starplus.htm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Maximus

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 01, 1998

Implementation Date:
January 01, 1998

Waiver Expiration Date:
August 31, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Vision, X-Ray

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

TEXAS
STAR Plus

Enrollment

Populations Voluntarily Enrolled:
None

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

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Substance Abuse, Physician, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Poverty Level Pregnant Woman

Lock-In Provision:
No lock-in

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-Mental Health Agency
-Public Health Agency

TEXAS
STAR Plus

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Americaid

HMO Blue

Texas Health Network - Birch & Davis

Texas Health Network - Birch & Davis

UTMB - ACCESS+

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-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 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 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, definitons, 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. CMS 1500, UB-92, 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

-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-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 (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)
-Medical record validation

TEXAS
STAR Plus

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Payment
-Provider ID
-Type of Service

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Texas Health Quality Alliance

EQRO Organization
-Private Accreditation Organization

EQRO 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
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-On-Site Reviews

Use of Collected Data:
-Program Evaluation
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data
None

UTAH
Choice Of Health Care Delivery

CONTACT INFORMATION

State Medicaid Contact:
Julie Olson
Utah State Health Department
(801)538-6503

State Website Address:
http://www.state.ut.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 23, 1982

Implementation Date:
July 01, 1982

Waiver Expiration Date:
July 23, 2003

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

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Diabetes self-management, Durable Medical Equipment, Emergency Transportation, 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, Skilled Nursing Facility (less than 30 days), Speech Therapy, Vision, Well-adult care, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

UTAH
Choice Of Health Care Delivery

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Pregnant Women
-Medically Needy Children and Adults

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)
-During Retroactive Eligibility Period
-If Approved as Exempt from Mandatory Enrollment

Lock-In Provision:
1 month lock-in

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
-Use fee-for-service claims to idenfify members who received a carve-out service such as Early Intervention
-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
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

American Family Care (AFC Utah)
IHC Health Plans Inc.
Healthy U
MedChoice (UnitedHealthcare)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation

UTAH
Choice Of Health Care Delivery

-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

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/PHPs 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)
-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-Established standards to ensure 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
-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to aggregate data submitted by plans
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date 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
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care

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

UTAH
Choice Of Health Care Delivery

-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Well-child care visit rates

Access/Availability of Care
-Ratio of PCPs to beneficiaries

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
-Net income
-Net worth
-Total revenue

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

Beneficiary Characteristics
-Beneficiary need for interpreter
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name
-HealthInsight

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

UTAH
Prepaid Mental Health Program

CONTACT INFORMATION

State Medicaid Contact:
Karen Ford
Utah State Health Department
(801)538-6637

State Website Address:
http://www.health.state.ut.us/Medicaid

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
July 01, 1991

Implementation Date:
July 01, 1991

Waiver Expiration Date:
December 26, 2001

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

Mental Health (MH) PHP - Full Capitation

Service Delivery

Included Services:
Crisis, Inpatient Mental Health Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Transportation

Contractor Types:
-CMHC Operated Entity (Public)
-County Operated Entity (Public)
-CMHC - some private, some governmental

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Pregnant Women

UTAH
Prepaid Mental Health Program

-Foster Care (inpatient services only)

Subpopulations Excluded from Otherwise Included Populations:
-Resident of the Utah State Hospital (IMD)
-Resident of the State Developmental Center (DD/MR facility)

Lock-In Provision:
1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Use fee-for-service claims data to identify clients received Early Intervention services
-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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Bear River Mental Health
Central Utah Mental
Davis Mental Health
Four Corners Mental Health
Southwest Mental Health
Valley Mental Health
Wasatch Mental Health
Weber Mental Health

ADDITIONAL INFORMATION

Community Mental Health Centers serve as Prepaid Mental Health Plans to provide/coordinate all mental health services in 8 of Utahs 10 mental health service areas.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements 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
-Program Modification, Expansion, or Renewal
-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 measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

UTAH
Prepaid Mental Health Program
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, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for initial encounter data submission
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Validation: Methods
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Continuity of care
-Symptom reduction

Health Status/Outcomes Quality
-Patient satisfaction with care
-Recidivism
-Symptom reduction

Access/Availability of Care
-Average wait time for intake
-Use of Services/Utilization

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net worth
-State minimum reserve requirements

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on age and gender
-Information on primary languages spoken by beneficiaries

Performance Improvement Projects

UTAH
Prepaid Mental Health Program

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-State of Utah

EQRO Organization
-In-house

EQRO 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 client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

UTAH
Voluntary PCCM/Managed Care Organization Program

CONTACT INFORMATION

State Medicaid Contact:
Julie Olson
Utah State Health Department
801-538-6503

State Website Address:
None

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

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:
October 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, EPSDT, Family Planning, Immunization, Physician

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

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Populations Mandatorily Enrolled:
None

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-During Retroactive Eligibility Period
-Reside in the State Hospital (IMD) or in the State Development Center (DD/MR)

Lock-In Provision:
1 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Diabetes Self-Management, Durable Medical Equipment, Emergency Transportation, EPSDT, Family Planning, Hearing, Hospice, Immunization, Inpatient Hospital, Inpatient Medical Detoxification, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility (less than 30 days), Vision, Well-Adult Care, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Pregnant Women
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Reside in State Hospital (IMD) or in the State Developmental Center (DD/MR)
-During Retroactive Eligibility Period

Lock-In Provision:
1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

UTAH
Voluntary PCCM/Managed Care Organization Program

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
-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

American Family Care (AFC Plus)

Voluntary PCCM/MCO Program

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation

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/PHPs 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)
-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-Established requirements for data validation
-Established standards to ensure 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

-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Established guidelines for initial encounter data submission
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Required 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)

UTAH
Voluntary PCCM/Managed Care Organization Program

-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physician and suppliers
-UB-92 (CMS 1450) – (Uniform Billing) – the CMS approved electronic file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities
-Comparison to aggregate data submitted by plans
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements

-Date 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
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Well-child care visit rates

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

None

Health Plan Stability/ Financial/Cost of

-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
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics

-Beneficiary need for interpreter
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Performance Improvement Projects

Project Requirements

-MCOs/PHPs are required to conduct a project(s) of their own choosing

Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

UTAH
Voluntary PCCM/Managed Care Organization Program

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

EQRO Name
-Peer Review Organization

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines

Use of Collected Data:
-Provider Profiling
-Regulatory Compliance/Federal Reporting

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

VERMONT
Vermont Health Access

CONTACT INFORMATION

State Medicaid Contact:
Ann E. Rugg
Vermont Health Access Plan
(802)241-2766

State Website Address:
http://www.dsw.state.vt.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

Initial Waiver Approval Date:
July 28, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2003

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(A)
-1902(a)(13)(C)
-1902(a)(13)(E)
-1902(a)(14)
-1902(a)(23) Freedom of Choice
-1902(a)(30)(A)
-1902(a)(34)

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Eligibility Expansion, Guaranteed Eligibility, IMD

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

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

Allowable PCPs:
-Pediatricians
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Indian Health Service (IHS) Providers
-Obstetricians/Gynecologists or Gynecologists
-General Practitioners
-Family Practitioners
-Internists

VERMONT
Vermont Health Access

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Spenddown
-Children who participate in Vermont High Tech Home Care Program
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

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
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

PC PLUS

ADDITIONAL INFORMATION

Allowable PCP Specialists: OB/GYNs or GYNs may be approved to be PCPs on a case-by-case basis.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting

VERMONT
Vermont Health Access

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire

Performance Measures

Process Quality
-Asthma care
-Depression management
-Diabetes management

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
None

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
-Coordination of primary and behavioral health care
-Depression management
-Pharmacy management

Non-Clinical Topics
None

VIRGINIA
Medallion

CONTACT INFORMATION

State Medicaid Contact:
Adrienne Fegans
Department of Medical Assistance Services
(804) 225-4714

State Website Address:
http://www.dmas.state.va.us

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Benova, Inc.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 23, 1991

Implementation Date:
March 01, 1992

Waiver Expiration Date:
March 21, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-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, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Transportation, Vision, X-Ray

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

Enrollment

VIRGINIA
Medallion

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Refugees
-Other Insurance
-Spenddown
-Hospice

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Initial interview with new enrollees
-Reviews claims activity of all new enrollees for special indicators.

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medallion

ADDITIONAL INFORMATION

Medallion PCPs are paid $3 per member per month plus fee-for-service claims reimbursement.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-On-Site Reviews
-Provider Data

Use of Collected Data:
-Fraud and Abuse
-Health Services Research

Consumer Self-Report Data
None

VIRGINIA
Medallion II

CONTACT INFORMATION

State Medicaid Contact:
Mary Mitchell
Department of Medical Assistance Services
(804)786-3594

State Website Address:
http://www.dmas.state.va.us

PROGRAM DATA

Program Service Area:
City
County

Initial Waiver Approval Date:
December 18, 1995

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
January 01, 1996

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Waiver Expiration Date:
September 27, 2002

Enrollment Broker:
Benova, Inc.

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-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

MCO (Comprehensive Benefits) - Full 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 Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

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

Enrollment

VIRGINIA
Medallion II

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Poverty Level Pregnant Women
-Hospice

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Initial interview with new enrollees
-Review claims activity of all new enrollees for special indicators.

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthkeepers Plus - Inc.
Healthkeepers Plus - Peninsula
Healthkeepers Plus - Priority
Sentara Family Care
Southern Health Services
VA Premier Health Plan

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-Fraud and Abuse
-Monitor Quality Improvement
-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 DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the

VIRGINIA
Medallion II

HEDIS measures listed for Medicaid in the future

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
-Data submission requirements including documentation describing set of encounter data elements, definitons, 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. CMS 1500, UB-92, 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
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-92 (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)
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Delmarva Foundation

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Validation of client level data, such as claims and encounters

WASHINGTON
Healthy Options

CONTACT INFORMATION

State Medicaid Contact:
Michael Paulson
Division of Program Support
(360) 725-1641

State Website Address:
http://www.dshs.wa.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 01, 1993

Implementation Date:
October 01, 1993

Waiver Expiration Date:
February 24, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-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:
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants

Enrollment

WASHINGTON
Healthy Options

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Pregnant Women and Optional Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Pregnant Women and Optional Children

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Retroactive Eligibility
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

MCO (Comprehensive Benefits) - Full 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:
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Pregnant Women and Optional Children

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Retroactive Eligibility

Lock-In Provision:
No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna US Healthcare Of Washington

BHP Plus

Columbia United Providers

Community Health Plans of Washington

Group Health

Healthy Options/PCCM

Molina

Northwest Washington Medical Bureau

WASHINGTON
Healthy Options

Premera Blue Cross

ADDITIONAL INFORMATION

Native Americans have the option to enroll in PCCM, MCOs or fee-for service. All Health Options populations must enroll in MCOs. For some counties, enrollment for MCOs is on a voluntary basis.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-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

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/PHPs 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)
-Established requirements for data validation
-Established standards to ensure complete, accurate, timely encounter data submission
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-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. CMS 1500, UB-92, NCPDP, ADA)
-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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)

care facilities

MCO conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Breast Cancer screening rate
-Check-ups after delivery
-Diabetes management
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

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

-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of

-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
-State minimum reserve requirements
-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
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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/EPSDT

WASHINGTON
Healthy Options

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-OMPRO and PROWest

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct performance improvement projects
-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
-Validation of performance measures

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines

Use of Collected Data:
-Program Evaluation

Consumer Self-Report Data
-Promoting Healthy Development

WASHINGTON
Hospital Selective Contracting

CONTACT INFORMATION

State Medicaid Contact:
Dee Hahn
Washington State Medical Assistance Administration
(360) 725-1832

State Website Address:
wws2.wa.gov/dshs/maa

PROGRAM DATA

Program Service Area:
Selective Hospitals

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
March 10, 1988

Implementation Date:
April 01, 1988

Waiver Expiration Date:
December 28, 2002

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

Hospital Selective Contracting - Fee-for-Service

Service Delivery

Included Services:
Inpatient Hospital, Outpatient Hospital

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Pregnant Women and Optional Children

WASHINGTON
Hospital Selective Contracting

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

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

ADDITIONAL INFORMATION

All enrollees are auto-assigned exclusively to selected hospitals.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews

Use of Collected Data:
-Program Evaluation

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
-State-developed Survey

WASHINGTON
The Integrated Mental Health Services

CONTACT INFORMATION

State Medicaid Contact:
Judy Gosney
Mental Health Divison
(360) 902-0827

State Website Address:
http://www.mhdsql.mhd.dshs.wa.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
April 27, 1993

Implementation Date:
July 01, 1993

Waiver Expiration Date:
October 31, 2001

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PHP - Full Capitation

Service Delivery

Included Services:
Case Management, Crisis, EPSDT, Inpatient Mental Health Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Psychologists
-Clinical Social Workers
-Other Specialists Approved on a Case-by-Case Basis
-Indian Health Service Providers
-Physician Assistants
-Psychiatrists
-Nurse Practitioners

Contractor Types:
-Regional Authority Operated Entity (Public)

Enrollment

WASHINGTON
The Integrated Mental Health Services

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Reside in Nursing Facility or ICR/MR
-Other Insurance

Subpopulations Excluded from Otherwise Included Populations:
-American Indians/Alaska Native can at their option disenroll
-Medicare Dual Eligible
-Residents of State-owned institutions
-Eligibles for Tribal Health services who elect not to

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

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 enrollment forms to identify members of these groups

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Chelan/Douglas Regional Support Network

Clark County Regional Support Network

Grays Harbor Regional Support Network

Greater Columbia Regional Support Network

King County Regional Support Network

North Central Washington Regional Support Network

North Sound Regional Support Network

Northeast Washington Regional Support Network

Pierce County Regional Support Network

Southwest Regional Support Network

Spokane County Regional Support Network

The Peninsula Regional Support Network

WASHINGTON
The Integrated Mental Health Services

Thurston/Mason Regional Support Network | Timberland Regional Support Network

ADDITIONAL INFORMATION

Due to the nature of the waiver which is for a limited segment of services, the program does designate a primary care provider. Individuals choose their own providers. Pregnant women in the Basic Health program (state funded program) are excluded from the Mental Health program.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Average distance to 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/SA providers per beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Standards/Accreditation

MCO/PHP Standards
-16 state pilot indicator project
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation
None

WASHINGTON
The Integrated Mental Health Services

-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Name
-Does not Apply

EQRO Organization
-State Mental Health Authority

EQRO Activities
-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

WEST VIRGINIA
Mountain Health Trust

CONTACT INFORMATION

State Medicaid Contact:
Randy Myers
Office of Managed Care, Bureau for Medical Service
(304) 558-5974

State Website Address:
http://www.wvdhhr.org

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
Automated Health
Systems, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 29, 1996

Implementation Date:
September 01, 1996

Waiver Expiration Date:
December 22, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

WEST VIRGINIA
Mountain Health Trust

-Aged and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medically Needed

Lock-In Provision:
No lock-in

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carelink Health Plan

Health Plan of the Upper Ohio Valley

ADDITIONAL INFORMATION

In counties with only one MCO, clients can choose to remain in the PCCM program. In counties with only one MCO, clients can choose to remain in the PCCM program.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

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
-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 use/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

WEST VIRGINIA
Mountain Health Trust

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
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Established guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)

Collection: Standardized Forms
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO 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
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care
-Lead screening rate
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

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

WEST VIRGINIA
Mountain Health Trust

Access/Availability of Care
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Days/1000 and average length of stay for IP administration, ER visits, Ambulatory surgery, maternity care, newborn care
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per benificiary
-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.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue
-Total Third Party Liability Collections made by source

Health Plan/ Provider Characteristics
-Board Certification
-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/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs 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 care for persons with physical disabilities
-Post-natal Care

Non-Clinical Topics
None

WEST VIRGINIA
Mountain Health Trust
Standards/Accreditation

MCO/PHP 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
-NCQA (National Committee for Quality Assurance) Standards
-QARI (Quality Assurance Reform Initiative) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Delmarva

EQRO Organization
-Peer Review Organization (PRO)

EQRO 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
-Review of MCO compliance with structural and operational standards established by the State
-Sentinel Event Review
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

WEST VIRGINIA
Physician Assured Access System

CONTACT INFORMATION

State Medicaid Contact:
Ellen Cannon
Office of Managed Care, Bureau for Medical Service
(304) 558-1707

State Website Address:
http://www.wvdhhr.org

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Automated Health
Systems, Inc.

For All Areas Phased-In:
Yes

Initial Waiver Approval Date:
August 29, 1991

Implementation Date:
June 01, 1992

Waiver Expiration Date:
January 27, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
12 months guaranteed eligibility for children

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Most West Virginia Medicaid Services, Outpatient Hospital, Physician, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

WEST VIRGINIA
Physician Assured Access System

-Foster Care Children
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Other Insurance
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver

Lock-In Provision:
1 month lock-in

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:
-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Physician Assured Access System

ADDITIONAL INFORMATION

PAAS program operates solely in counties not covered by Mountain Health Trust program and Options programs. The state granted one year eligibility for any child under the age of nineteen who is eligible for Medicaid beginning June 1, 2001. The State granted one year eligibility for any child , under the age of nineteen, who is eligible for Medicaid, beginning June 1, 2001.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

Use of Collected Data:
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
-Consumer/Beneficiary Focus Groups
-Contractor developed survey

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds

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

WEST VIRGINIA
Physician Assured Access System

-Initiation of prenatal care
-Lead screening rate
-Well-child care visit rates

Access/Availability of Care
-Average distance to primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Emergency room visits
-Inpatient admissions

Provider Characteristics
None

Beneficiary Characteristics
None

WISCONSIN
BadgerCare [SCHIP]

CONTACT INFORMATION

State Medicaid Contact:
Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:
http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health
Systems,

For All Areas Phased-In:
Yes

Initial Waiver Approval Date:
April 01, 1999

Implementation Date:
July 01, 1999

Waiver Expiration Date:
March 31, 2004

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1916(a) Cost Sharing
-Eligibility Expansion

Guaranteed Eligibility:
12 months guaranteed eligibility for children

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

Allowable PCPs:
-General Practitioners
-Pediatricians
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-TITLE XXI SCHIP
-Custodial Parents (And Their Spouses) Of Children Eligible

WISCONSIN
BadgerCare [SCHIP]

Through Title XXI SCHIP (BadgerCare)

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Residents residing in FFS counties
-Migrant workers

Lock-In Provision:
12 month lock-in

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 Incorporated
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-County Departments for Mental Health, Substance Abuse, Social Services, Etc.
-Maternal and Child Health Agency
members of these groups -Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Atrium Health Plan -- BadgerCare SCHIP

Dean Health Plan -- BadgerCare SCHIP

Greater La Crosse Health Plan -- BadgerCare SCHIP

Group Health Cooperative Of Eau Claire -- BadgerCare SCHIP

Group Health Cooperative Of South Central WI -- BadgerCare SCHIP

Managed Health Services -- BadgerCare SCHIP

Mercy Care Health Plan -- BadgerCare SCHIP

Network Health Plan -- BadgerCare SCHIP

Security Health Plan -- BadgerCare SCHIP

Touchpoint Health Plan -- BadgerCare SCHIP

UnitedHealthCare of WI -- BadgerCare SCHIP

Unity Health Plan -- BadgerCare SCHIP

Valley Health Plan -- BadgerCare SCHIP

ADDITIONAL INFORMATION

WISCONSIN
BadgerCare [SCHIP]

BadgerCare is the Wisconsin Title XXI SCHIP managed care program. It has the same benefit package and contracts with the same HMO plans as the Wisconsin Medicaid HMO Program. BadgerCare enrolls children and parents with specific requirements for income level, lack of other insurance coverage, and other factors. On 07/01/1999, BadgerCare began operating under an 1115 demonstration waiver initially approved on 04/01/1999 and ammended on 01/18/2001.

BadgerCare also received waiver authority on 04/01/1999, and as later ammended on 01/18/2001, regarding Title XIX and Title XXI requirements as follows:
* T-19= Retroactive Eligibility, waiving Section 1902(a)(34)
* T-19= Costs Not Otherwise Matchable for three Demonstration Populations, under Section 1115(a)(2) authority
* T-19= Freedom of Choice, waiving Section 1902(a)(23)
* T-19= Comparability of Services, waiving Section 1902(a)(10)(B)
* T-19= Eligibility, waiving Sections 1902(a)(17), 1902(a)(34), and 1931(b)
* T-19= Cost Sharing Limitations, waiving Section 1916(a)
* T-21= Costs Not Otherwise Matchable for Demonstration Population # 3, under Section 1115(a)(2) authority
* T-21= General Requirements, Eligibility and Outreach, waiving Section 2102
* T-21= Restrictions on Coverage and Eligibility to Targeted Low Income Children, waiving Sections 2103 and 2110
* T-21= Federal Matching Payment and Family Coverage Limits, waiving Section 2105
* T-21= Annual Reporting Requirements, waiving Section 2108

Other special circumstances: Enrollment varies by county; Summary and detailed claims data required; HMOs required to coordinate with WIC, County non-MA programs, and other local agencies and programs.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements 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
-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 uses/requires MCOs/PHPs 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/PHPs 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
None

WISCONSIN
BadgerCare [SCHIP]

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)
-Per member per month analysis and comparisons across

MCO 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
-Asthma care
-Dental services
-Diabetes management
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality
-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
-Number of specialist 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.)
-Medical loss ratio

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/PHPs

Performance Improvement Projects

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

Clinical Topics
-Asthma management
-Breast cancer screening (Mammography)

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BadgerCare [SCHIP]

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

-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Coordination of primary and behavioral health care
-Diabetes management
-Emergency Room service utilization
-Hypertension management
-Lead toxicity
-Low birth-weight baby
-Primary and behavioral health care coordination
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-MetaStar

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Calculation of performance measures
-Validation of performance improvement projects
-Validation of performance measures

WISCONSIN
Children Come First (CCF)

CONTACT INFORMATION

State Medicaid Contact:
Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:
http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

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

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:
Crisis, IMD Services, Inpatient Mental Health Services, Inpatient Substance Abuse Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Abuse Services

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

Contractor Types:
-County Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children
-Blind/Disabled Children and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

WISCONSIN
Children Come First (CCF)

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

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

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 Must Have Special Needs To Be Eligible For Enrollment.
-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 Agencies

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. Reallocates previous funding for institutional placement into community based care. 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 & substance abuse carve-out program does not designate a primary care provider for physical health care.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (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
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Encounter Data

WISCONSIN
Children Come First (CCF)

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-Established requirements for data validation
-Established standards to ensure 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
-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Established guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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 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

State conducts general data completeness assessments
Yes

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
440

WISCONSIN
Children Come First (CCF)

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Other Demographic, Clinical, And Service System Characteristics Of Enrollees.

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Care Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-MetaStar

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Quality Of Care Reviews
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

WISCONSIN
Independent Care (I-Care)

CONTACT INFORMATION

State Medicaid Contact:
Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:
http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health
Systems,

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1994

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) - Full Capitation

Service Delivery

Included Services:
All Wisconsin Medicaid Covered Sevices, Coordination With Non-Medicaid Services (Social & Vocational Services, Recreational & Wellness Progr, Skilled Nursing Facility Only Covered Up To 90 Days.

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

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
None

WISCONSIN
Independent Care (I-Care)

Subpopulations Excluded from Otherwise Included Populations:
-Beneficiaries Who After Enrollment Are Placed In A Nursing Home For Longer Than 90 Days.
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Children Under Age 15
-Reside in Nursing Facility or ICF/MR

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

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 Recipients May Enroll
-Uses eligibility data to identify members of these Incorporated 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:
-Local Public Health Agency
-Mental Health Agency
-Milwaukee County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Humana/Wisconsin Health Organization (Voluntary,

ADDITIONAL INFORMATION

Humana/Wisconsin Health Organization (an HMO) and the Milwaukee Center for Independence (a community vocational services agency) are partners in a joint venture agreement to operate Independent Care (I-Care). Program goals are to integrate medical and social services and to improve quality, access, and coordination of medical services. Reallocates resources to better serve disabled recipients. Care coordinators in addition to PCPs. Initially, I-Care was a 3-year research and demonstration grant from CMS. Evaluation was completed in 1998 by an independent firm using interviews, claims data encounter forms, etc.

Optional Chiropractic and Dental Services and Target Case Management are excluded from this program.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement

WISCONSIN
Independent Care (I-Care)

Consumer Self-Report Data
-CAHPS
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups
-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 uses/requires MCOs/PHPs 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/PHPs 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)
-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-Established requirements for data validation
-Established standards to ensure 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
-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Established guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Required 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)
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Diabetes management
-Follow-up after hospitalization for mental illness
-Influenza Vaccination Rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality
-Patient satisfaction with care

WISCONSIN
Independent Care (I-Care)

Access/Availability of Care
-Monitoring Voluntary Disenrollments
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Hospitalization Rate For Ambulatory Sensitive Conditions
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care
None

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

Beneficiary Characteristics
-Beneficiary need for interpreter
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-MetaStar

EQRO Organization
-Peer Review Organization (PRO)

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

WISCONSIN
Medicaid HMO Program

CONTACT INFORMATION

State Medicaid Contact:
Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:
http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health
Systems,

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 31, 1997

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) - Full Capitation

Service Delivery

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

Allowable PCPs:
-General Practitioners
-Pediatricians
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

WISCONSIN
Medicaid HMO Program

-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Residents residing in FFS counties
-Migrant workers

Lock-In Provision:

12 month lock-in

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 enrollment forms to identify members of these Incorporated 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

Atrium Health Plan -- Medicaid HMO
Dean Health Plan -- Medicaid HMO
Greater La Crosse Health Plan -- Medicaid HMO
Group Health Cooperative Of Eau Claire -- Medicaid
Group Health Cooperative Of South Central WI -- Medicaid HMO
Managed Health Services -- Medicaid HMO
Mercy Care Health Plan -- Medicaid HMO
Network Health Plan -- Medicaid HMO
Security Health Plan -- Medicaid HMO
Touchpoint Health Plan -- Medicaid HMO
UnitedHealthCare of WI -- Medicaid HMO
Unity Health Plan -- Medicaid HMO
Valley Health Plan -- Medicaid HMO

ADDITIONAL INFORMATION

The Wisconsin Medicaid HMO program started in 1977 with voluntary enrollment in three urban counties. The program changed to mandatory enrollment in 1984, and expanded into additional counties in 1994 and 1995. The program began to phase in statewide coverage in 1996 and completed the statewide expansion in March 1997. After the 1997 Balanced Budget Act changed the waiver rules, the program authority was converted from a 1915(b) waiver to a 1932(a) state plan managed care option on 04/01/1999.

Other special circumstances: Enrollment varies by county; Summary and detailed claims data required; HMOs required to coordinate with WIC, County non-MA programs, and other local agencies and programs.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman

Use of Collected Data

-Contract Standard Compliance
-Monitor Quality Improvement

WISCONSIN
Medicaid HMO Program

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

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 uses/requires MCOs/PHPs 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/PHPs 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
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)
-Per member per month analysis and comparisons across MCOs/PHPs

MCO 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
-Asthma care
-Dental services
-Diabetes management
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds

Health Status/Outcomes Quality
-Patient satisfaction with care

WISCONSIN
Medicaid HMO Program

-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

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
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio

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/PHPs

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-MetaStar

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Calculation of performance measures
-Validation of performance improvement projects
-Validation of performance measures

WISCONSIN
Wisconsin Partnership Program

CONTACT INFORMATION

State Medicaid Contact:
Steven Landkamer
Office of Strategic Finance, Center for Delivery
(608) 261-7811

State Website Address:
http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1996

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(17)
-1902(a)(23) Freedom of Choice
-1902(a)(34)
-1931(b)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1916(a) Cost Sharing
-HCBS

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Other WI Medicaid Services, Case Management, Durable Medical Equipment, Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Internists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

WISCONSIN
Wisconsin Partnership Program

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Must Meet Nursing Home Level-Of-Care Or Have Substantial Illness Or Disability.
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care For The Elderly - Partnership

Community Health Partnership -- Partnership

Community Living Alliance -- Partnership

Elder Care Of Dane County - Partnership

ADDITIONAL INFORMATION

Wisconsin Partnership Project began operating under a dual Medicaid--Medicare waiver in January 1999. This demonstration project provides comprehensive Medicaid and Medicare services for older adults (ages 65+) and people with physical 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.

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 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.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement

WISCONSIN
Wisconsin Partnership Program

-Performance Measures (see below for details)

Consumer Self-Report Data
-CAHPS
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
-State-developed Survey

Use of HEDIS
-The State DOES NOT use any of the HEDIS measures
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Encounter Data

Collection: Requirements
-CMS established requirements

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)

MCO 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

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

WISCONSIN
Wisconsin Partnership Program

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-MetaStar

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Calculation of performance measures
-Validation of performance improvement projects
-Validation of performance measures

WISCONSIN
Wraparound Milwaukee

CONTACT INFORMATION

State Medicaid Contact:
Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:
http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
1915(b)(4)

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

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:
Crisis, IMD Services, Inpatient Mental Health Services, Inpatient Substance Abuse Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Abuse Services

Contractor Types:
-County Operated Entity (Public)

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

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children
-Blind/Disabled Children and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

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Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

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

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 Must Have Special Needs To Be Eligible For Enrollment.
-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 Agencies

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. Reallocates previous funding for institutional placement into community based care. 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 & substance abuse carve-out program does not designate a primary care provider for physical health care.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (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
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Encounter Data

WISCONSIN
Wraparound Milwaukee

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Established incentives/sanctions to insure complete, accurate, timely encounter data submission
-Established requirements for data validation
-Established standards to ensure 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
-Established deadlines for regular/ongoing encounter data submission(s)
-Established guidelines for frequency of encounter data submission
-Established guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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 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
-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
None

Health Plan/ Provider Characteristics
-Internal Quality Assurance Review Of Sub-Contracted Providers

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Wraparound Milwaukee

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Other Demographic, Clinical, And Service System Characteristics Of Enrollees.

Performance Improvement Projects

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

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Care Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-MetaStar

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct performance improvement projects
-Quality Of Care Reviews
-Validation of performance improvement projects

WYOMING
Hospital Inpatient Selective Contracting

CONTACT INFORMATION

State Medicaid Contact:
Iris Oleske
Office of Medicaid
(307) 777-7848

State Website Address:
None

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 01, 1994

Implementation Date:
July 01, 1994

Waiver Expiration Date:
June 30, 2001

Sections of Title XIX Waived:
-1902(a)(13)(A)
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

The reimbursement arrangement waiver is described as: This waiver provides a reimbursement mechanism through selective contracting for NICU Level III, transplants for children <21, and inpatient psychiatric services for children <21. The waiver addresses EPSDT requirements. Wyoming Medicaid did not renew the FOC waiver upon expiration 5/31/2001, however, the selective contracts were valid through the contract period 6/30/2001. Selective contract process ended effective 7/1/2001.

National Summary of State Medicaid Managed Care Programs Glossary as of June 30, 2001

Section: Program Data--Operating Authority Terms

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.
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 PHPs which act as PCCMs.
PHP	***Prepaid Health Plan*** is a prepaid managed care entity that provides less than comprehensive services on an at risk basis or one that provides any benefit package on a non-risk basis. Comprehensive services are defined in 42 CFR 434.21(B). There are several types of PHPs that States use to deliver a range of services. For example, a Mental Health (MH) PHP is a managed care entity that provides only mental health services. This category does not include those PHPs which contract as primary care case management.
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.

National Summary of State Medicaid Managed Care Programs Glossary as of June 30, 2001

Section: Service Delivery--Reimbursement Arrangement Terms

Fee-For-Service	The plan or Primary Care Case Manager is paid for providing services to enrollees solely through fee-for-service payments, plus in most cases, a case management fee.
Full Capitation	The plan or Primary Care Case Manager is paid for providing services to enrollees solely through capitation.
Partial Capitation	The plan or Primary Care Case Manager is paid for providing services to enrollees through a combination of capitation and fee-for-service reimbursements.

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 or PHP. 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 or PHP 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".

National Summary of State Medicaid Managed Care Programs
Glossary as of June 30, 2001

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/PHP. 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/PHP administrative data such as enrollment files and encounter /claims data. State staff, EQRO staff, MCO/PHP staff or more than one of these entities may perform such studies at the discretion of the State.
MCO/PHP Standards	These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each MCO/PHP must have in order to participate in the Medicaid program.
Monitoring of MCO/PHP 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/PHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PHP, and the provider (as appropriate) to resolve individual enrollee problems.
On-Site Reviews	Reviews performed on-site at the MCO/PHP 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/PHPs 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/PHP.
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.