National Summary of State Medicaid Managed Care Programs as of June 30, 2004

Table of Contents

1915(b) PROGRAMS

National Summary of State Medicaid Managed Care Programs as of June 30, 2004

Table of Contents

National Summary of State Medicaid Managed Care Programs as of June 30, 2004

Table of Contents

National Summary of State Medicaid Managed Care Programs as of June 30, 2004

Table of Contents

1115 PROGRAMS

National Summary of State Medicaid Managed Care Programs as of June 30, 2004

Table of Contents

1932(a) PROGRAMS

National Summary of State Medicaid Managed Care Programs as of June 30, 2004

Table of Contents

National Summary of State Medicaid Managed Care Programs as of June 30, 2004

Table of Contents

National Summary of State Medicaid Managed Care Programs as of June 30, 2004

Table of Contents

National Summary of State Medicaid Managed Care Programs as of June 30, 2004

Table of Contents

ARKANSAS
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:
Roy Jeffus
Medicaid Agency
(501)682-8740

State Website Address:
http://medicaid.state.ar.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:
December 04, 1997

Implementation Date:
March 01, 1998

Waiver Expiration Date:
November 21, 2005

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - 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
-TITLE XXI SCHIP

ARKANSAS
Non-Emergency Transportation

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligible
-Special Low Income Beneficiaries
-ARKids First-B
-Women Health (FP)
-Eligibility only Retroactive
-Tuberculosis
-Special Needs Children (State defined)

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

The State contracts with transportation brokers on a capitation basis.

QUALITY ACTIVITIES FOR PAHP

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

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

Consumer Self-Report Data
-State-developed Survey

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

Encounter Data

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

Collections: Submission Specifications
None

data submission

Collection: Standardized Forms
None

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

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

State conducts generate data completeness assessments
Yes

Standards/Accreditation

PAHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

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:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 30, 1996

Implementation Date:
November 01, 1996

Waiver Expiration Date:
December 17, 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:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT(25 counties), Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Physician, Podiatry, X-Ray

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

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

-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-1115 Demonstration Waiver (AR Kids B)

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

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
None

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

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:
-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 referral.

QUALITY ACTIVITIES FOR PCCM

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

Use of Collected Data:
-Beneficiary Provider Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Track Health Service provision

Consumer Self-Report Data
-Satisfaction Survey

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Number of children with diagnosis of rubella(measles)/1,000 children

ARKANSAS
Primary Care Physician

-Percentage of low birth weight infants

Access/Availability of Care
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Inpatient admissions/1,000 beneficiaries

Provider Characteristics
None

Beneficiary Characteristics
None

CALIFORNIA
Caloptima

CONTACT INFORMATION

State Medicaid Contact:
Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

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:
October 01, 1995

Implementation Date:
October 01, 1995

Waiver Expiration Date:
July 10, 2005

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

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
-Foster Care Children

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

Lock-In Provision:
No lock-in

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

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

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

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-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
Child with Special Needs Questionnaire

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

CALIFORNIA
Caloptima

of the HEDIS measures listed for Medicaid that it collects

Encounter Data

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

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

Collection: Standardized Forms
None

Validation: Methods
None

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

State conducts general data completeness assessments
No

Performance Measures

Process Quality
None

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

Clinical Topics
-Adolescent Health statewide collabortive
-Hospital Quality small group collaborative
-Post-natal Care

Non-Clinical Topics
-Adolescent Health
-Initial Health Assessment

CALIFORNIA
Caloptima

Standards/Accreditation

MCO Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Delmarva Foundation

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

CALIFORNIA
Central Coast Alliance for Health

CONTACT INFORMATION

State Medicaid Contact:
Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

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:
July 10, 2005

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:
None

SERVICE DELIVERY

HIO - Capitation

Service Delivery

Included Services:
Case Management, Developmental, 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:
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Pediatricians
-General Practitioners

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
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

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 MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-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
Central Coast Alliance for Health

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

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

Encounter Data

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

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

Collection: Standardized Forms
None

Validation: Methods
None

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

State conducts general data completeness assessments
No

Performance Measures

Process Quality
None

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

Clinical Topics
-Adolescent Health Statewide Collaborative
-Asthma
-Diabetes management
-Increasing Access to Perinatal Services

CALIFORNIA
Central Coast Alliance for Health

Non-Clinical Topics
-Adolescent Health

Standards/Accreditation

MCO Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Delmarva Foundation

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

CALIFORNIA
Health Plan of San Mateo

CONTACT INFORMATION

State Medicaid Contact:
Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

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:
September 30, 2006

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 - 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, Pharmacy, Physician, Transportation, Vision, X-Ray

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

CALIFORNIA
Health Plan of San Mateo

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Reside in ICF/MR
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligiblity and claims data to identify members of these groups,
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

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 MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of MCO 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
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

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

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

CALIFORNIA
Health Plan of San Mateo

Encounter Data

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

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

Collection: Standardized Forms
None

Validation: Methods
None

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

State conducts general data completeness assessments
No

Performance Measures

Process Quality
None

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

Clinical Topics
-Adolescent Health statewide collaborative
-Breast/Cervical CA Screening
-Diabetes management small group collaborative

Non-Clinical Topics
-Adolescent Health
-Initial Health Assessments

CALIFORNIA
Health Plan of San Mateo

Standards/Accreditation

MCO Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Delmarva Foundation

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

CALIFORNIA
Hudman

CONTACT INFORMATION

State Medicaid Contact:
Benjamin C. Thomas
Medi-Cal Operations Division
(916) 552-9115

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:
October 14, 2005

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

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
Medi-Cal Mental Health Care Field Test (San Mateo County)

CONTACT INFORMATION

State Medicaid Contact:
Rita McCabe-Hax
Mental Health
(916) 654-5691

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

PROGRAM DATA

Program Service Area:
San Mateo 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:
February 13, 1995

Implementation Date:
April 01, 1995

Waiver Expiration Date:
July 25, 2005

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

Mental health plan - Fee-for-Service

Service Delivery

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

Allowable PCPs:
-Not Applicable

Contractor Types:
-County Operated Entity (Public)

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
-State-Only Medi-Cal and Emergency Services Only populations

CALIFORNIA
Medi-Cal Mental Health Care Field Test (San Mateo County)

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

Subpopulations Excluded from Otherwise Included Populations:
-Not Applicable

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Individuals with Special Health Care Needs
Performance Outcome Surveys

Agencies with which Medicaid Coordinates the Operation of the Program:
-Department of Mental Health

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Not Applicable

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

CALIFORNIA
Medi-Cal Specialty Mental Health Services Consolidation

CONTACT INFORMATION

State Medicaid Contact:
Rita McCabe-Hax
Mental Health
(916) 654-5691

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

PROGRAM DATA

Program Service Area:
Statewide, except San Mateo an

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:
March 15, 1995

Implementation Date:
March 15, 1995

Waiver Expiration Date:
April 27, 2005

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental health plans - Fee-for-Service

Service Delivery

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

Contractor Types:
None

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

CALIFORNIA
Medi-Cal Specialty Mental Health Services Consolidation

Subpopulations Excluded from Otherwise Included Populations:
-Not Applicable

-State-Only Medi-Cal and Emergency Services only populations

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Individuals with special health care needs by performance outcome surveys.

Agencies with which Medicaid Coordinates the Operation of the Program:
-Department of Mental Health

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Not Applicable

ADDITIONAL INFORMATION

Plan not at risk for federal financial participation. 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

CALIFORNIA
Partnership Health Plan of California

CONTACT INFORMATION

State Medicaid Contact:
Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

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, 2005

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:
None

SERVICE DELIVERY

HIO - 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 (Solano Co. only), Laboratory, Long Term Care - Counseling and Social Support, Outpatient Hospital, Outpatient Mental Health (Solano County only), Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

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

Enrollment

CALIFORNIA
Partnership Health Plan of California

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medi-Cal eligibles with a share of cost and Medically Needy
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

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

Lock-In Provision:
No lock-in

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

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

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. In Yolo County, a small Health Plan, Sutter Senoir Care, that serves a limited number of zip codes coexist in a county with a County Organized Health System.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-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
Partnership Health Plan of California

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

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

Encounter Data

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

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

Collection: Standardized Forms
None

Validation: Methods
None

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

State conducts general data completeness assessments
No

Performance Measures

Process Quality
None

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

Clinical Topics
-Adolescent Health statewide collorative
-Asthma Small group collaborative
-Breast Cancer Screening
-Child IZ Small group collaborative
-Diabetes Small group collaborative

CALIFORNIA
Partnership Health Plan of California

Non-Clinical Topics
-Adolescent Health

Standards/Accreditation

MCO Standards
None

Accreditation Required for Particpation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Delmarva Foundation

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

CALIFORNIA
Sacramento Geographic Managed Care

CONTACT INFORMATION

State Medicaid Contact:
Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

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, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs
-1902(a)(5)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

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

Allowable PCPs:
-Obstetricians/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
-Medicare Dual Eligibles

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
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

Dental PAHP - 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
-Medicare Dual Eligibles

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:
-Other Insurance
-Enrolled In Another Medicaid Program
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

CALIFORNIA
Sacramento Geographic Managed Care

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
-Social Services Agency
-Substance Abuse Agency
-Title V

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 MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-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
  Child with Special Needs Questionnaire

Use of HEDIS

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

CALIFORNIA
Sacramento Geographic Managed Care

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

-Guidelines for initial encounter data submission

Validation: Methods
None

Performance Measures

Process Quality
None

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

Clinical Topics
-Asthma
-Breathe w/Ease
-Childhood Immunization
-Dep Pharmacy
-Diabetes
-Hospital Quality
-Motherhood Matters
-Timeliness of Pre-natal and Postpartum Care

Non-Clinical Topics
-Adolescent Health
-Improve CHDP
-Improve Initial Health Assessment

CALIFORNIA
Sacramento Geographic Managed Care

Standards/Accreditation

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

State conducts general data completeness assessments
No

MCO Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Delmarva Foundation

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

CALIFORNIA
San Diego Geographic Managed Care

CONTACT INFORMATION

State Medicaid Contact:
Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

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:
August 12, 2005

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:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

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

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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
-Foster Care Children
-Adoption Assist/Medically indigent-Child
-Foster Care/Medically indigent-Child
-Pregnant/Medically Indigent-Adult
-Medicare Dual Eligibles

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
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

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

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR MCO/HIO

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

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

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

Encounter Data

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

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

Collection: Standardized Forms
None

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

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

State conducts general data completeness assessments
No

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-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

CALIFORNIA
San Diego Geographic Managed Care

Beneficiary Characteristics
None

Performance Improvement Projects

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

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

Non-Clinical Topics
-Adolescent statewide collaborative
-Hospital Quality small group collaborative
-Improving Denial Letter Process

Standards/Accreditation

MCO Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Delmarva Foundation

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

CALIFORNIA
Santa Barbara Health Initiative

CONTACT INFORMATION

State Medicaid Contact:
Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

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:
September 01, 1983

Implementation Date:
September 01, 1983

Waiver Expiration Date:
January 11, 2005

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 - 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 Use Disorders, Laboratory, Outpatient Hospital, Outpatient Substance Use Disorders, Pharmacy, Physician, Rual Health Clinic (RHC) Services, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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:
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

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 Regional Health Authority

ADDITIONAL INFORMATION

Established under State Statute of 1982. All categories of federally eligible Medi-Cal beneficiaries are eligible to participate in this program.

QUALITY ACTIVITIES FOR MCO/HIO

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

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid

CALIFORNIA
Santa Barbara Health Initiative

Child Medicaid AFDC Questionnaire
Child with Special Needs Questionnaire

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

Encounter Data

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

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

Collection: Standardized Forms
None

Validation: Methods
None

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

State conducts general data completeness assessments
No

Performance Measures

Process Quality
None

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

Clinical Topics
-Adolescent Health Statewide
-Asthma small group collabortive
-Diabetes management

CALIFORNIA
Santa Barbara Health Initiative

Non-Clinical Topics
-Adolescent Health

Standards/Accreditation

MCO Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Delmarva Foundation

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

CALIFORNIA
Selective Provider Contracting Program

CONTACT INFORMATION

State Medicaid Contact:
Benjamin C. Thomas
Medi-Cal Operations
(916) 552-9116

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:
September 21, 1982

Implementation Date:
September 21, 1982

Waiver Expiration Date:
December 31, 2004

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

ADDITIONAL INFORMATION

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
Two-Plan Model Program

CONTACT INFORMATION

State Medicaid Contact:
Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

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:
August 12, 2005

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) - Capitation

Service Delivery

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

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

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
-Medicare Dual Eligibles

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
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

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:
-California Childrens Services
-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
LA Care Health Plan
San Francisco Health Plan
Blue Cross of California-TPMP
Health Net-TPMP
Inland Empire Health Plan
Molina Medical Centers-TPMP
Santa Clara Family Health Plan

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR MCO/HIO

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

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

CALIFORNIA
Two-Plan Model Program

-Ombudsman
-On-site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures and use of services
-Regulatory Compliance/Federal Reporting

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

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-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
-Not Applicable

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

State conducts general data completeness assessments
No

Performance Improvement Projects

Project Requirements
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are

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

Two-Plan Model Program

required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

-Diabetes management
-Well Child Care/EPSDT

Non-Clinical Topics
-Adolescent Health
-Improve authorized time for Pharmacy
-Improve Encounter Data - Adolescent Health
-Increasing Specialist reports to PCP
-Initial Health Assessments

Standards/Accreditation

MCO Standards
None

Non-Duplication Based on Accreditation
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-Delmarva Foundation

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

COLORADO
Mental Health Capitation Program

CONTACT INFORMATION

State Medicaid Contact:
Antoinette Taranto
Department of Health Care and Financing
(303) 866-2220

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:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
October 04, 1993

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2005

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Capitation

Service Delivery

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

Contractor Types:
-Behavioral Health MCO (Private)

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

COLORADO
Mental Health Capitation Program

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

Subpopulations Excluded from Otherwise Included Populations:
-Title XXI SCHIP
-Medicare Dual Eligible

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

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

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

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:
-Developmental Disabilities Agency
-Mental Health Agency
-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
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 Assessment and Services Agencies (MHASA)) for referral. The contractor acts as the gatekeeper.

QUALITY ACTIVITIES FOR PIHP

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

COLORADO
Mental Health Capitation Program

Encounter Data

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

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 PIHPs

PIHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-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
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SUD providers 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

Performance Improvement Projects

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

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

COLORADO
Mental Health Capitation Program

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

Standards/Accreditation

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

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Health Services Advisory Group, Inc.

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
None

CONNECTICUT
HUSKY A

CONTACT INFORMATION

State Medicaid Contact:
Ellen Tracy
Department of Social Services
(860) 424-5215

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:
Affiliated Computer Systems

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 20, 1995

Implementation Date:
October 01, 1995

Waiver Expiration Date:
June 30, 2006

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) - 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 Use Disorders, 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
-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
-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

Medicare Dual Eligibles Included:
None

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

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
FirstChoice Health Plan - Preferred One
Community Health Network of Connecticut
HealthNet - Healthy Options

ADDITIONAL INFORMATION

12 month Continuous Eligibility for children under 19 and the 6 month Guaranteed Eligibility for HUSKY Adults was eliminated from Connecticut Department of Social Services policy effective 4/1/2003.

QUALITY ACTIVITIES FOR MCO/HIO

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

CONNECTICUT
HUSKY A

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

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

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

Encounter Data

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

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

Collection: Standardized Forms
None

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

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality
None

-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care

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

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-EPSDT Visit Rates
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility

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

Health Plan/Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

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

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

Non-Clinical Topics
None

CONNECTICUT
HUSKY A

Standards/Accreditation

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

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Mercer

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State

EQRO Optional 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
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:
Maude Holt
Department of Health, Medical Assisstance Administrator
(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:
ACS, Inc.

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:
June 30, 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:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - 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, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives
-Addictionologists
-Clinical Social Workers
-Psychologists
-Psychiatrists
-Other Specialists Approved on a Case-by-Case Basis

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

Enrollment

Populations Voluntarily Enrolled:
-TANF HIV Patients:Pregnant >26 Weeks
-Immigrant 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
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Advantage Health, Incorporated
DC Chartered Health Plan, Incorporated
AMERIGROUP
Health Right Incorporated

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

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

Consumer Self-Report Data
None

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

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

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

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

State conducts general data completeness assessments
Yes

Performance Measures

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

Process Quality
-Adolescent immunization rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Number of children with diagnosis of rubella(measles)/1,000 children
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit

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
None

Beneficiary Characteristics
None

Performance Improvement Projects

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

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Adult hearing and vision screening
-Asthma management
-Beta Blocker treatment after a heart attack
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Depression management
-Diabetes management/care
-Low birth-weight baby
-Newborn screening for heritable diseases
-Post-natal Care
-Pre-natal care
-Primary and behavioral health care coordination
-Well Child Care/EPSDT

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

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

Standards/Accreditation

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

Accreditation Required for Participation
-AAAHC (Accreditation Association for Ambulatory Health Care)

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-MCO must be accredited by appropriate body

Non-Duplication Based on Accreditation
None

EQRO Name
-Delmarva Foundation for Medical Care

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

FLORIDA
Managed Health Care

CONTACT INFORMATION

State Medicaid Contact:
Anna Garcia
Agency for Health Care Administration (AHCA)
(850) 414-2000

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)(3)
1915(b)(4)

Enrollment Broker:
Concera Corp.

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 26, 2004

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Disease Management PAHP - Other

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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
-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)
-Participate in HCBS Waiver
-Retroactive Eligibility

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

FLORIDA
Managed Health Care

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Advanced Registered Nurse Practitioner Services, Ambulatory Surgical Centers, Birth Center Services, Case Management, Child Health Checkup Services, Chiropractic Services, Community Mental Health Services in Area 6 only, County Heatlh Department Services, Dental, Dialysis, Durable Medical Equipment, Emergency Services, EPSDT, Family Planning, FQHCs, Freestanding Dialysis Centers, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, License Midwives Services, Mental Health Targeted Case Management in specific areas only, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry Services, Respiratory Therapy, Rural Health Clinic Centers, Speech Therapy, Transportation, Vision, X-Ray

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

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
-Enrolled in Another Managed Care Program
-Poverty Level Pregnant Woman
-Share of Cost (Medically needy)
-State Hospital Services
-Hospice
-Medically needy
-Medicaid Eligibles in Residential Committment Facilities
-Eligibles in Residential Group Care
-Children in Residential Treatment Facilities
-Residents in ADM Residential Treatment Facilities
-HIV/AIDS Waiver Enrollees
-Participate in HCBS Waiver
-Prescribed Pediatric Extended Care Center Residents
-Medically Complex Children in CMS Program
-Other Insurance
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

FLORIDA
Managed Health Care

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Case Management, Community Mental Health Services in Area 6 only, Dental, Durable Medical Equipment, EPSDT, Family Planning, Freestanding Dialysis Centers, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mental Health Targeted Case Management in specific areas only, Occupational Therapy, Outpatient Hospital, Physical Therapy, Respiratory Therapy, Speech Therapy, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

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

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Poverty Level Pregnant Woman
-Other Insurance
-Hospice
-Share of Cost (medically needy)
-Participate in HCBS Waiver

Lock-In Provision:
12 month lock-in

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

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility criteria for special codes
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

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

FLORIDA
Managed Health Care

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Behavioral Health, Inc.
Amerigroup
DiabetikSmart
Florida: A Healthy State
Healthease
Humana Family Health Plan
LifeMasters
Preferred Medical Plan
Staywell Health Plan
Vista
AIDS Healthcare Foundation
Citrus Healthcare
Florida Health Partners, Inc.
Health and Home Connection
Healthy Palm Beaches
JMH Health Plan
Medipass
Provider Service Network
United Healthcare Plans of Florida

ADDITIONAL INFORMATION

The Disease Management PAHP is specifically for persons with one or more of the following diseases: HIV/AIDS, Congestive Heart Failure, Diabetes, Asthma, and Hypertension. The Disease Management program reimbursement arrangement is not capitated or ffs but is based on shared savings.

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.

Children may be enrolled in the prepaid dental health plan and a managed care organization or PCCM.

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 MCO/HIO

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 Standards
-Monitoring of MCO 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
-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
-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 to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

FLORIDA
Managed Health Care

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-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)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Beta Blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

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

FLORIDA
Managed Health Care

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

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

Health Plan Stability/ Financial/Cost of
-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, 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

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for

Performance Improvement Projects

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

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-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/care
-Domestic violence
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment
-Hepatitis B screening and treatment
-Hypertension management
-Lead toxicity
-Pharmacy management
-Pregnancy Prevention
-Pre-natal care
-Referral for Cervical cancer screening
-Sexually transmitted disease screening
-Sexually transmitted disease treatment
-Sickle cell anemia management
-Treatment of myocardial infraction
-Tuberculosis screening and treatment
-Well Child Care/EPSDT

FLORIDA
Managed Health Care

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

Standards/Accreditation

MCO Standards
-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 Parcipation
-AAAHC (Accreditation Association for Ambulatory Health Care)

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

Non-Duplication Based on Accreditation
None

EQRO Name
-None

EQRO Organization
-None

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

EQRO Optional Activities
None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Monitoring of PAHP Standards
-PAHP Standards

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

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

PAHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

FLORIDA
Managed Health Care

QUALITY ACTIVITIES FOR PCCM

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
-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
-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

Performance Measures

Process Quality
-Asthma care - medication use
-Check-ups after delivery
-Diabetes management/care
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Pregnancy Prevention
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

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

Access/Availability of Care
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Average cost per patient for a period of time
-DME/100 beneficiaries
-Emergency room visits/100 beneficiaries
-Inpatient admissions/100 beneficiaries
-Lab and x-ray procedures/100 beneficiaries
-Office visit/100 beneficiaries
-Outpatient visits/100 beneficiaries
-Physician referrals/100 beneficiaries
-Therapies/100 beneficiaries

Provider Characteristics
-Board Certification

Beneficiary Characteristics
-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 Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and

Non-Clinical Topics
-Availability of language interpretation services

FLORIDA
Managed Health Care

-Provider Data Services
-Childhood Immunization
-Cholesterol screening and management
-Coordination of primary and behavioral health care
-Coronary artery disease prevention
-Coronary artery disease treatment
-Deprssion management
-Diabetes management
-Hepatitis B screening and treatment
-HIV Status/Screening
-HIV/AIDS Prevention and/or Management
-Hypertension management
-Lead toxicity
-Medical prblems of the frail elderly
-Pre-natal care
-Sexually transmitted disease screening
-Sexually transmitted disease treatment

FLORIDA
Prepaid Mental Health Plan

CONTACT INFORMATION

State Medicaid Contact:
Anna Garcia
Agency for Health Care Administration
(850) 414-2000

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:
September 26, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Capitation

Service Delivery

Included Services:
Crisis, IMD, Inpatient Mental Health, 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.
-PIHP/PAHP subcontracting with local community mental health providers and an Administrative Service

Enrollment

FLORIDA
Prepaid Mental Health Plan

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
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Eligibility Period Less Than 3 Months
-Reside in Nursing Facility or ICF/MR
-Poverty Level Pregnant Woman
-Medicare Dual Eligible
-Medically Needy
-Retroactive Eligibility
-Children admitted to a residential group care facility designated by Medicaid
-Adults who are admitted to services under a Florida Assertive Community Treatment Team
-Children listed in the HomeSafeNet Database

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

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

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

Access Behavioral Health, Inc.

Florida Health Partners, Inc.

ADDITIONAL INFORMATION

Medicaid recipients who do not voluntarily choose a managed care plan are mandatorily assigned. In nine 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. Children who are admitted to a Statewide Inpatient Pyschiatric Program (SIPP) are also disenrolled from the PMHP upon admission and re-enrolled upon returning to the community. Adults admitted to Florida community Treatment Team services are disenrolled from the PMPH and re-enrolled upon discontinuance of this service.

QUALITY ACTIVITIES FOR PIHP

FLORIDA
Prepaid Mental Health Plan

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

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

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

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

Encounter Data

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

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

Collection: Standardized Forms
None

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

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

State conducts general data completeness assessments
Yes

Performance Measures

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

FLORIDA
Prepaid Mental Health Plan

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/SUD conditions/1,000 beneficiaries

-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
None

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

Beneficiary Characteristics
None

Performance Improvement Projects

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

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

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

Standards/Accreditation

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

Accreditation Required for Participation
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

Non-Duplication Based on Accreditation
None

EQRO Name
-University of South Florida

EQRO Organization
-State
-University

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

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

FLORIDA
Statewide Inpatient Psychiatric Program

CONTACT INFORMATION

State Medicaid Contact:

Anna Garcia
Agency for Health Care Administration
(850) 414-2000

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)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
March 23, 1998

Implementation Date:
April 01, 1999

Waiver Expiration Date:
December 31, 2005

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

ADDITIONAL INFORMATION

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

GEORGIA
Non-Emergency Transportation Broker Program

CONTACT INFORMATION

State Medicaid Contact:
Janine Gardner
Department of Community Health/Division of Medical
(404) 651-6917

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:
June 30, 2005

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 PAHP - 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

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible

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

GEORGIA
Non-Emergency Transportation Broker Program

-Aged and Related Populations

Medicare Dual Eligibles Included:
None

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

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:

-Social Services Agencies

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 PAHP

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards
-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)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for PAHPs to collect and maintain encounter data
-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

GEORGIA
Non-Emergency Transportation Broker Program

Collection: Standardized Forms
None

Validation: Methods
-Accuracy Audits

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

Clinical Topics
Not Applicable - PAHPs are not required to conduct common project(s)

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

Standards/Accreditation

PAHP Standards
-State-Developed/Specified Standards

Accreditation Required for Particpation
None

Non-Duplication Based on Accreditation
None

GEORGIA
Preadmission Screening and Annual Resident Review (PASARR)

CONTACT INFORMATION

State Medicaid Contact:
Nell Moton-Kapple
Department of Community Health/Division of Medical
(404) 657-7211

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:
October 05, 2005

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) PIHP - Capitation

Service Delivery

Included Services:
Inpatient Mental Health Services, Mental Health/Mental Retardation

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

Contractor Types:
-Private Nursing Homes

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:
-American Indian/Alaskan Native
-Medicare Dual Eligible
-Poverty Level Pregnant Women
-Reside in ICF/MR
-Enrolled in another managed care program
-Participate in HCBS Waiver
-Special Needs Children (State defined)

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

Medicare Dual Eligibles Included:
None

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

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.

QUALITY ACTIVITIES FOR PIHP

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)

PIHP 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

PIHP Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-OASYS

EQRO Organization
-Quality Improvement Organization (QIO)

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

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

IDAHO
Healthy Connections

CONTACT INFORMATION

State Medicaid Contact:
Pam Mason
Bureau of Medicaid Policy
(208) 364-1863

State Website Address:
http://www2.state.id.us/medicaid/index.htm

PROGRAM DATA

Program Service Area:
Statewide

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:
November 26, 1993

Implementation Date:
October 01, 1993

Waiver Expiration Date:
September 30, 2006

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, Childhood Immunizations through District Health, Chiropractic, Dental, Durable Medical Equipment, EPSDT, Family Planning, Flu shots, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Podiatry, Standard/HIV Testing and Treatment, Transportation, Vision, X-Ray

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

Enrollment

IDAHO
Healthy Connections

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
-TITLE XXI SCHIP

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:
-Have Existing Relationship With a Non-participating PCP
-QMB-only or SLMB-only
-Live in a Non-participating County
-Retro-Eligibility Only
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-If travel > 30 Minutes or 30 Miles
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

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
-Developmental Disabilities Agency
-Education Agency
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Healthy Connections

ADDITIONAL INFORMATION
Case management fee per member per month. The program is mandatory in 35 of 44 counties. Enrollment is mandatory in 35 of our 44 counties and voluntary in the remaining 9 counties

QUALITY ACTIVITIES FOR PCCM

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

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

IDAHO
Healthy Connections

Consumer Self-Report Data
-Access to specialists
-Appointment wait times
-Disenrollment reasons
-Distance to provider
-ER usage
-In office wait times
-Satisfaction with care

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-24/7 access to live Health Care Professional
-Average wait time for an appointment with primary care case manager

Use of Services/Utilization
-Number of enrollees who use the ER

Provider Characteristics
None

Beneficiary Characteristics
-Disenrollment rate
-Disenrollment reasons

INDIANA
Hoosier Healthwise

CONTACT INFORMATION

State Medicaid Contact:
John Barth
Indiana Family and Social Services Administration
(317) 233-0237

State Website Address:
http://www.state.in.us/fssa/hoosier_healthwise/ind

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:
No guaranteed eligibility

Initial Waiver Approval Date:
September 13, 1993

Implementation Date:
July 01, 1994

Waiver Expiration Date:
September 22, 2005

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
-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:
-Enrolled in Another Managed Care Program
-Illegal Aliens
-Refugees
-Spend Down
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Pregnant Women

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

MCO (Comprehensive Benefits) - 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
-Obstetricians/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:
No lock-in

Medicare Dual Eligibles Included:
None

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

INDIANA
Hoosier Healthwise

Disease Management PCCM - Fee-for-Service

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Registered Nurses

Enrollment

Populations Voluntarily Enrolled:
-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
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Poverty-Level Pregnant Women
-American Indian/Alaskan Native
-Medicare Dual Eligibles
-Section 1931 (AFDC/TANF) Children and Related Populations

Populations Mandatorily Enrolled:
None

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

Lock-In Provision:
No lock-in

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

Medicare Dual Eligibles Excluded:
None

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

Disease Management PCCM
ICDMP
MDwise
Harmony Health Plans of Indiana
Managed Health Services (MHS)
PCCM (PrimeStep)

ADDITIONAL INFORMATION

INDIANA
Hoosier Healthwise

Inpatient psychiatric hospital and outpatient pyschiatric services are generally carved-out. However, when 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.

The goal of the Indiana Chronic Disease Management Program (ICDMP) is to build a comprehensive, locally based infrastructure that is sustainable and that will strengthen the existing public health infrastructure and help improve quality of health care in all populations, not just Medicaid recipients. The 3 diseases that are currently covered are Diabetes, Asthma, and Congestive Heart Failure. The ICDMP will be valuable not only for the patient but also for healthcare providers. Thus, Indiana pursued an "assemble" approach to developing a disease management program. The call center for less severe patients, the nurse care managers for more severe patients and the evaluation contractor are all locally based entities that were already part of the public health safety net in the State.

QUALITY ACTIVITIES FOR MCO/HIO

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

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

Consumer Self-Report Data
-CAHPS
  Adult Survey
  Child 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 modifies/requires MCOs 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
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

INDIANA
Hoosier Healthwise

State conducts general data completeness 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

MCO/HIO conducts data accuracy check(s) assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Breast Cancer screening rate
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-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 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

INDIANA
Hoosier Healthwise

Standards/Accreditation

MCO Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Navigant Consulting Inc. (formerly Tucker Alan Inc.)

EQRO Organization
-QIO-like entity

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State

EQRO Optional Activities
-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 encounter data

QUALITY ACTIVITIES FOR PCCM

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:
None

Consumer Self-Report Data
-CAHPS
  Adult Survey
  Child Survey
-State Generated 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 - timeliness of
-Well-child care visit rates in first 15 months of life

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
-Statistical Data on Access to Pediatric Care

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Cervical cancer treatment
-Childhood Immunization

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

-Low birth-weight baby
-Pre-natal care

Quality Activities for Disease Management PCCM

Quality Oversight Activities:
-Enrollee Hotlines
-Performance Measures (see below for details)

Use of Collected Data:
-Health services research
-Monitor quality improvement
-Program evaluation

Consumer Self-Report Data
None

Performance Measures

Process Quality
-Asthma care
-CHF management/care
-Diabetes management/care

Health Status/Outcomes Quality
-Clinical indicators

Access/Availability of Care
None

Use of Services/Utilization
None

Provider Characteristics
None

Beneficiary Characteristics
None

INDIANA
Medicaid Select

CONTACT INFORMATION

State Medicaid Contact:
John Barth
Office of Medicaid Policy and Planning
(317) 233-0237

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
AmeriChoice

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 22, 2002

Implementation Date:
January 01, 2003

Waiver Expiration Date:
July 22, 2005

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, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Children Receiving Adoption Assistance
-Room and Board Assistance (RBA)
-Qualified Medicare Beneficiary (QMB)

INDIANA
Medicaid Select

-Special Low Income Beneficiary (SLIMB)
-Ticket to Work (MedWorks)
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Wards or Foster Children

Lock-In Provision:
No lock-in

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

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

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medicaid Select

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM

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

INDIANA
Medicaid Select

-Provider Data

Consumer Self-Report Data
-Survey Based on CAHPS Model

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
None

Use of Services/Utilization
None

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
-Asthma management
-Congestive Heart Failure Management
-Diabetes management
-Emergency Room service utilization

Non-Clinical Topics
None

IOWA
Iowa Plan For Behavioral Health

CONTACT INFORMATION

State Medicaid Contact:
Dennis Janssen
Department of Human Services
(515) 281-8747

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:
June 30, 2005

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

MH/SUD PIHP - Capitation

Service Delivery

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

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

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

-Medicare Dual Eligibles
-Foster Care Children

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

Lock-In Provision:
No lock-in

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

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Iowa Plan For Behavioral Health

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PIHP

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

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

Consumer Self-Report Data
None

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

Encounter Data

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

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

data submission

Collection: Standardized Forms
None

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

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

State conducts general data completeness assessments
No

Standards/Accreditation

PIHP Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Iowa Foundation for Medical Care

EQRO Organization
-Quality Improvement Organization (QIO)

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

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

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:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
February 01, 1996

Implementation Date:
June 01, 1998

Waiver Expiration Date:
June 02, 2005

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - 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
-TITLE XXI SCHIP

KENTUCKY
Human Service Transportation

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

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

-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Human Service Transportation

ADDITIONAL INFORMATION

Title XXI SCHIP is included up to 150% of FPL.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-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 PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Comparsion to plan claims payment data
-Per member per month analysis and comparisons across PAHPs

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

State conducts general data completeness assessments
Yes

Standards/Accreditation

PAHP Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

LOUISIANA
Community Care

CONTACT INFORMATION

State Medicaid Contact:
Leah Schwartzman
Department of Health and Hospitals
(225) 342-9520

State Website Address:
http://www.dhh.state.la.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:
No

Initial Waiver Approval Date:
June 01, 1992

Implementation Date:
June 01, 1992

Waiver Expiration Date:
February 28, 2005

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
Continuous eligibility for children under age 19

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

Enrollment

Populations Voluntarily Enrolled:
None

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

LOUISIANA
Community Care

Subpopulations Excluded from Otherwise Included Populations:
-Recipients who have retroactive eligibility
-Recipients who have other primary insurance that includes physician benefits
-Presumptive Eligible (PE) recipients
-Hospice residents
-Eligibility Period Less Than 3 Months
-Reside in Nursing Facility or ICF/MR
-American Indian/Alaskan Native
-Recipients who are 65 or older
-Residents of Psychiatric facilities
-Foster children, or children receiving adoption assistance
-Office of Youth Development recipients
-Recipients in SURS lock-in (except "pharmacy-only" lock in)
-Medically high-risk on a case-by-case basis
-recipients in the Hospice program
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

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
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Community Care Program

ADDITIONAL INFORMATION
Program includes a $3 monthly case management fee.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-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
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

LOUISIANA
Community Care

-Provider Data

Consumer Self-Report Data
None

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Children's access to primary care practitioners

Use of Services/Utilization
-Drug Utilization
-ER visits per 100 beneficiaries
-Inpatient admits per 100 beneficiaries
-Number of primary care case manager visits per beneficiary

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
-Asthma management
-Diabetes management
-Emergency Room service utilization
-Well Child Care/EPSDT

Non-Clinical Topics
-PCP on-office tracking tool used for management of referrals for developmental delays

MICHIGAN
Comprehensive Health Plan

CONTACT INFORMATION

State Medicaid Contact:
Judith Kloko
Michigan Department of Community Health
(517) 241-5714

State Website Address:
http://www.michigan.gov/mdch

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:
April 21, 2005

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) - Capitation

Service Delivery

Included Services:
Durable Medical Equipment, Emergency, EPSDT, Family Planning, Health education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Intermittent or Short-term Restorative or Rehab Skilled Nursing Care, Laboratory, Maternal and Infant Support, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Prosthetics and Orthotics, Transplant, Transportation, Vision, X-Ray

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

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

-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Other Insurance
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program
-Spenddown
-Court Wards
-Kosovo Refugees
-Persons enrolled in CSHCS
-Person with full medicaid coverage, including those in the state medical program or pluscare
-Medicare Dual Eligible

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

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

Cape Health Plan
Great Lakes Health Plan
HealthPlus Partners, Inc.
McLaren Health Plan
Molina Healthcare of Michigan
Physicians Health Plan of Mid-Michigan - Family Care
Priority Health
Upper Penninsula Health Plan
Community Choice Michigan
Health Plan of Michigan
M-Caid HMO
Midwest Health Plan
Omnicare Health Plan
Physicians Health Plan of Southwest Michigan
Total Health Care
Wellness Plan

ADDITIONAL INFORMATION

The enrollment basis for included populations will depend if they fall under the Special needs population.

QUALITY ACTIVITIES FOR MCO/HIO

MICHIGAN
Comprehensive Health Plan

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 Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Timely and Compliant Claims Reporting
-Timely Provider File Submissions

Use of Collected Data
-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor quality improvement efforts
-Monitor service provision
-Program Evaluation
-Regulatory Compliance/Federal Reporting

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

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

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

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

Standards/Accreditation

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

Accreditation Required for Participation
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-Plan is required to have applied or be accredited

Non-Duplication Based on
None

EQRO Name
-Health Services Advisory Group (HSAG)

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Breast Cancer screening rate
-Cervical cancer screening rate
-Childhood immunization rates
-Chlamydia screening rates
-Comprehensive diabetes care rates
-Controlling high blood pressure
-Medical assistance with smoking cessation
-Prenatal and Postpartum care rates
-Use of appropriate medications for people with asthma
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care

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

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

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

Performance Improvement Projects

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

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

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

EQRO Optional Activities

-Conduct studies on quality and access that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

MINNESOTA
Consolidated Chemical Dependency Treatment Fund

CONTACT INFORMATION

State Medicaid Contact:
Christine Bronson
Minnesota Department of Human Services
(651) 296-4332

State Website Address:
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:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1998

Implementation Date:
January 01, 1998

Waiver Expiration Date:
March 27, 2007

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:
Extended Rehabilitation (Extended Care), Inpatient Substance Use Disorders (Fee-Standing and Hospital-Based), Outpatient Substance Use Disorders, Transitional Rehabilitation (Halfway House)

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

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

MINNESOTA
Consolidated Chemical Dependency Treatment Fund

-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses enrollment forms to identify members of these groups

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Consolidated Chemical Dependency Treatment Fund (CCDTF)

ADDITIONAL INFORMATION

All Medicaid recipients are eligible to participate in this program.

Quality Activities for County Case Manager

Quality Oversight Activities:
-Does not perform any of the Quality Activities

Use of Collected Data:
None

Consumer Self-Report Data
None

MISSOURI
MC+ Managed Care/1915b

CONTACT INFORMATION

State Medicaid Contact:
Susan Eggen
Department of Social Services, Division of Medical Svcs.
(573) 751-5178

State Website Address:
http://www.state.mo.us

PROGRAM DATA

Program Service Area:
City
County

Initial Waiver Approval Date:
October 01, 1995

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
September 01, 1995

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

Waiver Expiration Date:
June 30, 2006

Enrollment Broker:
Policy Studies, 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) - 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 Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physician, Prenatal Case Management, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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
-MC+ for Pregnant Women
-Children in the Legal Custody of Department of Social Services
-Mentally Retarded Developmentally Disabled (MRDD) Waiver

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
-Aid to the Blind and Blind Pension Individuals
-Children with Developmental Disabilities Program
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Presumptive Eligibility Program for Pregnant Women
-American Indian/Alaskan Native
-Medical assistance for workers with disabilities
-Presumptive Eligibility for Children

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Data Match with Other State Agencies
-Health Risk Assessment
-Helpline
-MCO uses ER Encounters
-MCOs use Drug Usage
-MCOs use Hospital Admissions
-MCOs use Hospital Encounters
-Reviews grievances and appeals to identify members of 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 Cross Blue Shield of Kansas City, Blue Advantage+ Plus
Community Care Plus
Family Health Partners
FirstGuard

MISSOURI
MC+ Managed Care/1915b

HealthCare USA
Missouri Care

Mercy Health Plans

ADDITIONAL INFORMATION

Vision services - Eye glasses for members 21 and over are not covered except for one pair following cataract surgery. Dental services for members 21 and older limited to dentures and trauma to the mouth or teeth as a result of injury. All other vision and dental services are carved out of the MC+ Managed Care Program and are covered through the MC+ Fee-For-Service Program. 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 the MC+ Managed Care Program at any time. Enrollment is mandatory for special needs children but individuals may request to opt out. HealthCare USA health plan participates in Eastern, Central, and Western Regions. Individuals with special health care needs include those with needs due to physical and/or mental illnesses, foster care children, homeless individuals, individuals with serious and persistent mental illness and/or substance abuse, and individuals who are disabled or chronically ill with developmental or physical disabilities.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO 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
-Fraud and Abuse
-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
Child Medicaid AFDC Questionnaire

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

Encounter Data

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

Collections: Submission Specifications
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

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

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

-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
-Use of Medicaid Identification Number for beneficiary

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

-Date of Service
-Provider ID
-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
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-C-Section Rates
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-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
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality

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

Access/Availability of Care

-Average distance to PCP

Use of Services/Utilization

-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of

-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
-Weeks of pregnancy at time of enrollment in MCO, for

MISSOURI
MC+ Managed Care/1915b

Performance Improvement Projects

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

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

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

Standards/Accreditation

MCO Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Behavioral Health Concepts (BHC)

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Validation of encounter data

MONTANA
Passport To Health

CONTACT INFORMATION

State Medicaid Contact:
Mary Angela Collins
Montana Department of Public Health and Human Services
(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, 1994

Waiver Expiration Date:
March 31, 2006

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 Infusion Therapy, Home Personal Attendant, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nursing Homes, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplants, Transportation, Vision, X-Ray

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

MONTANA
Passport To 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:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Medically Needy
-Area Without Managed Care
-Subsidized Adoption
-Only Retroactive Eligibility
-Restricted card
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

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

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

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

MONTANA
Passport To Health

-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Program Evaluation
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data
-State-developed Survey

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
None

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent 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
-Availability of language interpretation services
-Native American Adults access to preventative/ambulatory health services
-Native American Children's access to primary care practitioners

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

CONTACT INFORMATION

State Medicaid Contact:
David Cygan
Nebraska Medicaid
(402) 471-9050

State Website Address:
http://www.hhs.state.ne.us

PROGRAM DATA

Program Service Area:
Statewide

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:
No guaranteed eligibility

Initial Waiver Approval Date:
June 05, 1995

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2005

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, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Transportation, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

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

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

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Special Needs Children (BBA defined)
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Presumptive Eligibles
-Transplant Recipients

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

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

MCO (Comprehensive Benefits) - 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:
-Obstetricians/Gynecologists
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists

Enrollment

Populations Voluntarily Enrolled:
None

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

Subpopulations Excluded from Otherwise Included Populations:
-Presumptive Eligibility
-Transplant Recipients
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-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

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

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

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

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

Service Delivery

Included Services:
EPSDT, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Intensive Case Management, Laboratory, Opiate Treatment Program, Outpatient Mental Health, Outpatient Substance Use Disorders, Transportation, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

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

Subpopulations Excluded from Otherwise Included Populations:
-Presumptive Eligibles
-Transplant Recipients
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

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

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:
-Title V Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Magellan Behavioral Health
Share Advantage
Primary Care Plus

ADDITIONAL INFORMATION

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

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

QUALITY ACTIVITIES FOR MCO/HIO

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 Standards
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-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
-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
-State-developed Survey

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

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

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

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

State conducts general data completeness assessments
Yes

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

Performance Measures

Process Quality
-Adolescent well-care visit rates
-Antibiotics for Children
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

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

Access/Availability of Care
-Average distance to PCP
-Ratio of PCPs to beneficiaries

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
-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
-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
-Weeks of pregnancy at time of enrollment in MCO, for

Performance Improvement Projects

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

Clinical Topics
-(Newborn) Failure to thrive
-Emergency Room service utilization
-Low birth-weight baby
-Pre-natal care

Non-Clinical Topics
None

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

Standards/Accreditation

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

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

Non-Duplication Based on Accreditation
-Medicare+ Choice Accreditation
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Nebraska Foundation for Medical Care

EQRO Organization
-QIO-like entity

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

EQRO Optional Activities
None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Ombudsman
-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
-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
-Consumer/beneficiary Focus Groups
-State-developed Survey

Performance Measures

Process Quality
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamydia screening in women
-Diabetes management/care
-Immunizations for two year olds
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to primary care case manager

Use of Services/Utilization
None

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
-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 Combined Waiver Program - 1915(b)

Performance Improvement Projects

Clinical Topics	Non-Clinical Topics
-Adolescent Immunization	None
-Childhood Immunization	
-Diabetes Management	

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/dmahs/index.h

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:
December 29, 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:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Audiology, Chiropractor, Dental, Durable Medical Equipment/Assistive Technology Devices, Emergency Medical Care, EPSDT, Family Planning, Hearing Aid Service, Home Health, Hospice, Immunization, Inpatient Hospital including acute care, Laboratory, Medical Supplies, MH/SUD for enrollees who are clients of the Division of Developmental Disabilities, Optical Appliances, Optometry, Organ Transplants, Outpatient Hospitals, Pharmacy, Physician, Podiatry, Post-acute Care, Preventive Health Care, Counseling, and Health Prevention, Prosthetics and Orthotics including certified shoe provider, Rehabilitation and Special Hospitals, Transportation, Vision, X-Ray

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

Enrollment

NEW JERSEY
New Jersey Care 2000+ (1915 {b})

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Non duals DDD/CCW children <19
-Non duals Blind and Disabled Children and Related Populations <19

Subpopulations Excluded from Otherwise Included Populations:
-Participate in HCBS Waiver (except DDD/CCW non-duals)
-Individuals institutionalized in an inpatient psychiatric facility

-Full-time students attending school but resides outside the country
-Medically needy and presumptive eligibility beneficiaries
-Individuals with eligibility period that is only retroactive
-Individuals in out-of-state placements
-Reside in Nursing Facility or ICF/MR
-Enrolled in another managed care program without Department of Human Services contract
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

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 Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of New Jersey, Inc.
Health Net
University Health Plans, Inc.
AMERIGROUP New Jersey, Inc.
Horizon NJ Health

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-After Hours Beneficiary Call-in Sessions
-Consumer Self-Report Data (see below for details)

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

NEW JERSEY
New Jersey Care 2000+ (1915 {b})

-Data Analysis
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Geographic Mapping
-Independent Assessment
-MCO Marketing Material Approval Requirement
-Medical and Dental Provider Spot Checks
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Test 24/7 PCP Availability
-Utilization Review
-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
Survey included ABD adult and SCHIP children specific questions

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

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-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
-Use of Medicaid Identification Number for beneficiaries

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

Collection: Standardized Forms
None

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

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

State conducts general data completeness assessments
Yes

NEW JERSEY
New Jersey Care 2000+ (1915 {b})

-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Comparison of reported changes to reasonable and customary fees.

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Analysis of pharmaceutical services
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical Cancer Screening
-Check-ups after delivery
-Cholesterol screening and management
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Quality and utilization of dental services
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Lead Toxicity Study

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries

-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Average inpatient length of stay
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Inpatient days per 1000 members
-Pharmacy services per member
-Physician visits per 1000 members

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
None

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to

Performance Improvement Projects

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

Clinical Topics
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)

NEW JERSEY
New Jersey Care 2000+ (1915 {b})

-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management/care
-Lead Screenings
-Post-natal Care
-Prenatal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Encounter Data Improvement
-Hospital Appeals and Denials

Standards/Accreditation

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

Accreditation Required for Participation
-Department of Banking and Insurance
-Department of Health and Senior Services

Non-Duplication Based on Accreditation
None

EQRO Name
-PRONJ The Healthcare Quality Improvement Organization of New Jersey, Inc.

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-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
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

NEW MEXICO
SALUD!

CONTACT INFORMATION

State Medicaid Contact:
Pao Her
HSD-Medical Assistance Division
(505) 827-1329

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:
No guaranteed eligibility

Initial Waiver Approval Date:
May 13, 1997

Implementation Date:
July 01, 1997

Waiver Expiration Date:
December 31, 2005

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) - Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Emergency Room, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

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

NEW MEXICO
SALUD!

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Native Americans
-Clients participating in the health insurance premium program (HIPP)
-Children and adolescents in out-of-state foster care or adoption placement
-Family Planning Waiver clients

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

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:
-Aging Agency
-Developmental Disabilities Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Lovelace
Presbyterian Salud
Molina (formerly Cimarron)

ADDITIONAL INFORMATION

HMOs designate PCPs.

QUALITY ACTIVITIES FOR MCO/HIO

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 Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews

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

-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
-State-developed Survey

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

MCO/HIO 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

NEW MEXICO
SALUD!

Health Plan Stability/Financial/Cost of Care
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue
-Provider turnover

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to

Performance Improvement Projects

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

Clinical Topics
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services

Standards/Accreditation

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

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

Non-Duplication Based on
None

EQRO Name
-IPRO

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State

EQRO Optional 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

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:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 16, 1996

Implementation Date:
July 01, 1996

Waiver Expiration Date:
February 13, 2005

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

Transportation PAHP - Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not Applicable

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

NEW YORK
Non-Emergency Transportation

-All Medicaid Beneficiaries
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Not applicable

ADDITIONAL INFORMATION

Selective contracting for non-emergency transportation.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Not Applicable

Use of Collected Data
-Not applicable

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

PAHP Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

OHIO
PremierCare

CONTACT INFORMATION

State Medicaid Contact:
Jon Barley
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:
1915(b) - Waiver Program

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

Enrollment Broker:
Automated Health Systems, Incorporated

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 23, 2001

Implementation Date:
July 01, 2001

Waiver Expiration Date:
June 30, 2005

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) - Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Private Duty Nurse, Skilled Nursing Facility, Speech Therapy, Vision, X-Ray

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

Enrollment

OHIO
PremierCare

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Special Needs Children (BBA defined)

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
-Special Needs Children (BBA defined)

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
-Medicare Dual Eligible
-Other Insurance
-Eligibility only Retroactive

Lock-In Provision:
No lock-in
12 month lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

Buckeye Community Health Plan
MediPlan
Qualchoice Health Plan
CareSource
Paramount Health Care
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. An enrollment designation called "Preferred Option" is found in six counties. In these counties, Medicaid eligibles that do not choose fee for service Medicaid are enrolled in the single MCO operating in the county. Enrollees may opt out of the MCO and return to fee for service at any time. Those children age 17 and under who are pregnant, and members under 21 years of age with one or more of the following:

- Asthma
- HIV/AIDS
- A chronic physical, emotional, or mental condition for which they need or are receiving treatment or counseling
-Suppemental security income (SSI) for a health-related condition
- A current letter of approval from the bureau of Children with Medical records
- Handicaps (BMCM), Ohio Department of Health In voluntary and mandatory enrollment counties, members must remain in the selected MCP for up to a year, although disenrollment during this period is permitted within the first three months of enrollment or if

there is a justifiable reason or "just cause". The Preferred Option counties may request to disenroll at any time from the MCP and return to Medicaid Fee For Service or choose another MCP, if available. Ohio Bureau of Comprehensive Managed Care Plans contracts with six MCPs throughout the state. Voluntary or Mandatory enrollment into one of these six plans is determined by the county in which an eligible lives.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-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
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

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

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-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

-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.)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCOs

OHIO
PremierCare

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent well-care visit rates
-Asthma care - medication use
-Check-ups after delivery
-Dental services
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

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

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

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

Health Plan/ Provider Characteristics
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for

OHIO
PremierCare

Performance Improvement Projects

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

Clinical Topics
-Well Child Care/EPSDT

Non-Clinical Topics

Standards/Accreditation

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

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-URAC (Utilization Review Accreditation Commission)

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Quality Improvement Organization (QIO)

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

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

PENNSYLVANIA
Family Care Network

CONTACT INFORMATION

State Medicaid Contact:
Candy Spahr
Pennsylvania Department of Welfare
(717) 772-6162

State Website Address:
http://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:
October 14, 1993

Implementation Date:
February 01, 1994

Waiver Expiration Date:
October 26, 2005

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 Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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:
-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
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-Medicare Dual Eligible
-Restricted Beneficiaries
-State Blind Pension Recipients

Lock-In Provision:
No lock-in

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

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

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 management fee of $3.00 paid to the provider for each recipient.

QUALITY ACTIVITIES FOR PCCM

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

PENNSYLVANIA
Family Care Network

-Performance Measures (see below for details)

Consumer Self-Report Data
-State-developed Survey

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

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

Use of Services/Utilization
None

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
None

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

PENNSYLVANIA
HealthChoices

CONTACT INFORMATION

State Medicaid Contact:
Patricia 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:
ACS State Healthcare

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 31, 1996

Implementation Date:
February 01, 1997

Waiver Expiration Date:
December 12, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State mandate to PIHP or PAHP

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - 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
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners

PENNSYLVANIA
HealthChoices

Enrollment

Populations Voluntarily Enrolled:

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
-Medicare Dual Eligibles
-State Only Categorically and Medically Needy
-Special Needs Children (State defined)
-Poverty-Level Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-Monthly Spend Downs
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligible
-State Blind Pension Recipients

Lock-In Provision:
No lock-in

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

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

MH/SUD PIHP - Capitation

Service Delivery

Included Services:
Behavioral Health Rehab Services for Children and Adolescents, Crisis, Detoxification, Family Based Services, Inpatient Mental Health Services, Inpatient Substance Use Disorders Services, Mental Health Outpatient, Mental Health Residential, Mental Health Support, Opioid Treatment Programs, Outpatient Substance Use Disorders Services, Pharmacy, Residential Substance Use Disorders Treatment Programs

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Medicare Dual Eligibles
-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:
-Monthly Spend Downs
-Reside in Nursing Facility or ICF/MR
-State Blind Pension Recipients
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

PENNSYLVANIA
HealthChoices

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

AmeriChoice of Pennsylvania
AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan
County of Adams - Community Care Behavioral Health
County of Allegheny - Community Care Behavioral
County of Armstrong - Value Behavioral Health of PA
County of Beaver - Value Behavioral Health of PA
County of Berks - Community Care Behavioral Health
County of Bucks - Magellan Behavioral Health
County of Butler - Value Behavioral Health of PA
County of Chester - Community Care Behavioral Health
County of Cumberland - Community Behavioral Healthcare Network of PA, Inc.
County of Dauphin - Community Behavioral Healthcare Network of PA, Inc.
County of Delaware - Magellan Behavioral Health
County of Fayette - Value Behavioral Health of PA
County of Indiana - Value Behavioral Health of PA
County of Lancaster - Community Behavioral Healthcare Network of PA, Inc.
County of Lawrence - Value Behavioral Health of PA
County of Lebanon - Community Behavioral Healthcare Network of PA, Inc.
County of Lehigh - Magellan Behavioral Health
County of Montgomery - Magellan Behavioral Health
County of Northampton - Magellan Behavioral Health
County of Perry - Community Behavioral Healthcare Network of PA, Inc.
County of Philadelphia - Community Behavioral Health
County of Washington - Value Behavioral Health of PA
County of Westmoreland - Value Behavioral Health of PA
County of York - Community Care Behavioral Health
Gateway Health Plan, Inc.
Health Partners of Philadelphia
Keystone Mercy Health Plan
Three Rivers Health Plans, Inc. / MedPLUS
UPMC Health Plan, Inc./UPMC for You
Value Behavioral Health of PA (Greene County)

ADDITIONAL INFORMATION

Special Needs Children: (state defined) Broadly defined non-categorical to include all children.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse

PENNSYLVANIA
HealthChoices

-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-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
3.0H adult and children

Use of HEDIS
-The State uses ALL of the HEDIS measures listed for Medicaid

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

Encounter Data

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

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

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

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

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

State conducts general data completeness assessments
Yes

PENNSYLVANIA
HealthChoices

of the HEDIS measures listed for Medicaid that it collects

Performance Measures

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

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to 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 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 in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

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

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

-Weeks of pregnancy at time of enrollment in MCO, for

PENNSYLVANIA
HealthChoices

Performance Improvement Projects

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

Clinical Topics
-Adolescent Pregnancy
-Child/Adolescent Dental Screening and Services
-Smoking prevention and cessation

-Adult/Children access to dental care

Standards/Accreditation

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

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-IPRO

EQRO Organization
-Quality Improvement Organization (QIO)

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

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

QUALITY ACTIVITIES FOR PIHP

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

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

Consumer Self-Report Data
-Consumer/Family Satisfaction Team 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 PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

PENNSYLVANIA
HealthChoices

Encounter Data

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

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

Collection: Standardized Forms
None

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

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

State conducts general data completeness assessments
Yes

Performance Measures

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

Health Status/Outcomes Quality
None

Access/Availability of Care
-Access to MH/SUD services within time and distance requirements
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percent of beneficiaries accessing MH/SUD services compared to estimated population w/MH/SUD need/illness.

PENNSYLVANIA
HealthChoices

-Re-admission rates of MH/SUD

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

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 PIHPs

Performance Improvement Projects

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

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

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

Standards/Accreditation

PIHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-IPRO

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

TEXAS
* Lonestar Select I

CONTACT INFORMATION

State Medicaid Contact:
Doug Odle
Texas Health & Human Services Commission
(512) 794-5167

State Website Address:
www.hhsc.state.tx.us

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, 2004

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

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:
www.hhsc.state.tx.us

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:
September 05, 2004

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

Lonestar Select II is a program that enables the State of Texas to selectively contract with freestanding psychiatric facilities for inpatient services to children. Under Lonestar Select II, providers must bid all inclusive per diem rates for Medicaid reimbursement. The State of Texas either accepts or negotiates those rates so that providers may serve the under 21 Medicaid population for a

TEXAS
NorthSTAR

CONTACT INFORMATION

State Medicaid Contact:
Dena Stoner
Texas 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:
September 30, 2005

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

MH/SUD PIHP - Capitation

Service Delivery

Included Services:
Assertive Community Treatment Team, Crisis, Detoxification, Dual Diagnosis, Inpatient Mental Health, Inpatient Substance Use Disorders, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Use Disorders, Residential Substance Use Disorders Treatment Programs, Targeted Case Management

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

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:
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligible
-Children in Protective Foster Care
-Individuals Residing Outsider of the Service Region
-Individuals Receiving Inpatient Medicaid IMD Services

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Individuals on SSI and QMB Plus

Medicare Dual Eligibles Excluded:
SLMB Plus

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:
-Local School Districts
-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

Individuals on SSI and QMB plus are the only categories that are eligibled to participate in this program.

QUALITY ACTIVITIES FOR PIHP

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

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

-Provider Data

Consumer Self-Report Data
-Modified MHSIP survey

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

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

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

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

State conducts general data completeness assessments
Yes

Performance Measures

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

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Number and types of providers
-Time Distance to Providers

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

TEXAS
NorthSTAR

-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
-Re-admission rates of MH/SUD
-Behavioral Health Specialty Network
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
None

Performance Improvement Projects

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

Clinical Topics
-Coordination of primary and behavioral health care

Non-Clinical Topics
None

Standards/Accreditation

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

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Institute for Child Health Policy (ICHP)

EQRO Organization
-QIO-like entity

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

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

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CONTACT INFORMATION

State Medicaid Contact:
Dave Balland
Texas Health and Human Services Commission
(512) 491-1867

State Website Address:
http://www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
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:
June 30, 2006

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, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

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

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

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

Medicare Dual Eligibles Included:
None

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

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Nurse Practitioners
-Obstetricians/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
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)

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

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

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Texas
Community Health Choice
First Care
Parkland Community Health Plan
Texas Children's Health Plan
Community First
El Paso First Premier
JPS Star
Superior Health Plan
Texas Health Network (STAR)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO 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
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, 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

-Behavioral health layout
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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 commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy Check(s) On specified data elements

-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Preparing HEDIS and risk adjustment software

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Dental services
-Depression management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Pregnancy Prevention
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality

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

Access/Availability of Care

-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization

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

-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at

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Standards/Accreditation

MCO Standards
-CMS Quality Assessment and Performance Improvement (QAPI) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Institute for Child Health Policy, University of Florida

EQRO Organization
-QIO-like entity

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

EQRO Optional 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
-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

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
-Total revenue

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

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for

Performance Improvement Projects

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

Clinical Topics
-Adolescent Well Care/EPSDT
-Childhood Immunization
-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

UTAH
Choice Of Health Care Delivery

CONTACT INFORMATION

State Medicaid Contact:
Julie Olson
Utah State Health Department
(801) 538-6358

State Website Address:
http://health.utah.gov/medicaid

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:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 23, 1982

Implementation Date:
July 01, 1982

Waiver Expiration Date:
October 21, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PIHP (non-risk, comprehensive) - Other

Service Delivery

Included Services:
Case Management, Diabetes self-management, Durable Medical Equipment, Enhanced Services to Pregnant Women, EPSDT, ESRD, Family Planning, Hearing, HIV Prevention, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient medical detoxification, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Private Duty Nursing, Skilled Nursing Facility (less than 30 days), Speech Therapy, Vision, Well-adult care, X-Ray

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

UTAH
Choice Of Health Care Delivery

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Individuals who qualify for Medicaid by paying a spenddown and are aged or disabled
-Special Needs Children (State defined)
-Pregnant Women
-Medicare Dual Eligibles

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
-Medicare Dual Eligible

Subpopulations Excluded from Otherwise Lock-In Provision:
1 month lock-in

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

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

UTAH
Choice Of Health Care Delivery

PCCM Provider - Fee-for-Service

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Individuals who qualify for Medicaid by paying a spenddown and are aged or disabled
-Special Needs Children (State defined)
-Pregnant Women
-Individuals who qualify for Medicaid by paying a spenddown and are under age 19
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Individuals age 19 and older who quality for Medicaid by paying a spenddown and who are not aged or disabled
-Individuals residing in the Utah State Hospital of the Utah Developmental Center
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Have an eligibility period that is only retroactive
-Section 1931 non-pregnant adults age 19 and older and related poverty level populations
-Medicare Dual Eligible

Lock-In Provision:
1 month lock-in

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

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

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 identify members who received a carve-out service such as Early

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

Intervention

-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy U

IHC Health Plans Inc.

Molina Healthcare of Utah (Molina)

ADDITIONAL INFORMATION

Child with special health care needs means a child under age 21 who has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions and required health and related services of a type or amount beyond that required by children generally, including a child who (1) is blind or disabled; (2) is in foster care or other out-of-home placement ; (3) is receiving foster care or adoption assistance; or (4) is receiving services that receives grant funds described in setion 501(a)(1)(D) of title V. Follows non-risk requirements under 42 CFR 447.362.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PIHP Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-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

-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 measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)

UTAH
Choice Of Health Care Delivery

-Use of Medicaid Identification Number for beneficiaries

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

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across PIHPs

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of adults 50 and older who received an influenza vaccine
-Percentage of low birth weight infants

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

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

Health Plan Stability/ Financial/Cost of
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Total revenue

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

Beneficiary Characteristics
None

UTAH
Choice Of Health Care Delivery

Performance Improvement Projects

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

Clinical Topics
-Diabetes management

Non-Clinical Topics
-Coordination of care between physical and mental health plans.

Standards/Accreditation

PIHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Health Services Advisory Group

EQRO Organization
-QIO-like entity

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

EQRO Optional Activities
None

QUALITY ACTIVITIES FOR PCCM

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

Use of Collected Data:
-Contract Standard Compliance

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

UTAH
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:
Don Hawley
Utah State Department of Health
(801) 538-6483

State Website Address:
http://health.utah.gov/medicaid

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:
September 19, 2000

Implementation Date:
July 01, 2001

Waiver Expiration Date:
September 18, 2004

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - 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
-Pregnant Women
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles

UTAH
Non-Emergency Transportation

-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Reside in the State Hospital or in the State Developmental Center
-Medicare Dual Eligible

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

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

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

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

Use of Collected Data
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data
None

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

UTAH
Non-Emergency Transportation

Collection: Standardized Forms

None

Validation: Methods

-Comparison to benchmarks andnorms (e.g. comparisons to State FFs utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

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

None

State conducts general data completeness assessments

No

Standards/Accreditation

PAHP Standards

-State-Developed/Specified Standards

Accreditation Required for Participation

None

Non-Duplication Based on Accreditation

None

UTAH
Prepaid Mental Health Program

CONTACT INFORMATION

State Medicaid Contact:
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)(1)
1915(b)(3)
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, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Capitation

Service Delivery

Included Services:
Crisis, Inpatient Mental Health, 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

UTAH
Prepaid Mental Health Program

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Pregnant Women
-Foster Care (inpatient services only)
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Resident of the State Developmental Center (DD/MR facility)
-Resident of the Utah State Hospital (IMD)
-Medicare Dual Eligible

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

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

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

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
Davis Mental Health
Northeastern Counseling Center
Valley Mental Health
Weber Mental Health
Central Utah Mental
Four Corners Mental Health
Southwest Mental Health
Wasatch Mental Health

ADDITIONAL INFORMATION

Community Mental Health Centers serve as Prepaid Mental Health Plans to provide/coordinate all mental health services in 9 of Utahs 10 mental health service areas.

QUALITY ACTIVITIES FOR PIHP

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

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

UTAH
Prepaid Mental Health Program

-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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, etc.

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

PIHP 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
-Racidivism
-Symptom reduction

Access/Availability of Care
-Average time for intake
-Use of Services/Utlization

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan

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

UTAH
Prepaid Mental Health Program

Beneficiary Characteristics
-Information of beneficiary ethnicity/race

Performance Improvement Projects

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

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

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

Standards/Accreditation

PIHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-In-house

EQRO Organization
-State of Utah

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

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

VIRGINIA
MEDALLION

CONTACT INFORMATION

State Medicaid Contact:
Alissa Nashwinter
Department of Medical Assistance Services
(804) 225-4714

State Website Address:
http://www.dmas.virginia.gov/

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
MAXIMUS, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 23, 1991

Implementation Date:
March 01, 1992

Waiver Expiration Date:
December 25, 2004

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, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Transportation, Vision, X-Ray

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

Enrollment

VIRGINIA
MEDALLION

Populations Voluntarily Enrolled:
None

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

Subpopulations Excluded from Otherwise Included Populations:
-Refugees
-Spenddown
-Hospice
-Other Insurance
-Foster Care
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-Subsidized Adoption

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

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:
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

MEDALLION

ADDITIONAL INFORMATION

Fee-for-Service with Management Fee.

QUALITY ACTIVITIES FOR PCCM

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

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement

VIRGINIA
MEDALLION

-On-Site Reviews

-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
Adult Medicaid AFDC Questionnaire

VIRGINIA
Medallion II

CONTACT INFORMATION

State Medicaid Contact:
Mary Mitchell
Department of Medical Assistance Services
(804) 786-3594

State Website Address:
http://www.dmas.virginia.gov/

PROGRAM DATA

Program Service Area:
City
County

Initial Waiver Approval Date:
December 18, 1995

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
January 01, 1996

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

Waiver Expiration Date:
December 25, 2004

Enrollment Broker:
MAXIMUS, 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:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

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

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

Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Eligibility Less Than 3 Months
-Hospice
-Subsidized Adoption
-Refugees
-Spend-down
-Foster Care

Subpopulations Excluded from Otherwise Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

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
-Initial interviews with new enrollees
-Review claims activity of all new enrollees for special indicators
-Uses eligibility data to identify members of these

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

CareNet
Peninsula Health Care, Inc.
Sentara Family Care
Virginia Premier
Healthkeepers, Inc.
Priority Health Care, Inc.
UniCare Health Plan of Virginia, Inc.

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

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

Use of Collected Data
-Fraud and Abuse
-Health Services Research

VIRGINIA
Medallion II

-Encounter Data (see below for details)
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Measures (see below for details)
-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
-State-developed Survey

Use of HEDIS
-The State uses ALL of the HEDIS measures listed for Medicaid

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

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

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

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

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

VIRGINIA
Medallion II

Access/Availability of Care
-Average distance to 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

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

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

Standards/Accreditation

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

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

Non-Duplication Based on Accreditation
None

EQRO Name
-Delmarva Foundation for Medical Care, Inc.

EQRO Organization
-Quality Improvement Organization (QIO)

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

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

WASHINGTON
Disease Management Program

CONTACT INFORMATION

State Medicaid Contact:
Alice Lind
Medical Assistance Administration/Dept. of Social and Health
(360)725-1629

State Website Address:
http://www.dshs.wa.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:
None

Initial Waiver Approval Date:
April 10, 2003

Implementation Date:
April 01, 2002

Waiver Expiration Date:
April 09, 2005

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

Disease Management PAHP - Capitation

Service Delivery

Included Services:
Disease Management

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

Enrollment

Populations Voluntarily Enrolled:
-SSI eligible beneficiaries having one or more of the following: Asthma, Diabetes, Heart Failure, COPD
-TANF beneficiaries with Asthma

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

WASHINGTON
Disease Management Program

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Claims data
-Self-reporting via initial assessment

Agencies with which Medicaid Coordinates the Operation of the Program:
-Social Services Agencies
-State Department of Health

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

McKesson Health Solutions LLC

Renaissance Health Care, Inc.

ADDITIONAL INFORMATION

The State contracts with McKesson and Renaissance to provide enrollment, assessment and education and targets beneficiaries with one or more of the following diseases: Asthma, Diabetes, Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), End Stage Renal Disease (ESRD) and Chronic Kidney Disease. As part of their program, McKesson provides a face-to-face program component with high risk enrollees to ensure they receive necessary services.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Enrollee Hotlines
-Medical Review
-Performance Measures (see below for details)
-Self Reported Health Outcomes

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

Consumer Self-Report Data
None

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

Performance Measures

Process Quality
-Asthma Care/Action Plan
-Diabetes management/care

Health Status/Outcomes Quality
-clinical indicators
-Patient satisfaction with care

Access/Availability of Care
None

Use of Services/Utilization
None

WASHINGTON
Disease Management Program

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Standards/Accreditation

PAHP Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

WASHINGTON
The Integrated Mental Health Services

CONTACT INFORMATION

State Medicaid Contact:
Judy Gosney
Mental Health Divison
(360) 902-0827

State Website Address:
http://www1.dshs.wa.gov/mentalhealth

PROGRAM DATA

Program Service Area:
County
Region

Initial Waiver Approval Date:
April 27, 1993

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
July 01, 1993

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

Waiver Expiration Date:
March 04, 2006

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Capitation

Service Delivery

Included Services:
Crisis, EPSDT, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Rehabilitation Case Management

Allowable PCPs:
-Service Providers Under This Waiver Do Not Meet PCP Definition

Contractor Types:
-Regional Authority Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
None

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

WASHINGTON
The Integrated Mental Health Services

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Residents of State-owned institutions
-Pregnant Women included in Family Planning Waiver
-Homeless People not Enrolled in Medicaid

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

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-All Persons Meet SCHN

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
Peninsula Regional Support Network
Pierce County Regional Support Network
Southwest Regional Support Network
Spokane County Regional Support Network
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 PIHP

WASHINGTON
The Integrated Mental Health Services

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

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

Consumer Self-Report Data
-Consumer/Beneficiary Focus Groups
-MHSIP Child, Family, and Adult Survey

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Our data is rolled up from the providers to the entity to the MHD
-Use of Medicaid Identification Number for beneficiaries

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

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

PIHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-our encounter system is in development, the current data dictionary requires date of service, type of service, diagnosis codes, age and gender

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

WASHINGTON
The Integrated Mental Health Services

Access/Availability of Care
-Access to Appointment
-Availability of MHPs
-Average Distance to Service
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Crisis Contacts
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-Information of beneficiary ethnicity/race

Standards/Accreditation

PIHP Standards
-16 state pilot indicator project
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-APS Healthcare Inc.

EQRO Organization
-QIO-like entity

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

EQRO Optional Activities
-None

WEST VIRGINIA
Mountain Health Trust

CONTACT INFORMATION

State Medicaid Contact:
Shelley Baston
Office of Managed Care, Bureau for Medical Service
(304) 558-5978

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:
June 30, 2004

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) - 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
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Internists
-Nurse Practitioners

Enrollment

WEST VIRGINIA
Mountain Health Trust

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

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
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medically Needed

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

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

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

Carelink Health Plan
Health Plan of the Upper Ohio Valley
Unicare Health Plan of WV

ADDITIONAL INFORMATION

Reason for multiple enrollment for Children and Related populations and Adults and Related Populations: In counties with only one MCO, clients can choose to remain in the PCCM program.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Complaints, grievances and disenrollment data
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards
-Monitoring of MCO 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
-Track Health Service provision

-Performance Measures (see below for details)

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-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 commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

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

WEST VIRGINIA
Mountain Health Trust

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management/care
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality

-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

-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 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

-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

Performance Improvement Projects

Project Requirements

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

Clinical Topics

-Coordination of care for persons with physical disabilities
-Post-natal Care

Non-Clinical Topics

None

WEST VIRGINIA
Mountain Health Trust

Standards/Accreditation

MCO Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-QARI (Quality Assurance Reform Initiative) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Delmarva

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-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:
Shelley Baston
Office of Managed Care, Bureau for Medical Service
(304) 558-5978

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
Automated Health Systems, Inc.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
August 29, 1991

Implementation Date:
June 01, 1992

Waiver Expiration Date:
June 30, 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:
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, Physician, Vision, X-Ray

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

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
-Pregnant Women

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

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

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

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

The PAAS Program operates soley in counties not covered by an HMO. In counties with HMO coverage, The PAAS Program operates as the second managed care program. The PAAS Program is not a choice when there are two HMOs in a county.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection

Consumer Self-Report Data
None

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

CONTACT INFORMATION

State Medicaid Contact:
Tom Betlach
AHCCCS
(602) 417-4483

State Website Address:
http://www.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, 2006

Sections of Title XIX Waived:
-1902(a)(10)((a)(ii)(V) - Hospitalized Individuals
-1902(a)(10)(B) - Supported Employment
-1902(a)(10)(B)(i) - MCO Enrollees
-1902(a)(13) except 1902(a)(13)(A)
-1902(a)(14) - Copays
-1902(a)(17) - Quarterly Income
-1902(a)(18) - Estate Recovery
-1902(a)(23) - Freedom of Choice
-1902(a)(30)
-1902(a)(34) - Prior Quarter
-1902(a)(4) - Reimbursement Arrangements
-1902(a)(54) - Outpatient Drugs

For All Areas Phased-In:
No

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) - Capitation

Service Delivery

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

Included Services:
Case Management (DDD only), Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing (EPSDT only), Home Health, Hospice (EPSDT only), Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Maternity, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplantation of Organs and Tissue and Related Immunosuppresant Drugs, Transportation, Vision (EPSDT only), X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-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

-Title XIX Waiver Spend Down Population
-HIFA Parents
-Foster Care Children
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

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

Medicare Dual Eligibles Excluded:
QI and QDWI

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

MH/SUD PIHP - Capitation

Service Delivery

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

Allowable PCPs:
-PCP is in Medicaid Health Plan

Enrollment

Populations Voluntarily Enrolled:
None

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

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

Lock-In Provision:
No lock-in

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

Medicare Dual Eligibles Excluded:
QI and QDWI

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses enrollment forms to identify members of these groups

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

AZ Physicians IPA (Family Planning Extension)
Care 1st Health Plan (Family Planning Extension)
Department of Economic Security/Childrens Medical and Dental Program (Family Planning Extension)
Department of Economic Security/Division of Developmental Disabilities (PC)
Evercare Select (PC)
Health Choice Arizona (HP)
Maricopa County Health Plan (HP)
Mercy Care Plan (Family Planning Extension)
Mercy Care Plan (PC)
Phoenix Health Plan/Community Connection (HP)
Pima Health System (HP)
Pinal County Long Term Care (PC)
University Family Care (HP)
Care 1st Health Plan
Cochise Co. Dept. of Health Services (PC)
Department of Economic Security/Childrens Medical and Dental Program (HP)
Department of Health Services (Behavioral Health)
Health Choice Arizona (Family Planning Extension)
Maricopa County Health Plan (Family Planning Extension)
Maricopa County Health Plan (PC)
Mercy Care Plan (HP)
Phoenix Health Plan/Community Connection (Family Planning Extension)
Pima Health System (Family Planning Extension)
Pima Health System (PC)
University Family Care (Family Planning Extension)
Yavapai County Long Term Care (PC)

ADDITIONAL INFORMATION

A managed care system based on prepaid capitation to health plans and long term 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 MCO/HIO

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 Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Physician Survey
-Provider Data
-Quality Improvement Projects (QIPS)
-Quality Management/Quality Improvement Annual Plans and Annual Evaluations

Use of Collected Data

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

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 to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing

encounter data submission and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-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)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCO

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent well-care visit rates
-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 rate
-Cervical cancer screening rate
-Children's Access to Primary Care Providers
-Children's Access to Primary Care Providers - KidsCare Population
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Health Screenings
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Influenza Immunizations and Pneumococcal Vaccination Rates in the Elderly and Physically Disabled
-Initiation of prenatal care - timeliness of
-Lead screening rate

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

-Low Birth Weight Deliveries
-Patient Satisfaction with Care

-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Population in Nursing Facilities and In Home Community Based Setting (ALTCS indicator)
-Prenatal Care in the First Trimester
-Utilization of Family Planning Services (Internal Report Only)
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care
-Alzheimer study to evaluate appropriateness of HCBS care

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

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.)
-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 MCO

Performance Improvement Projects

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

Clinical Topics
-Adolescent Well Care/EPSDT
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Children's Access to Primary Care Providers
-Children's Access to Primary Care Providers - KidsCare populations
-Coordination of primary and behavioral health care
-Diabetes management
-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
-Pregnancy Prevention
-Pre-natal care
-Prevention of Influenza
-Timeliness of Initiation of Services
-Well Child Care/EPSDT

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

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 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

Non-Duplication Based on Accreditation
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

QUALITY ACTIVITIES FOR PIHP

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
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Physician Survey
-PIHP Standards
-Provider Data
-Quality Improvement Projects (QIPS)
-Quality Management/Quality Improvement Annual Plans and Annual Evaluations

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

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-Member Survey
-State-developed Survey

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires PIHPs to modify some or all NCQA specifications in ways other than continous enrollment

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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, etc.

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

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Appropriateness of services
-Coordination of care with acute contractors/pcp's
-Cultural competency
-Informed consent for psychotropic medication presciption
-Member/Family involvement
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Sufficiency of assessments

Health Status/Outcomes Quality
-Patient satisfaction with care
-Symptomatic and functional improvement

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

Standards/Accreditation

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

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Health Services Advisory Group
-Mercer and Health Care Excel

EQRO Organization
-Quality Improvement Organization (QIO)

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

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

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

-Inpatient admissions/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan

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

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to PIHPs

Performance Improvement Projects

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

Clinical Topics
-Behavior health assessment - birth to 5 years of age
-Coordination of primary and behavioral health care
-Follow-up after hospitalization
-Informed consent for psychotropic medication prescription
-Pharmacy management
-Reducing the use of seclusion & restraint

Non-Clinical Topics
-Availability of language interpretation services
-Provider education regarding cultural health care needs of members

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

CALIFORNIA
Senior Care Action Network

CONTACT INFORMATION

State Medicaid Contact:
Carol Freels
DHS
(916) 440-7535

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, 2007

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 - Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Chiropractic Care, Dental, Durable Medical Equipment, Emergency Care, Health Education, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Mental Health, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Speach Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-General 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
Senior Care Action Network

-Medicare Dual Eligibles

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
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Senior Care Action Network (SCAN)

ADDITIONAL INFORMATION

SCAN eligibility requires the beneficiary to be dually eligible, over 65 and for long term care 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 limited long term care services.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Does not perform any of the Quality Activities

Use of Collected Data
None

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO Standards
None

Accreditation Required for Participation
None

CALIFORNIA
Senior Care Action Network

Non-Duplication Based on Accreditation
None

EQRO Name
None

EQRO Organization
None

EQRO Mandatory Activities
None

EQRO Optional Activities
None

DELAWARE
Delaware Physicians Care , Inc.

CONTACT INFORMATION

State Medicaid Contact:
Kay Holmes
Delaware Social Services
(302) 255-9529

State Website Address:
www.dmap.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:
No guaranteed eligibility

Initial Waiver Approval Date:
May 17, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2006

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B) Comparability of Services
-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:
-Eligibility Expansion
-Family Planning
-Inst. For Mental Disease

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Durable Medical Equipment, Emergency Transport only, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Private Duty Nursing, Skilled Nursing Facility, Vision and hearing children under 21, 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
-Nurse Midwives

DELAWARE
Delaware Physicians Care , Inc.

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
-Special Needs Children (State defined)
-Poverty-Level Pregnant Women
-Special Needs Children (BBA defined)

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Tricare/CHAMPUS

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Delaware Physicians Care, Inc

ADDITIONAL INFORMATION

Special Needs Children (State-defined): All children below 21, no income or resource limit that meet the SSN Functional Disability Requirements.

QUALITY ACTIVITIES FOR MCO/HIO

DELAWARE
Delaware Physicians Care , Inc.

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO 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
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation

Consumer Self-Report Data
-CAHPS
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups
-State-developed Survey

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-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)

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

State conducts general data completeness assessments
Yes

DELAWARE
Delaware Physicians Care , Inc.

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Blood tests results for diabetes
-Obesity rates for adolescents
-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 admission for MH/SUD conditions/1,000 beneficiaries

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
None

Beneficiary Characteristics
None

Performance Improvement Projects

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

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

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

Standards/Accreditation

MCO Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Mercer, Inc.

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures

DELAWARE
Diamond State Partners

CONTACT INFORMATION

State Medicaid Contact:
Kay Holmes
Delaware Medicaid
(302)255-9529

State Website Address:
www.dmap.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:
No guaranteed eligibility

Initial Waiver Approval Date:
May 17, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2006

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(E)
-1902(a)(23) Freedom of Choice
-1902(a)(24)
-1902(a)(30)(A)
-1902(m)(2)(A)(ii)(vi)
-1903(f)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Inst. For Mental Disease

SERVICE DELIVERY

Enhanced Fee for Service Model - Fee-for-Service

Service Delivery

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

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

DELAWARE
Diamond State Partners

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
-Poverty-Level Pregnant Women
-Expanded Adults at or below 100 % FPL

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

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Diamond State Partners

ADDITIONAL INFORMATION

None

HAWAII
Hawaii QUEST

CONTACT INFORMATION

State Medicaid Contact:
Angelina Payne
Hawaii Department of Human Services, Med-QUEST Div
(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

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 16, 1993

Implementation Date:
August 01, 1994

Waiver Expiration Date:
June 30, 2005

Sections of Title XIX Waived:
-1902(a)(10)(A)(i)(I),(III),(IV),(VII)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(C)
-1902(a)(13)(A)(IV)
-1902(a)(17)(D)
-1902(a)(18)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(34)
-1902(a)(4)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi)
-MCO Definition 1903(m)(1)(A)
-MCO Definition 1903(m)(2)(A)(i)

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

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

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

HAWAII
Hawaii QUEST

Enrollment

-Quest-Net Expansion Groups

-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
-Participate in HCBS Waiver
-Special Needs Children
-Adults eligible to receive ESI

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

MH/SUD PIHP - Capitation

Service Delivery

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

Allowable PCPs:
-Psychiatrists
-Psychologists

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
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

HAWAII
Hawaii QUEST

Strategies Used to Identify Persons with Complex

-Asks advocacy groups to identify members of these groups

Agencies with which Medicaid Coordinates the

-Education Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aloha Care

Child & Adolescent Mental Health Division, Department of Health

Early Intervention Programs, Department of Health

HMSA-Behavior Health for SMI

HMSA-Medical

Kaiser Permanente

ADDITIONAL INFORMATION

This program provides medical 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.

The dental services are still carved out of MCO contracts, but instead of delivering them through pre-paid dental plans, they are now paid FFS. The change was effective 10/1/01.

QUALITY ACTIVITIES FOR MCO/HIO

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 Standards
-Monitoring of MCO 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

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

Use of HEDIS

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

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing

HAWAII
Hawaii QUEST

encounter data submission and editing
-Requirements for data validation

-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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 commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Dental services
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

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

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Average wait time for an appointment with PCP

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

-Children's access to primary care practitioners\

-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of PCP visits per beneficiary
-Re-admission rates of MH/SUD

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.)
-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
None

Performance Improvement Projects

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

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

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

Standards/Accreditation

MCO Standards
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-NCQA (National Committee for Quality Assurance) Standards

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

Non-Duplication Based on Accreditation
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Private accreditation organization

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Validation of encounter data

QUALITY ACTIVITIES FOR PIHP

HAWAII
Hawaii QUEST

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

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

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

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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, etc.

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

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

State conducts general data completeness assessments
Yes

HAWAII
Hawaii QUEST

Standards/Accreditation

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

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

Non-Duplication Based on Accreditation
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Private accreditation organization

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

Performance Measures

Process Quality
-Follow-up after hospitalization for mental illness

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/SUD providers per beneficiary
-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility

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

Performance Improvement Projects

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

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

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

HAWAII
Hawaii QUEST

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of encounter data

KENTUCKY
Kentucky Health Care Partnership Program

CONTACT INFORMATION

State Medicaid Contact:
Debbie Salleng
Kentucky Department for Medicaid Services
(502) 564-8196

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:
October 31, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(15)
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive eligibility
-1902(aa)

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

SERVICE DELIVERY

MCO (Comprehensive Benefits) - 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, X-Ray

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

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:
-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
-Medicare Dual Eligible

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

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

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

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

None

QUALITY ACTIVITIES FOR MCO/HIO

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

Use of Collected Data
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement

KENTUCKY
Kentucky Health Care Partnership Program

-MCO Standards
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data
None

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing

Collection: Standardized Forms
None

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

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

State conducts general data completeness assessments
Yes

KENTUCKY
Kentucky Health Care Partnership Program

Standards/Accreditation

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

Accreditation Required for Participation
-Plan required to obtain MCO accreditation by NCQA or other accrediting body

Non-Duplication Based on Accreditation
None

EQRO Name
-Health Care Review Corporation

EQRO Organization
-QIO-like entity

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

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of high cost services and procedures
-Technical assistance to MCOs to assist them in conducting

Performance Measures

Process Quality
None

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

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

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

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

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

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

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

MARYLAND
HealthChoice

CONTACT INFORMATION

State Medicaid Contact:
James Gardner
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:
Affiliated Computer Services State Health Care, LLC

Initial Waiver Approval Date:
October 30, 1996

Implementation Date:
June 02, 1997

Waiver Expiration Date:
May 31, 2005

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:
No

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) - Capitation

Service Delivery

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

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

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

Subpopulations Excluded from Otherwise Included Populations:
-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
-A child in an out-of-State placement
-Inmates of public institutions
-Enrolled in Family Planning Waiver Program

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

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.
Coventry Diamond Plan
Helix Family Choice
JAI Medical System
Maryland Physicians Care
Priority Partners MCO
United Health Care

ADDITIONAL INFORMATION

An eligible HealthChoice enrollee may be permitted to disenroll "for cause" from an MCO and enroll in another MCO outside of his/her annual right to change period if he/she is not hospitalized. Dental services provided for enrollees under 21 years old. The Department and not the MCOs are responsible for purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers. There are additional optional services that some MCOs provide for their enrollees such as dental services for adults. Medicaid recipients eligible for Maryland Medicaid Managed Care are guaranteed 6 months eligibility with exception of: Pregnant women in the Maryland Childrens Health Program, who are guaranteed eligibility for the duration of the pregnancy and 2 months postpartum, Children younger than 19 years old with income greater than 185 percent but less than 300 percent of federal poverty level enrolled in Maryland Childrens Health Program.

MARYLAND
HealthChoice

QUALITY ACTIVITIES FOR MCO/HIO

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

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
- Adult Medicaid SSI Questionnaire
- Child Medicaid AFDC Questionnaire
- Child Medicaid SSI 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 measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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 commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCOs

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

State conducts general data completeness assessments
Yes

MARYLAND
HealthChoice

-Medicaid Eligibility
-Plan Enrollment

-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services (preventive, restorative, diagnostic)
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Vision exams for Diabetics
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Prenatal and postpartum care
-Ratio of dental providers to beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Adolescent Well-care visits
-Births and average length of stay, newborns
-Children in foster care access to services (well child, ambulatory, dental and mental health)
-Discharge and average length of stay-maternity care
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Frequency of ongoing prenatal care
-Inpatient admissions/1,000 beneficiary
-Percentage of adults diagnosed with substance abuse who receive treatment
-Percentage of beneficiaries with at least one dental visit
-Percentage of children receiving well-child services
-Percentage of population receiving an ER service
-Percentage of the population receiving ambulatory care services
-Well-child visits in the first 15 months of life
-Well-child visits in the third, fourth, fifth and sixth year of life

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
-Practitioner turnover
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

MARYLAND
HealthChoice

Performance Improvement Projects

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

Clinical Topics
-Adolescent Well Care/EPSDT
-Childhood Immunization
-Diabetes management/care
-Lead toxicity
-Pre-natal care
-Well Child Care/EPSDT

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

Standards/Accreditation

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

Accreditation Required for Participation
None

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

EQRO Name
-Delmarva Foundation for Medical Care, Inc.

EQRO Organization
-Quality Improvement Organization (QIO)

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

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

MASSACHUSETTS
Mass Health

CONTACT INFORMATION

State Medicaid Contact:
Beth Waldman
Executive Office of Health and Human Services
(617) 573-1770

State Website Address:
http://www.mass.gov/masshealth

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

Initial Waiver Approval Date:
April 24, 1995

Implementation Date:
July 01, 1997

Waiver Expiration Date:
June 30, 2005

Sections of Title XIX Waived:
-1902(a)(10)(A)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(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)
-1902(a)(4)(A)
-1920(a)(18)

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:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility,

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

MASSACHUSETTS
Mass Health

Transportation, Vision, X-Ray

-Hospital Outpatient Departments
-Rural Health Clinics (RHCs)
-Nurse Midwives
-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
-TITLE XXI SCHIP
-Foster Care Children (BH carve-out)

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Over 65 years old
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

MH/SUD PIHP - Capitation

Service Delivery

Included Services:
Crisis, Detoxification, Diversionary Services, Emergency Services Programs, Inpatient Mental Health, Inpatient Substance Use Disorders Services, Mental Health Outpatient, Mental Health Residential, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Use Disorders Services, Residential Substance Use Disorders Treatment Programs, Screening, Identification, and Brief Intervention

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
-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
-Enrolled in Another Managed Care Program
-Over 65

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

MASSACHUSETTS
Mass Health

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Case Management, Chiropractic (for under 21), Dental/Maxillofacial Only, Durable Medical Equipment, Early Intervention, Emergency Transportation, EPSDT, Family Planning, Hearing Aids, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Orthotics/Prosthetics, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Podiatry, Skilled Nursing Facilty Up To 100 Days, Therapy, Vision (medical), X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-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
-TITLE XXI SCHIP
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Over 65 years old
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

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:
-Developmental Disabilities 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

Boston Medical Center HealthNet Plan

Fallon Community Health Plan - MCO

MASSACHUSETTS
Mass Health

MA Behavioral Health Partnership
Network Health
Neighborhood Health Plan
Primary Care Clinician Plan

ADDITIONAL INFORMATION

Mass Health has a behavioral carve-out for PCCM enrollees and for children in the care or custody of the Commonwealth. Regarding the MH/SUD PIHP included services, there is no long-term care in mental health residential or residential substance abuse treatment programs. The Outpatient Day programs are defined as full or part-time substance abuse or mental health services provided in an ambulatory setting. Some MCO Program services have age limitations.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-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
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 to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-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 commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

MASSACHUSETTS
Mass Health

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Breast Cancer screening rate
-Check-ups after delivery
-Depression management/care
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care

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

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Audited Financial Statements
-Cost/Utilization
-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
-Outlier Spending
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
-Provider turnover

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

Performance Improvement Projects

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

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Childhood Immunization
-Coordination of care for persons with physical disabilities

MASSACHUSETTS
Mass Health

-Coordination of primary and behavioral health care
-Diabetes management
-Emergency Room service utilization
-HIV/AIDS Prevention and/or Management
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Prescription drug abuse
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Center for Health Policy and Research

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Currently exempt from EQR regs per 1115 waiver

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

QUALITY ACTIVITIES FOR PIHP

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

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

Consumer Self-Report Data
-Consumer Satisfaction Surveys
-Consumer/Beneficiary Focus Groups

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

Encounter Data

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

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

MASSACHUSETTS
Mass Health

-Incentives/sanctions to insure complete, accurate, timely sets of acceptable values, standards for data processing
encounter data submissionand editing

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

-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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, etc.

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

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Continuing Care Rate
-Depression management/care
-Follow-up after hospitalization for mental illness
-Med Monitoring Rates
-Re-admission Rates
-Service after a diversion from inpatient care

Health Status/Outcomes Quality
-Community Tenure Post Hospitalization
-Patient satisfaction with care

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

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Emergency Service Program Use/1000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Audited Financial Statement

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

MASSACHUSETTS
Mass Health

-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.)
-IBNR Methodology
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue
-Provider turnover
-Type of Service Provided

Beneficiary Characteristics
-Age Categories
-DMH Affiliation
-DSS Affiliation
-Rating Categories

Performance Improvement Projects

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

Clinical Topics
-Coordination of primary and behavioral health care
-Depression management
-ETOH and other substance abuse screening and treatment

Non-Clinical Topics
-Member Access to Behavioral Health Services

Standards/Accreditation

PIHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-UMass Med Center for Healthcare Policy and Research

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-External Auditors
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of encounter data

QUALITY ACTIVITIES FOR PCCM

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
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

MASSACHUSETTS
Mass Health

-Provider Data

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
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Depression medication management
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

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

Access/Availability of Care
-Adult access to preventive/ambulatory health services
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners

Use of Services/Utilization
-ALOS overall MH/SUD
-Average number of visits to MH/SUD providers per beneficiary
-Continuing Care rates/MH
-DIscharge per 1000 MH/SUD
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-Intensive Clinical Management/MH/SUD/1000
-Number of inpt days MH/SUD
-Percentage of beneficiaries with at least one dental visit
-Pregnancy-Enhanced Services MH/SUD/1000
-Re-admission rates of MH/SUD

Provider Characteristics
None

Beneficiary Characteristics
-Disenrollment rate
-Information of beneficiary ethnicity/race
-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)
-Childhood Immunization
-Coordination of primary and behavioral health care
-Deprssion management
-Diabetes management
-Emergency Room service utilization
-Hepatitis B screening and treatment
-Hospital Discharge Planning
-Inpatient maternity care and discharge planning
-Pharmacy management
-Post-natal Care
-Pre-natal care

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

MASSACHUSETTS
Mass Health

-Presciption drug abuse
-Sexually transmitted disease screening
-Well Child Care/EPSDT

MINNESOTA
MinnesotaCare Program For Families And Children

CONTACT INFORMATION

State Medicaid Contact:
Christine Bronson
Minnesota Department of Human Services
(651) 296-4332

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:
6 months guaranteed eligibility

Initial Waiver Approval Date:
April 27, 1995

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2005

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) - Capitation

Service Delivery

Included Services:
All other MA Benefits Covered Except NF, ICF/MR and Home And Community Based Waiver, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, 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

Medicare Dual Eligibles Included:
None

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

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

Blue Plus
Health Partners
Medica
UCARE
First Plan Blue
Itasca Medical Care
Metropolitan Health Plan

ADDITIONAL INFORMATION

Contractors are not required to identify PCPs. PCP provider types are designated by HMOs rather than State.

QUALITY ACTIVITIES FOR MCO/HIO

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

Use of Collected Data
-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

MINNESOTA
MinnesotaCare Program For Families And Children

-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
-Disenrollment Survey

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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
-Ad hoc comparison to benchmarks and norms
-Ad hoc per member per month analysis and comparisons across MCOs
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Limited analysis of encounter data submission to help determine data completeness

MCO/HIO 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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Cervical cancer screening rate
-Cholesterol screening and management
-Depression management
-Diabetes management/care
-Immunizations for two year olds

Health Status/Outcomes Quality
-Patient satisfaction with care

MINNESOTA
MinnesotaCare Program For Families And Children

Standards/Accreditation

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

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-FMAS (QIO-like)
-MetaStar (QIO)
-Michigan PRO (QIO)
-NCQA (Accreditation)
-PRS (QIO)
-Stratis Health (QIO)

EQRO Organization
-Private Accreditation Organization
-QIO-like entity
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of
-Validation of client level data, such as claims and encounters

Access/Availability of Care
-Average distance to PCP

Use of Services/Utilization
-Well-child care visit rates in first 15 months of life

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

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Senior Influenza Immunization
-Smoking prevention and cessation
-Well Child Care

Non-Clinical Topics
None

MINNESOTA
Prepaid Medical Assistance Program

CONTACT INFORMATION

State Medicaid Contact:
Christine Bronson
Minnesota Department of Human Services
(651) 296-4332

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, 2005

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) HMO Definition
-1903(m)(2)(A)(vi) Medical Education Trust Fund, Eligibility Expansion

SERVICE DELIVERY

MCO (Comprehensive Benefits) - 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 Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable

MINNESOTA
Prepaid Medical Assistance Program

Enrollment

Populations Voluntarily Enrolled:
-Children with SED
-Enrolled in another managed care program
-Medicare Dual Eligibles

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:
-Non-documented Alien Recipients Who Only Receive Emergency MA Under Minn. Stat. 256B.06(4)
-QMBs And SLMBs Who Are Not Otherwise Receiving MA
-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
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Health Partners
Medica
PrimeWest Health System
UCARE
First Plan Blue
Itasca Medical Care
Metropolitan Health Plan
South Country Health Alliance

ADDITIONAL INFORMATION

Contractors are not required to identify PCPs. PCP provider types are designated by HMOs rather than State; county staff perform enrollment functions.

QUALITY ACTIVITIES FOR MCO/HIO

MINNESOTA
Prepaid Medical Assistance Program

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO 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
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
-Disenrollment Survey

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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
-Ad hoc per member per month analysis and comparisons across MCOs
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Limited analysis of encounter data submissions to help determine data completeness

MCO/HIO 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

State conducts general data completeness assessments
Yes

MINNESOTA
Prepaid Medical Assistance Program

Standards/Accreditation

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

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-FMAS (QIO-like)
-MetaStar (QIO)
-Michigan PRO (QIO)
-NCQA (Accreditation)
-PRS (QIO)
-Stratis Health (QIO)

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Cervical cancer screening rate
-Cholesterol screening and management
-Depression management
-Diabetes management/care
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP

Use of Services/Utilization
-Well-child care visit rates in first 15 months of life

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

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Senior Influenza Immunization
-Smoking Cessation
-Well Child Care

Non-Clinical Topics
None

MINNESOTA
Prepaid Medical Assistance Program

EQRO Organization
-Private Accreditation Organization
-QIO-like entity
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

MISSOURI
MC+ Managed Care/1115

CONTACT INFORMATION

State Medicaid Contact:
Susan Eggen
Department of Social Services, Division of Medical Services
(573) 751-5178

State Website Address:
http://www.state.mo.us

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Policy Studies, Inc.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 29, 1998

Implementation Date:
September 01, 1998

Waiver Expiration Date:
March 01, 2007

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(u) MEQC
-Eligibility Expansion
-Family Planning Eligibility Expansion
-Indigent/Clinic Expenditures

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation - Emergency only, Vision, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-PCP Teams
-Obstetricians/Gynecologists (Health Plans can choose to designate OB/GYNs for PCPs)
-PCP Clinics - which can include FQHCs/RHCs
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners

MISSOURI
MC+ Managed Care/1115

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-TITLE XXI SCHIP
-UNINSURED PARENTS - ME CODE 76

Subpopulations Excluded from Otherwise Included Populations:
-Presumptive Eligibility for Children
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

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 ER Encounters
-MCOs use Hospital Admissions
-MCOs use Hospital Encounters
-Reviews grievances and appeals 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 Cross Blue Shield of Kansas City, Blue Advantage+ Plus
Community Care Plus
Family Health Partners
FirstGuard
HealthCare USA
Mercy Health Plans
Missouri Care

ADDITIONAL INFORMATION

Uninsured women losing their MC+ eligiblity 60 days after the birth of their child are eligible for womens health services for one year plus 60 days, regardless of income level. These women obtain services through the MC+ Fee-For-Service Program.

QUALITY ACTIVITIES FOR MCO/HIO

MISSOURI
MC+ Managed Care/1115

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO 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
-Fraud and Abuse
-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
Child Medicaid AFDC Questionnaire

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

Encounter Data

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

Collections: Submission Specifications
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
No

MISSOURI
MC+ Managed Care/1115

Standards/Accreditation

MCO Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Behavioral Health Concepts (BHC)

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-C-Section Rates
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-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
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

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

Access/Availability of Care
-Average distance to PCP

Use of Services/Utilization
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-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
-Weeks of pregnancy at time of enrollment in MCO, for

Performance Improvement Projects

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

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

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

MISSOURI
MC+ Managed Care/1115

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Validation of encounter data

NEW YORK
Partnership Plan - Family Health Plus

CONTACT INFORMATION

State Medicaid Contact:
Linda LeClair
Office of Medicaid Management, New York State Department
(518) 474-8887

State Website Address:
http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus and Facilitated Enrollers

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
June 29, 2001

Implementation Date:
September 04, 2001

Waiver Expiration Date:
March 31, 2006

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(25)
-1902(a)(30)
-1902(a)(34) Retroactive Eligibility

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)

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Case Management, Dental (MCO option), Diabetic supplies and equipment, Durable Medical Equipment, Emergency ambulance transportation, EPSDT, Family Planning (MCO Option), Hearing, Home Health (40 visits), Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health (30 days per year), Inpatient Substance Use Disorders, Laboratory, Medically Managed Detox - Inpatient, Medically Supervised Withdrawal Services Inpatient/Outpatient, Outpatient Hospital, Outpatient Mental Health (60 days per year), Outpatient Substance Use Disorders, Physician, Prescription Drugs, Radiation Therapy, chemotherapy and hemodialysis, Smoking cessation products, Vision, X-Ray

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

NEW YORK
Partnership Plan - Family Health Plus

Enrollment

Populations Voluntarily Enrolled:
-Adults 19-64 no children up to 100% FPL
-Adults 19-64 w/children up to 150% FPL

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Equivalent Insurance
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

PPO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Case Management, Dental (Plan option), Diabetic supplies and equipment, Durable Medical Equipment, Emergency ambulance transportation, EPSDT, Family Planning, Home Health (40 visits), Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health (30 days per year), Inpatient Substance Use Disorders, Laboratory, Medically Necessary Detox Inpatient, Medically Supervised withdrawal service Inp/Out, Outpatient Hospital, Outpatient Mental Health (60 days per year), Outpatient Substance Use Disorders, Physician, Prescription Drugs, Radiation therapy, chemotherapy and hemodialysis, Smoking cessation products, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Adults 19-64 no children up to 100% FPL
-Adults 19-64 w/children up to 150% of FPL

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Other Equivalent Insurance
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ABC Health Plan
Affinity Health Plan
Americhoice
Buffalo Community Health/Univera Community Health
Capital District Physicians Health Plan
CarePlus Health Plan
Catholic Services Health Plan/Fidelis
Community Choice Health Plan

NEW YORK
Partnership Plan - Family Health Plus

Community Premier Plus
GHI
Health First
HIP Combined
Manhattan PHSP/Centercare
MVP Health Plan
NY Hospital Community PHSP
Syracuse PHSP/Total Care
United Healthcare of Upstate
Westchester PHSP/Hudson Health Plan
Excellus
GHI HMO Select
Health Now
LMC/Health Care Plus
MetroPlus Health Plan
Neighborhood Health Providers
St. Barnabas/Partners in Health
United Healthcare of NY
Wellcare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

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

Use of Collected Data
-Health Services Research
-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 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
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms
None

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

-Use of Medicaid Identification Number for beneficiaries

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

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Island Peer Review Organization

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

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

NEW YORK
Partnership Plan Medicaid 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:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
July 15, 1997

Implementation Date:
October 01, 1997

Waiver Expiration Date:
March 31, 2006

Sections of Title XIX Waived:
-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)

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)

SERVICE DELIVERY

MCO (Comprehensive Benefits) - 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 Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Skilled Nursing Facility, Transportation (Optional), Vision, X-Ray

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

NEW YORK
Partnership Plan Medicaid 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) Adults and Related Populations
-NYS Home Relief Adults
-Section 1931 (AFDC/TANF) Children and Related

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
-Reside in residential treatment facility for children and youth
-Infants weighing less than 1200 grams or infants who meet SSI criteria
-Special Needs Children (State defined)
-Admitted to hospice at the time of enrollment
-Foster children in direct care
-Eligible only for TB related services

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

NEW YORK
Partnership Plan Medicaid 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
-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

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Residential Treatment Facility for children and youth
-Special Needs Children (State defined)
-Admitted to hospice at the time of enrollment
-Reside in Nursing Facility or ICF/MR
-Participation in a LTC Demonstration Program
-Other Insurance
-Eligible less than 6 Months
-Spend downs
-Reside in State Operated Psychiatric Facility
-Enrolled in the Restricted Recipient Program
-Foster care children in direct care
-Eligible only for TB related services
-Enrolled in Another Managed Care Program
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

NEW YORK
Partnership Plan Medicaid Managed Care Program

PCCM Provider - Capitation

Service Delivery

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

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

Enrollment

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

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

Subpopulations Excluded from Otherwise Included Populations:
-Foster Care children in direct care
-Eligible only for TB Related Sevices
-Reside in residential treatment facility for children and yourth

-Special Needs Children (State defined)
-Enrolled in Another Managed Care Program
-Reside in Nursing Facility or ICF/MR
-Participation in LTC Demonstration
-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
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

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

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

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 Agencies
-Substance Abuse Agency

NEW YORK
Partnership Plan Medicaid Managed Care Program

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ABC Health Plan
Americhoice
Buffalo Community Health/Univera Community Health
CarePlus Health Plan
Community Choice Health Plan
Excellus
GHI HMO Select
Health First
HealthFirst PHSP SN
Independent Health/Hudson Valley&WNY
Manhattan PHSP/Centercare
MetroPlus Health Plan SN
Neighborhood Health Providers
NYPS Select Health SN
Preferred Care
Southern Tier Pediatrics
Suffolk Health Plan
Twin Tier/ Southern Tier Priority
United Healthcare of Upstate
Vytra
Westchester PHSP/Hudson Health Plan
Affinity Health Plan
Broome County MC
Capital District Physicians Health Plan
Catholic Services Health Plan/Fidelis
Community Premier Plus
FidelisCare HeatherLife SN
Health Choice
Health Now
HIP Combined
Managed Health Inc/A+ Health Plan
MetroPlus Health Plan
MVP Health Plan
NY Hospital Community PHSP
Physician Case Management Program
Primary Health
St. Barnabas/Partners in Health
Syracuse PHSP/Total Care
United Healthcare of NY
VidaCare Inc. SN
Wellcare

ADDITIONAL INFORMATION

Monthly premium for primary care services.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO 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 generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

NEW YORK
Partnership Plan Medicaid Managed Care Program

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

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

Collection: Standardized Forms
None

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

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-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
-Alcohol and Substance abuse use screening
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Depression management/care
-Diabetes medication 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 - timeliness of
-Lead Screening rate
-Smoking prevention and cessation
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

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

NEW YORK
Partnership Plan Medicaid Managed Care Program

Use of Services/Utilization
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Access/Availability of Care
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of
-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

Performance Improvement Projects

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

Clinical Topics
-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 Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Island Peer Review Organization

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct 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

NEW YORK
Partnership Plan Medicaid Managed Care Program

QUALITY ACTIVITIES FOR PCCM

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

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
None

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Number of primary care case manager visits per beneficiary

Provider Characteristics
None

Beneficiary Characteristics
None

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:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
FirstHealth

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
October 12, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2006

Sections of Title XIX Waived:
-1902(a)(10)(A)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(34)
-1902(a)(4)

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

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 Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

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

OKLAHOMA
SoonerCare

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-Children in permanent custody
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Covered by an HMO

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

Medical-only PAHP (risk, non-comprehensive) - 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
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Indian Health Service (IHS) Providers
-Rural Health Clinics (RHCs)

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
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Participate in HCBS Waiver
-Children In State Custody
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

OKLAHOMA
SoonerCare

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

SoonerCare American Indian PCCM

SoonerCare PAHP

ADDITIONAL INFORMATION

American Indians are the only population that is eligible to enroll in the PCCM portion of the SoonerCare program. American Indians have an option of enrolling in the PCCM or Medical-only PAHP under the SoonerCare program.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards
-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
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult with Special Needs Questionnaire
  Child with Special Needs Questionnaire
-State-developed Survey

Use of HEDIS

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

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing

encounter data submissionand editing
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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, etc.

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

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care

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

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-Percentage of beneficiaries who are auto-assigned to PAHPs

OKLAHOMA
SoonerCare

Performance Improvement Projects

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

Clinical Topics
-Emergency Room service utilization

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

Standards/Accreditation

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

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

QUALITY ACTIVITIES FOR PCCM

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:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult with Special Needs Questionnaire
  Child with Special Needs Questionnaire
-State-developed Survey

Performance Improvement Projects

Clinical Topics
-Emergency Room service utilization

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

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:
October 31, 2007

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)(A)
-1902(a)(14) Cost Sharing
-1902(a)(17)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(34)
-1902(a)(43)(A)
-1903(m)(1)(a)
-1903(m)(2)(a)
-1903(m)(2)(a)(vi)
-1905(a)(13)
-2103
-2103(e)

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(f)
-1903(m)(1)(A)
-1903(m)(2)(A)
-1903(m)(2)(A)(vi) Eligibility Expansion, Guarantee Eligibility, Disenrollment
-1905(a)(13) Chemical Dependency Treatment
-Employer Sponsored Insurance
-Inst. For Mental Disease

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

OREGON
Oregon Health Plan

MH/SUD PIHP - Capitation

Service Delivery

Included Services:
Crisis, IMD, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Opioid Treatment Programs, Outpatient Substance Use Disorders, Screening, Identification, and Brief Intervention

Allowable PCPs:
-Does not apply

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
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown
-Other Insurance

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

OREGON
Oregon Health Plan

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management

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

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Pregnant Women and Optional Children
-Medicare Dual Eligible
-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

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

Medicare Dual Eligibles Excluded:
None

OREGON
Oregon Health Plan

Dental PAHP - Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Does not apply

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligible

Populations Mandatorily Enrolled:
-TITLE XXI SCHIP
-Medicare Dual Eligible
-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:
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown
-Other Insurance

Lock-In Provision:
6 month lock-in

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

Medicare Dual Eligibles Excluded:
None

OREGON
Oregon Health Plan

MCO (Comprehensive Benefits) - Capitation

Service Delivery

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

Allowable PCPs:
-Rural Health Clinics (RHCs)
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-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
-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:
-QMB and MN Spenddown
-Other Insurance
-Enrolled in Another Managed Care Program

Lock-In Provision:
6 month lock-in

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

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-Asks advocacy groups to identify members of these groups
-Health Plans use multiple means to identify such members
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Employment Agencies
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

OREGON
Oregon Health Plan

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Accountable Behavioral Health
Care Oregon
Central Oregon Independent Health Solutions
Deschutes County CDO
Douglas County IPA
FamilyCare Health Plans
Hayden Family Dentistry
Jefferson Behavioral Health
Lane Individual Practice Association
Marion Polk Community Health Plan
Mid-Rogue Independent Practice Assoc.
Multnomah County Verity
Oregon Dental Service
PCCM
Tuality Health Alliance (Mental Health)
Washington County Health (Mental Health)
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
Lane Care MHO
Managed Dental Care of Oregon
Mid Valley Behavioral Care Network
Multicare Dental
Northwest Dental Services
Oregon Health Management Service
Providence Health Assurance
Tuality Health Care
Willamette Dental

ADDITIONAL INFORMATION

1902(a)(1) Statewideness was waived under the uniformity section. A $6.00 Case Management Fee is paid on a per member/per month basis. This fee is not a capitation payment. The Oregon PCCM program is fee-for-service. Under age one is guaranteed 12 months continuous eligibility.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO 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
  Adult with Special Needs Questionnaire
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire
  Child with Special Needs 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 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)

Collections: Submission Specifications

-Deadlines for regular/ongoing encounter data submission(s)

-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

-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-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 MCO

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Immunizations for two year olds
-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
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care

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

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

OREGON
Oregon Health Plan

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.)
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue
-Medical loss ratio

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

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

Clinical Topics
-Asthma management
-Childhood Immunization
-Early Childhood Cavities Prevention
-Smoking prevention and cessation

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

Standards/Accreditation

MCO Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-OMPRO

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Rapid Cycle Review
-Validation of encounter data

QUALITY ACTIVITIES FOR PIHP

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

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

OREGON
Oregon Health Plan

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 generates from encounter data SOME of the HEDIS measures listed for Medicaid

Encounter Data

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

Collections: Submission Specifications
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-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, etc.

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

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality
-Patient satisfaction with care

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

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

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
-Net worth
-State minimum reserve requirements

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

OREGON
Oregon Health Plan

-Total revenue

-Re-admission rates of MH/SUD

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Performance Improvement Projects

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

Clinical Topics
-Coordination of primary and behavioral health care
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment

Non-Clinical Topics
-Adults access to preventive/ambulatory health services

Standards/Accreditation

PIHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-OMPRO

EQRO Organization
-Quality Improvement Organization (QIO)

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

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

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards
-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
-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 modifies/requires PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

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Oregon Health Plan

1

Encounter Data

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

Collections: Submission Specifications
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-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, etc.

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

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Dental services

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Ratio of dental providers to beneficiaries

Use of Services/Utilization
-Early Childhood Cavities Prevention
-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 (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

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

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-PAHP/PCP-specific disenrollment rate

OREGON
Oregon Health Plan

Performance Improvement Projects

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

Clinical Topics
-Child/Adolescent Dental Screening and Services
-Early Childhood Dental Cavities
-Hospital Dentistry

Non-Clinical Topics
-Grievance Systems

Standards/Accreditation

PAHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Ombudsman

Use of Collected Data:
-Health Services Research
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data
-CAHPS
  - "Cores" Adult/Child Survey with elected Medicaid and Special Needs Questions

RHODE ISLAND
Rite Care

CONTACT INFORMATION

State Medicaid Contact:
Sharon Reniere
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

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 01, 1993

Implementation Date:
August 01, 1994

Waiver Expiration Date:
July 31, 2005

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B) Comparability of Services
-1902(a)(17)(b)
-1902(a)(23) Freedom of Choice
-1902(a)(34)

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

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter, Laboratory, Nutrition, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Smoking Cessation, Speech Therapy, Transportation, Vision, X-Ray

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

RHODE ISLAND
Rite Care

Populations Voluntarily Enrolled:
-Foster Care Children
-Special Needs Children (State defined)

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:
-Participate in HCBS Waiver
-Medicare Dual Eligible
-American Indian/Alaskan Native
-Access to Cost Effective, Comprehensive, Employer-Sponsored Coverage
-Special Needs Children with Other Insurance Coverage

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

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:

-Chlid Welfare Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coordinated Health Partners
Neighborhood Health Plan of Rhode Island
United HealthCare of NE

ADDITIONAL INFORMATION

Since September, 2003, Children with Special Health Care Needs are offered enrollment in Rite Care unless they have comprehensive medical insurance from another source -- these children include SSI recipients, children eligible through Katie Beckett provisions, and children in subsidized adoption settings. Coordination with other agencies in the care of Children with Special Health Care Needs takes place through the CEDARRS program, available to children in managed care as well as to those in fee-for-service Medicaid -- this program combines evaluation, diagnosis, referral, reevaluation and a range of other services for families of Children with Special Needs. SSI/State Supplement-eligible child; Child eligible under Katie Beckett provisions; Child in subsidized adoption setting. Note that managed care enrollment is currently voluntary for these groups, but is not offered if children are covered by comprehensive third-party insurance.

QUALITY ACTIVITIES FOR MCO/HIO

RHODE ISLAND
Rite Care

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
-Grievances and Appeals
-MCO Standards
-Monitoring of MCO 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 use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

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

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

Collection: Standardized Forms
None

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

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

State conducts general data completeness assessments
Yes

RHODE ISLAND
Rite Care

-Use of Medicaid Identification Number for beneficiaries

Performance Measures

Process Quality
-Cervical cancer screening rate
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

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

Access/Availability of Care
-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

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Discharges from Neonatal Intensive Care Unit per 1,000 live births
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Inpatient days per 1,000
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Prescriptions per 1,000 population by category (name brand, generic and OTC)
-Re-admission rates of MH/SUD

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)

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for

Performance Improvement Projects

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

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

RHODE ISLAND
Rite Care

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

Standards/Accreditation

MCO Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

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

Non-Duplication Based on Accreditation
None

QRO Name
-IPRO

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

TENNESSEE
TennCare

CONTACT INFORMATION

State Medicaid Contact:
Manny Martins
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:
June 30, 2007

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)(32)
-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) - 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, Physician, Transportation, Vision, X-Ray

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

TENNESSEE
TennCare

Enrollment

Populations Voluntarily Enrolled:
None

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

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

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

Medicare Dual Eligibles Excluded:
None

TENNESSEE
TennCare

MH/SUD PIHP - Capitation

Service Delivery

Included Services:
Crisis, Detoxification, Inpatient Mental Health, Inpatient Substance Use Disorders Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders Services, Residential Substance Use Disorders Treatment Programs

Allowable PCPs:
-Public Health Departments and Clinics
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Indian Health Service (IHS) Providers
-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
-Aged and Related Populations
-Foster Care Children
-Medically needy
-Uninsured
-Uninsurables

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

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

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Better Health Plan
Memphis Managed Care Corp. (TLC)
Preferred Health Partnership/PHP
John Deere/Heritage National Health Plan
Omnicare Health Plan
Premier Behavioral Systems of TN

TENNESSEE
TennCare

Tennessee Behavioral Health, Inc.
VUMC Care (VHP Community Care)
Volunteer State Health Plan (Bluecare)

ADDITIONAL INFORMATION

All medically necessary services are provided through the managed care organizations. All mental health and substance use disorder services are provided through behavioral health organizations. The State has carved out Pharmacy services for those individuals who are both TennCare enrollees and eligible for Medicare.

QUALITY ACTIVITIES FOR MCO/HIO

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 Standards
-Monitoring of MCO 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
-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

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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 commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation

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

-Per member per month analysis and comparisons across data between
-Specification/source code review, such as a programming language used to create an encounter data file for submission

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

-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Adolescent well-care visit rates
-Breast cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality

-Percentage of low birth weight infants

Access/Availability of Care

-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization

-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-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 OB/GYN visits per adult female beneficiary

Health Plan Stability/ Financial/Cost of

-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

Health Plan/ Provider Characteristics

-Board Certification
-Languages Spoken (other than English)
-Provider turnover

TENNESSEE
TennCare

-Ratio of PCPs to beneficiaries

-State minimum reserve requirements
-Total revenue
-Weekly Claims Inventory Reports

-Number of PCP visits per beneficiary

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

-Weeks of pregnancy at time of enrollment in MCO, for

Standards/Accreditation

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

Accreditation Required for Participation
-AAAHC (Accreditation Association for Ambulatory Health Care)

Non-Duplication Based on Accreditation
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

Performance Improvement Projects

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

Clinical Topics
-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
-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
-Post-natal Care
-Pre-natal care
-Prescription 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

TENNESSEE
TennCare

EQRO Optional Activities
None

QUALITY ACTIVITIES FOR PIHP

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

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

Consumer Self-Report Data
-State-developed Survey

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires PIHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837,

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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, etc.

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

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

State conducts general data completeness assessments
Yes

-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality
None

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

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

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

Performance Improvement Projects

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

Clinical Topics
None

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services

Standards/Accreditation

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

Accreditation Required for Particpation
-AAAHC (Accreditation Association for Ambulatory Health Care)

Non-Duplication Based on Accreditation
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
None

UTAH
Primary Care Network (PCN)

CONTACT INFORMATION

State Medicaid Contact:
Gayleen Henderson
Utah Department of Health
(801) 538-6135

State Website Address:
http://www.state.ut.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:
No guaranteed eligibility

Initial Waiver Approval Date:
February 08, 2002

Implementation Date:
July 01, 2002

Waiver Expiration Date:
July 31, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State Mandate to PIHPs or PAHPs
-1902(a)(43)(A) EPDST

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1916(a) Cost Sharing
-Eligibility Expansion

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Dental, Diabetes Products, Emergency Room Services, Emergency Transportation, Family Planning, Immunization, Laboratory, Pharmacy, Physician, Vision, X-Ray

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

Enrollment

UTAH
Primary Care Network (PCN)

Populations Voluntarily Enrolled:
-Adults age 19 and above at 150% of the FPL

Populations Mandatorily Enrolled:
-Medicare Dual Eligibles

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
-Special Needs Children (BBA defined)
-Other Insurance

Lock-In Provision:
1 month lock-in

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

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

Mental Health (MH) PIHP - Capitation

Service Delivery

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

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

Contractor Types:
-CMHC Operated Entity (Public)
-County Operated Entity (Public)
-CMHC - some private; some governmental

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Section 1925 (Traditional Medical Assistance) Adults
-Medically Needy (not aged, blind, or disabled) Adults
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Resident of the Utah State Hospital (IMD)
-Resident of the State Develpmental Center (DD/MR facility)
-Medicare Dual Eligible

Lock-In Provision:
1 month lock-in

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

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

UTAH
Primary Care Network (PCN)

Medical-only PIHP (non-risk, comprehensive) - Other

Service Delivery

Included Services:
Case Management, Diabetes self-management, Durable Medical Equipment, Enhanced Services to Pregnant Women, EPSDT, ESRD, Family Planning, Hearing, HIV Prevention, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient medical detoxification, Laboratory, Medical Supples, 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-

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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) Adults and Related Populations
-Section 1925 (Traditional Medical Assistance) Adults
-Medically Needy (not aged, blind, or disabled) Adults
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-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
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Medicare Dual Eligible

Lock-In Provision:
1 month lock-in

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Bear River Mental Health
Central Utah Mental
Davis Mental Health
Four Corners Mental Health
Healthy U
IHC Health Plans Inc.
Molina Healthcare of Utah (Molina Plus)
Molina Healthcare of Utah (Molina)
Northeastern Counseling Center
Southwest Mental Health
Valley Mental Health
Wasatch Mental Health
Weber Mental Health

ADDITIONAL INFORMATION

PCN program is a statewide section 1115 demonstration to expand Medicaid coverage. PCN also offers the full Medicaid state plan package to certain high-risk pregnant women with assets in excess of state plan levels, and a primary/preventive package to certain adults age 19 and above, with incomes under 150% FPL, who are not otherwise Medicaid-eligible. The PIHP contracts covering physical health care are non-risk. Medicaid reimburses each of these contractors for services. The PIHP contracts covering mental health care are risk-based.

Statutes Waived: 1902(a)(4) State mandate to PIHPs is waived for the Non-Traditional clients only. Medicare duals are included for the Non-Traditional clients only. Payment follows non-risk arrangement as described in 42 CFR 447.362.

UTAH
Primary Care Network (PCN)

QUALITY ACTIVITIES FOR PIHP

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

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for initial encounter data submission

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

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across PIHPs

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

State conducts general data completeness assessments
Yes

UTAH
Primary Care Network (PCN)

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

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

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Average time for intake
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

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

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 age and gender
-Information on primary languages spoken by beneficiaries

Performance Improvement Projects

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

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

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

UTAH
Primary Care Network (PCN)

Standards/Accreditation

PIHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-State of Utah

EQRO Organization
-In-house

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

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

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Ombudsman
-On-Site Reviews
-Provider Data

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

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

VERMONT
Vermont Health Access

CONTACT INFORMATION

State Medicaid Contact:
Ann Rugg
Vermont Health Access Plan
(802) 879-5911

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

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
July 28, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2005

Sections of Title XIX Waived:
-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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(i)(10) Drug-related expenditures
-1903(m)(2)(A)(vi) Eligibility Expansion, Guaranteed Eligibility, IMD
-Expenditures for payments to MCOs that restrict disenrollment rights

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 Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, 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
-General Practitioners
-Family Practitioners
-Internists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)

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

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Spenddown
-Children who participate in Vermont High Tech Home Care Program
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

PC PLUS

ADDITIONAL INFORMATION

Allowable PCP Specialists: OB/GYNs or GYNs may be approved to be PCPs on a case-by-case basis.

VERMONT
Vermont Health Access

QUALITY ACTIVITIES FOR PCCM

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

Use of Collected Data:
-Program Evaluation

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-IP hospital LOS
-Number of ED visits
-Number of Hospital visits

Access/Availability of Care
-Children's access to primary care practitioners

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

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
-Asthma management
-Diabetes management

Non-Clinical Topics
None

WISCONSIN
BadgerCare [SCHIP]

CONTACT INFORMATION

State Medicaid Contact:
Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:
http://dhfs.wisconsin.gov

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, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1916(a) Cost Sharing
-Annual Reporting Requirements
-Eligibility and Outreach
-Eligibility Expansion
-Federal Matching Payment and Family Coverage Limits
-Restrictions on Coverage and Eligibility to Targeted Low Income Children

Guaranteed Eligibility:
12 months guaranteed eligibility for children

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

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

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

WISCONSIN
BadgerCare [SCHIP]

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-TITLE XXI SCHIP
-Custodial Parents (And Their Spouses) Of Children Eligible Through Title XXI SCHIP (BadgerCare)

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Migrant workers
-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

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

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 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
-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
Group Health Cooperative Of Eau Claire -- BadgerCare SCHIP
Group Health Cooperative Of South Central WI -- BadgerCare SCHIP
Health Tradition Health Plan -- BadgerCare SCHIP
Managed Health Services -- BadgerCare SCHIP
MercyCare Insurance Company -- BadgerCare SCHIP
Network Health Plan -- BadgerCare SCHIP
Security Health Plan -- BadgerCare SCHIP
Touchpoint Health Plan -- BadgerCare SCHIP
UnitedHealthcare of WI -- BadgerCare SCHIP
Unity Health Insurance -- BadgerCare SCHIP
Valley Health Plan -- BadgerCare SCHIP

ADDITIONAL INFORMATION

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 amended on 01/18/2001. 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.

WISCONSIN
BadgerCare [SCHIP]

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-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
-Health Services Research
-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

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
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-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
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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
-Per member per month analysis and comparisons across MCOs

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

State conducts general data completeness assessments
Yes

-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

-Admission Source
-Admission Type
-Days Supply
-Modifier Codes
-Patient Status Code
-Place of Service Codes
-Quantity

Performance Measures

Process Quality
-Breast Cancer screening rate
-Cervical cancer screening rate
-Children with at least one comprehensive EPSDT well child visit in the look-back period at age 3-5 years,6-14 years, and 15-20 years
-Children with at least one non-EPSDT well-child visit in the look-back period at ages birth-1 year, 1-2 years, 3-5 years, 6-14 years and 15-20 years
-Comprehensive EPSDT well-child visits for children age birth to two years for those receiving 5,6,and 7, or more visits
-Dental services
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Hearing services for individuals of all ages
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals of all ages

Health Status/Outcomes Quality
-Breast malignancies detected
-Cervix/uterus malignancies detected
-HPV infections detected
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP
-Provider network data on geographic distribution
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Percentage of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Percentage of beneficiaries with at least one PCP visit
-Percentage of beneficiaries with at least one specialist visit

Health Plan Stability/ Financial/Cost of
None

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

Beneficiary Characteristics
None

Performance Improvement Projects

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

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

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

WISCONSIN
BadgerCare [SCHIP]

Standards/Accreditation

MCO Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

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

EQRO Name
-MetaStar

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional 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

WISCONSIN
Wisconsin Partnership Program

CONTACT INFORMATION

State Medicaid Contact:
Steven Landkamer
DHFS/DDES/CDSD
(608) 261-7811

State Website Address:
http://dhfs.wisconsin.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:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 01, 1998

Implementation Date:
January 01, 1999

Waiver Expiration Date:
December 31, 2006

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)
-1902(a)(20)
-1902(a)(23) Freedom of Choice
-1902(a)(7)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1916(a) Cost Sharing
-HCBS

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

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

Allowable PCPs:
-All certified Medicaid providers

Enrollment

WISCONSIN
Wisconsin Partnership Program

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

Populations Mandatorily Enrolled:
None

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

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

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

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

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:
-Aging Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care Organization - Partnership
Community Living Alliance -- Partnership
Community Health Partnership -- Partnership
Elder Care Of Dane County - Partnership

ADDITIONAL INFORMATION

The Wisconsin Partnership Program 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. Enrollees must meet nursing home level-of-care. The Partnership Program goals are to: improve quality of health care and service delivery while containing costs; reduce fragmentation and inefficiency in the existing health care delivery system; increase the ability of people to live in the community and participate in decisions regarding their own 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 MCO/HIO

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

WISCONSIN
Wisconsin Partnership Program

Consumer Self-Report Data
-None

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
None

Use of Services/Utilization
-Number of hospital admissions per member per year
-Number of hospital days per member per year
-Percentage of beneficiaries with at least one dental visit
-Percentage of people living at home, CBRF/group home, nursing home

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

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

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

WISCONSIN
Wisconsin Partnership Program

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

Standards/Accreditation

MCO Standards
None

Non-Duplication Based on Accreditation
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-MetaStar

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures

ALABAMA
Maternity Care Program

CONTACT INFORMATION

State Medicaid Contact:

Gloria Luster
Alabama Medicaid Agency
(334) 353-5539

State Website Address:

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

PROGRAM DATA

Program Service Area:
Statewide

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

Contracted Global Fee - Other

Service Delivery

Included Services:
Case Management, Home Visits, Inpatient Hospital, Outpatient Hospital, Physician

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Poverty-Level Pregnant Women
-SSI over 19 eligibles
-Section 1931 (AFDC/TANF) Children and Related

ALABAMA
Maternity Care Program

Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-American Indian/Alaskan Native
-Foster Children
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Other Insurance, if HMO

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Maternity Care Program

ADDITIONAL INFORMATION

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

Quality Activities for Contracted Global Fee

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

ALABAMA
Partnership Hospital Program

CONTACT INFORMATION

State Medicaid Contact:
Lynn Sharp
Alabama Medicaid Agency
(334) 242-5588

State Website Address:
http://www.medicaid.state.al.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:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 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

Medical-only PIHP - 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:
-Aged and Related Populations
-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

ALABAMA
Partnership Hospital Program

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-American Indian/Alaskan Native

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

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Partnership Hospital Program

ADDITIONAL INFORMATION
None

QUALITY ACTIVITIES FOR PIHP

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 edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national

ALABAMA
Partnership Hospital Program

norms, comparisons to submitted bills or cost-ratios)
-Medical record validation

PIHP conducts data accuracy check(s) on

-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

Yes

Standards/Accreditation

PIHP Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Alabama Quality Assurance Foundation

EQRO Organization
-Quality Improvement Organization (QIO)

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

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

CALIFORNIA
AIDS Healthcare Foundation

CONTACT INFORMATION

State Medicaid Contact:
Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

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

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:
August 13, 2003

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

Managed Care Organization (MCO) - Capitation

Service Delivery

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

Allowable PCPs:
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians
-General Practitioners
-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 (AFDC/TANF) Children and Related Populations

Populations Mandatorily Enrolled:
None

CALIFORNIA
AIDS Healthcare Foundation

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

-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period Less Than 3 Months
-Poverty Level Pregnant Woman
-Member approved for a Major Organ Transplant
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Plan is responsible to identify this group

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

ADDITIONAL INFORMATION

PCPs contract to provide and assume risk for primary care, specialty physician services, and selected outpatient preventive and treatment services. The Program is designed for people living with AIDS. Program changed from a PCCM program to AIDS Healthcare Foundation a PAHP (Prepaid Ambultory Health Plan) a single health plan. All categories of federally eligible Medi-Cal are eligible to participate.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Not Applicable

Use of Collected Data
-Not Applicable

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

PAHP Standards
None

Accreditation Required for Participation
None

CALIFORNIA
AIDS Healthcare Foundation

Non-Duplication Based on Accrediation
None

GEORGIA
Georgia Better Health Care

CONTACT INFORMATION

State Medicaid Contact:
Kathrine Driggers
Division of Managed Care and Quality
(404) 657-7793

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

PROGRAM DATA

Program Service Area:
Statewide

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, 2002

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Home Health, Immunization, In-home Nursing, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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
-Blind/Disabled Adults and Related Populations

GEORGIA
Georgia Better Health Care

-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
-Poverty Level Pregnant Woman
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)
-SOBRA Eligible Pregnant Women
-Medicare Dual Eligible

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Georgia Better Health Care

ADDITIONAL INFORMATION

Program was converted from a 1915(b) to 1932(a) on December 1, 2002.

QUALITY ACTIVITIES FOR PCCM

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

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

Consumer Self-Report Data
-State-developed Survey

GEORGIA
Georgia Better Health Care

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visits 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
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

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

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

IOWA
Iowa Medicaid Managed Health Care

CONTACT INFORMATION

State Medicaid Contact:
Dennis Janssen
Department of Human Services
(515) 281-8747

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:
December 01, 1986

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - 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
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Pediatricians
-Nurse Practitioners
-Nurse Midwives

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)

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

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
None

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

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:
-Pediatricians
-Nurse Practitioners
-Nurse Midwives
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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

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

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
None

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coventry Health Care
John Deere Health Plan, Inc.
Iowa Health Solutions
Medipass

ADDITIONAL INFORMATION

Coventry Health Care includes 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.

IOWA
Iowa Medicaid Managed Health Care

QUALITY ACTIVITIES FOR MCO/HIO

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

Use of Collected Data
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

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

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

Encounter Data

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

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

Collection: Standardized Forms
None

Validation: Methods
-Medical record validation

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Payment
-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 Improvement Projects

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

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Pre-natal care
-Prevention of Influenza
-Well Child Care/EPSDT

IOWA
Iowa Medicaid Managed Health Care

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

Standards/Accreditation

MCO Standards
None

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

Non-Duplication Based on Accreditation
None

EQRO Name
-Iowa Foundation for Medical Care

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State

EQRO Optional Activities
-Administration or validation of consumer or provider surveys

QUALITY ACTIVITIES FOR PCCM

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

Use of Collected Data:
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling

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

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners

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

Provider Characteristics
None

Beneficiary Characteristics
None

KANSAS
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:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
EDS

For All Areas Phased-In:
No

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1984

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

Guaranteed Eligibility:
Continuous eligibility for children under age 19

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Obstetrical, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physician, Therapies, Transportation, Vision, X-Ray

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

Enrollment

KANSAS
HealthConnect Kansas

Populations Voluntarily Enrolled:
-Special Needs Children (BBA-defined)
-Blind/Disabled Children and Related Populations
-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

Subpopulations Excluded from Otherwise Included Populations:
-Medically Needy-eligible
-Foster Care Children
-Receive Adoption Support
-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
-Reside in State Institution

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses information from Title V agency to identify members
-Uses provider referrals to identify members of these

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 Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HealthConnect Kansas

ADDITIONAL INFORMATION

Beneficiaries choose between a MCO and PCCM.

QUALITY ACTIVITIES FOR PCCM

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
-Fraud and Abuse
-Health Services Research
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

KANSAS
HealthConnect Kansas

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

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visits rates
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
None

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

Use of Services/Utilization
-Drug Utilization

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

Beneficiary Characteristics
None

KANSAS
HealthWave 19

CONTACT INFORMATION

State Medicaid Contact:
Debra Bachmann
Health Care Policy/Medical Policy
(785) 291-3438

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

PROGRAM DATA

Program Service Area:
County

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

Statutes Utilized:
Not Applicable

Enrollment Broker:
EDS

For All Areas Phased-In:
No

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
December 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

Guaranteed Eligibility:
Continuous eligibility for children under age 19

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, 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
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Special Needs Children (BBA-defined)
-American Indian/Alaskan Native

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

KANSAS
HealthWave 19

-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
-Reside in State Hospitals

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses information from the Title V agency to identify

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

Beneficiaries choose between an MCO and PCCM.

QUALITY ACTIVITIES FOR MCO/HIO

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

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

KANSAS
HealthWave 19

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-HIPAA 837 electronic submission format
-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/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-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

Health Plan Stability/ Financial/Cost of
-Days cash on hand
-Days in unpaid claims/claims outstanding

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)

-Medical loss ratio
-Net income
-Net worth
-Total revenue
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to

Performance Improvement Projects

Project Requirements
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Standards/Accreditation

MCO Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Kansas Foundation for Medical Care

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

KENTUCKY
Kentucky Patient Access and Care (KENPAC) Program

CONTACT INFORMATION

State Medicaid Contact:
Leah Brown
KY Department for Medicaid Services
(502) 564-5969

State Website Address:
http://chs.state.ky.us/

PROGRAM DATA

Program Service Area:
Statewide

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, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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

-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Special Needs Children
-Spenddown
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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
-Public Health Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Kentucky Patient Access and Care (KenPAC)

ADDITIONAL INFORMATION

For the following Included services- EPDST, Mental Health, and Maternaty Care including prenatal care delivery and post partum beneficiary may go to any participating provider for these services without a referral.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-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

MAINE
MaineCare Primary Care Case Management

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, Certain Family Planning, Chiropractic, Clinic (FQHC & RHC), Developmental & Behavioral Evaluation Clinic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatric, Speech/Language Pathology, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Physician Assistants
-Ambulatory Care Clinic or Hospital Based Outpatient Clinic

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

MAINE
MaineCare Primary Care Case Management

-TITLE XXI SCHIP
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-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)
-Special Needs Children (BBA defined)
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months

Lock-In Provision:
12 months lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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:
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

MaineCare Primary Care Case Management

ADDITIONAL INFORMATION

Included Services: Certain family planning services and family planning are different in the sense that all family planning services are exempt when provided in a family clinic. Certain family planning services generally refers to services in other setting such as a physicians office.

QUALITY ACTIVITIES FOR PCCM

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
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

MAINE
MaineCare Primary Care Case Management

-Provider Data

Consumer Self-Report Data
-HIV/AIDS Survey
-SCHIP Survey
-State-developed Survey

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamydia screening in women
-Dental services
-Diabetes management/care
-HIV/AIDS care
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of OB/GYN visits per adult female beneficiary
-Number of primary care case manager visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Provider Characteristics
-Board Certification
-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
-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
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-HIV/AIDS Prevention and/or Management
-Lead toxicity
-Otitis Media management
-Presciption drug abuse
-Prevention of Influenza
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

MISSISSIPPI
Disease Management Program

CONTACT INFORMATION

State Medicaid Contact:
Alicia Crowder
Mississippi Medicaid Agency
601-359-5243

State Website Address:
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:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 15, 2003

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

Disease Management PAHP - Capitation

Service Delivery

Included Services:
Disease Management

Allowable PCPs:
-Registered Nurses

Enrollment

Populations Voluntarily Enrolled:
-Persons having one or more of the following: Asthma, Diabetes, and/or Hypertension

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Participate in HCBS Waiver
-Hospice
-Participate in LTC Facility
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

MISSISSIPPI
Disease Management Program

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Claims data

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

McKesson

ADDITIONAL INFORMATION

The State contracts with McKesson to provide enrollment, assessment, interventions, and physican reporting services to target beneficiaries with one or more of the following diseases: asthma, hypertension, and diabetes.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Enrollee Hotlines
-Performance Measures (see below for details)

Use of Collected Data
-Program Evaluation

Consumer Self-Report Data
None

Use of HEDIS
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Performance Measures

Process Quality
-Asthma care
-Diabetes management/care
-Hypertension care

Health Status/Outcomes Quality
-Clinical Indicators

Access/Availability of Care
None

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

MISSISSIPPI
Disease Management Program

Beneficiary Characteristics
None

Standards/Accreditation

PAHP Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

CONTACT INFORMATION

State Medicaid Contact:
David Cygan
Nebraska Medicaid
(402) 471-9050

State Website Address:
http://www.hhs.state.ne.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Nebraska Health Connection/Access Medicaid

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

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, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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
-Aged and Related Populations
-Foster Care Children

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Special Needs Children (BBA defined)
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Presumptive Eligibles
-Transplant Recipients
-American Indian/Alaskan Native
-Special Needs Children (State defined)

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

MCO (Comprehensive Benefits) - 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:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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
-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
-Participate in HCBS Waiver
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Presumptive Eligibility
-Transplant Recipients
-Special Needs Children (BBA defined)
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Primary Care Plus

Share Advantage

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

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 Standards
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-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
-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
-State-developed Survey

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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
-Use of Medicaid Identification Number for beneficiaries

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

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent well-care visit rates
-Antibiotic Use in Children
-Asthma care – medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care – timeliness of
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Average distance to PCP
-Ratio of PCPs to beneficiaries

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
-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
-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
-Weeks of pregnancy at time of enrollment in MCO, for

Performance Improvement Projects

Project Requirements
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-(Newborn) Failure to thrive
-Emergency Room service utilization
-Low birth-weight baby
-Pre-natal care

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

Non-Clinical Topics
None

Standards/Accreditation

MCO Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation
-Department of Insurance Certification
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation
-Medicare+ Choice Accreditation
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Nebraska Foundation for Medical Care

EQRO Organization
-QIO-like entity

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)

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
-Consumer/beneficiary Focus Groups
-State-developed Survey

Performance Measures

Process Quality
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamydia screening in women
-Diabetes management/care
-Immunizations for two year olds
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to primary care case manager

Use of Services/Utilization
None

NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

-Performance Measures (see below for details)

Beneficiary Characteristics
-Languages spoken (other than English)
-Provider turnover

Provider 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 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
-Asthma management
-Childhood Immunization
-Diabetes management

Non-Clinical Topics
None

NEVADA
Mandatory Health Maintenance Program

CONTACT INFORMATION

State Medicaid Contact:
Cynthia Leech
Division of Health Care Financing and Policy
(775) 684-3635

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:
October 31, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Ambulatory Surgery Center, Case Management, Certified Registered Nurse Practioner, Chiropactor, Dental, 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, 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
-Obstetricians/Gynecologists

Enrollment

NEVADA
Mandatory Health Maintenance Program

Populations Voluntarily Enrolled:
-Severely Emotionally Disabled Children
-Seriously Mentally Ill Adults
-Children with Special Health Care Needs defined by State
-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
-Special Needs Children (BBA defined)
-Residents in Nursing Facilities beyond 45 Days
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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

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 MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation

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

-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data
-State's Quality Assessment and Performance Improvement Strategy and Work Plan

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, 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
-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 commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-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

NEVADA
Mandatory Health Maintenance Program

Performance Measures

-Validation of client level data, such as claims and encounters

Process Quality
-Adolescent well-care visit rates
-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 in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Ratio of dental providers to beneficiaries
-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/SUD facility
-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.)
-Medical loss ratio
-Net income
-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, for women giving birth during the reporting period

Standards/Accreditation

MCO Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

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/dmahs/index.h

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:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Audiology, Chiropractor, Dental, Durable Medical Equipment/Assistive Technology Devices, Emergency Medical Care, EPSDT, Family Planning, Hearing Aid, Home Health, Hospice, Immunization, Inpatient hospital including acute care, rehabilitation and special hospitals, Laboratory, Medical Supplies, MH/SA for enrollees who are clients of the Division of Developmental Disabilities, Optical Appliances, Optometrist, Organ Transplants, Outpatient Hospital, Pharmacy, Physician, Podiatrist, Post-acute care, Preventive Health Care and Counseling and Health Promotion, Prosthetics and Orthotics including certified shoe provider, Transportation, Vision, X-Ray

Allowable PCPs:
-Nurse Practitioners
-Nurse Midwives
-Family Practitioners
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Certified Nurse Specialists
-Pediatricians
-General Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

NEW JERSEY
New Jersey Care 2000+ (1932)

Populations Voluntarily Enrolled:
-Foster Care Children
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Non Dually Eligible Aged, Blind and Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Institutionalized in inpatient psychiatric facility
-Medically needy and presumptive eligibility beneficiaries
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program without Department of Human Services Contract
-American Indian/Alaskan Native
-Participate in HCBS Waiver except DDD/CCW non-duals
-Special Needs Children (BBA defined)
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

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

AmeriChoice of New Jersey, Inc.
AMERIGROUP New Jersey, Inc.
Health Net
Horizon NJ Health
University Health Plans, Inc.

ADDITIONAL INFORMATION

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, DDD or DYFS populations.

QUALITY ACTIVITIES FOR MCO/HIO

NEW JERSEY
New Jersey Care 2000+ (1932)

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-After-hours Beneficiary Call-in Sessions
-Consumer Self-Report Data (see below for details)
-Data Analysis
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Geographic Mapping
-MCO Marketing Material Approval Requirement
-Medical and Dental Provider Spot Checks
-Monitoring of MCO Standards
-Network Adequacy Assurance by Plan
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Self-Report Data
-Test 24/7 PCP Availability
-Utilization Review

Use of Collected Data
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
Survey included ABD adult and SCHIP children

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-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
-Use of Medicaid Identification Number for beneficiaries

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms
None

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID

State conducts general data completeness assessments
Yes

NEW JERSEY
New Jersey Care 2000+ (1932)

-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

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Analysis of pharmaceutical services
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical Cancer Screening
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Quality and utilization of dental services
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Lead Toxicity Study

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries

-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Average length of stay
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Inpatient Days per 1000 Members
-Pharmacy services per member
-Physician visits per 1000 members

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
None

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to

NEW JERSEY
New Jersey Care 2000+ (1932)

Performance Improvement Projects

Project Requirements
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management/care
-Lead Screenings
-Postnatal care
-Prenatal Care
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Encounter Data Improvement
-Hospital Denials and Appeals

Standards/Accreditation

MCO Standards
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
-Department of Banking and Insurance
-Department of Health and Senior Services

Non-Duplication Based on Accreditation
None

EQRO Name
-PRONJ, The Healthcare Quality Improvement Organization of New Jersey, Inc.

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Medical Record Review
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

NORTH CAROLINA
Access II/III

CONTACT INFORMATION

State Medicaid Contact:
Deborah Bowen
Division of Medical Assistance
(919) 647-8171

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

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

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Dialysis, Disease Management, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Outpatient Hospital, Personal Care, Physician, Private Duty Nursing, X-Ray

Allowable PCPs:
-Health Clinics
-Other Specialists Approved on a Case-by-Case Basis
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Health Departments
-Hospital Outpatient Clinics
-Community Health Centers

NORTH CAROLINA
Access II/III

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles
-American Indian/Alaskan Native
-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
-Eligibillity Period that is only Retroactive
-Refugees
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Medicaid-only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI
QMB-Plus
SLMB Plus

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 Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access II/III

ADDITIONAL INFORMATION

An Administrative Entity is paid an additional PCCM case management fee of $2.50 per recipient participating in Access II/III to monitor care and implement disease management initiatives and target preventive studies. ACCESS II/III manages the highest risk Medicaid enrollees to improve coordination and continuity of care.

NORTH CAROLINA
Access II/III

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-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
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data
-CAHPS
  Adult with Special Needs Questionnaire
  Child with Special Needs Questionnaire
-Consumer/beneficiary Focus Groups
-Disenrollment Survey

Performance Measures

Process Quality
-Asthma care - medication use
-Breast Cancer screening rate
-Depression medication management
-Diabetes management/care
-Immunizations for two year olds
-Influenza vaccination rate
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
-Asthma Emergency Department Visit Rates
-Asthma Inpatient Rates
-Diabetes Inpatient Rates
-Patient satisfaction with care

Access/Availability of Care
-Adult access to preventive/ambulatory health services
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics
-Best Practice Guideline Implementation for Asthma and Diabetes
-Board Certification
-Languages spoken (other than English)

Beneficiary Characteristics
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on Chronic Disease
-Information on primary languages spoken by beneficiaries

Performance Improvement Projects

Clinical Topics
-Asthma management
-Coordination of primary and behavioral health care
-Deprssion management
-Diabetes management
-Emergency Room service utilization
-Otitis Media management
-Pharmacy management

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners
-Practice Readiness for Quality Improvement

NORTH CAROLINA
Carolina ACCESS

CONTACT INFORMATION

State Medicaid Contact:
Deborah Bowen
Division of Medical Assistance
(919) 647-8171

State Website Address:
http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
Statewide

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

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Dialysis, Durable Medical Equipment, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Outpatient Hospital, Personal Care, Physician, Private Duty Nursing, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Public Health Departments
-Community Health Centers
-Health Clinics
-Hospital Outpatient Clinics
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Physician Assistants
-Nurse Practitioners

NORTH CAROLINA
Carolina ACCESS

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Medicaid Pregnant Women
-Blind/Disabled Children and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children
-Special Needs Children (BBA defined)
-Medicare Dual Eligibles
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period that is only Retroactive
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Private Insurance and PCP not willing to participate
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Medicaid-only Dual Eligibles

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI
QMB Plus
SLMB Plus

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

Carolina Access

ADDITIONAL INFORMATION

The recipient must choose and enroll with or be assigned to a primary care provider who is paid a monthly case management fee of $1.00 for each enrollee in addition to regular fee for service payments. Enrollment Broker: Public Consulting Group, is only used in Mecklenburg County.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)

Use of Collected Data:
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal

NORTH CAROLINA
Carolina ACCESS

-Performance Measures (see below for details)
-Provider Data
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data
None

Performance Measures

Process Quality
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
None

Access/Availability of Care
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-Inpatient admissions/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary

Provider Characteristics
None

Beneficiary Characteristics
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics
-Adult Preventive Services
-Anti-microbial Resistance
-Childhood Immunization
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Complaints and Grievances

NORTH CAROLINA
Health Care Connection

CONTACT INFORMATION

State Medicaid Contact:
Deborah Bowen
Division of Medical Assistance
(919) 647-8171

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:
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) - Capitation

Service Delivery

Included Services:
Adult Preventative Medicine, Ambulance, Chiropractic, Clinic Services-Except for Mental Health and Substance Use Disorders, Diagnostic Services, Dialysis, Durable Medical Equipment, Emergency Room, EPSDT, Family Planning and Supplies, Hearing Aids, Home Health, Home Infusion Therapy, Hospice, Immunization, Inpatient Hospital- Except for Mental Health and Substance Use Disorders, Laboratory, Midwife, Occupational, Physical and Speech Therapies, Optical Supplies, Outpatient Hospital, Physician Services including Physician Assistants and Family Nurse Practitioners, Podiatry, Postpartum Newborn Home Visits--EPSDT, Maternal Assessment and Newborn Assessment, Private Duty Nursing, Prosthetics/Orthotics, Sterilization, Total Parenteral Nutrition, 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

Enrollment

NORTH CAROLINA
Health Care Connection

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native
-Aged and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Special Needs Children (BBA defined)

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:
-Eligibility Period That Is Only Retro-active
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Wellpath Select, Inc. dba Southcare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews

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

-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 Medicaid SSI Questionnaire
-Complaints/Grievances/Appeals

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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 commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-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

NORTH CAROLINA
Health Care Connection

Process Quality
-Breast Cancer screening rate

-Cervical cancer screening rate
-Diabetes management/care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality
-Validation of client level data, such as claims and encounters
-Validation of encounter data
-New Member Health Assessment
-Patient satisfaction with care

Access/Availability of Care
-Adult's Access to Preventative Services
-Average wait time for an appointment with PCP
-Involuntary Disenrollments
-Non-authorized visits
-PCP Referral Denials
-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
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics
-After Hours Survey
-Enrollment by Product Line
-Languages Spoken (other than English)
-Provider Satisfaction Survey
-Provider turnover

Performance Improvement Projects

Project Requirements
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Diabetes management/care
-Pre-natal care

Non-Clinical Topics
-Initial Health Assessment/Health Check Review
-Provider Satisfaction Survey

Standards/Accreditation

MCO Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Medical Review of North Carolina
-Myers and Stauffers

EQRO Organization
-QIO-like entity
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State

EQRO Optional Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical and non-clinical studies

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/humanservices/services/medi

PROGRAM DATA

Program Service Area:
Statewide

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, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mid-level Practitioner, Non-Emergency Transportation, Nutritional, Occupational, Physical, and Speech Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, 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
-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

NORTH DAKOTA
North Dakota Access and Care Program

-Optional Categorically Needy
-Medically Needy
-Poverty Level

Subpopulations Excluded from Otherwise Included Populations:
-Eligiblity Period that is only Retroactive
-Special Needs Children (BBA defined)
-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

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

MCO (Comprehensive Benefits) - 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 Use Disorders, Laboratory, Mid-Level Practitioner, Non-Emergency Transportation, Nutritional, Occupational, Physical, and Speech Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Podiatry, Public Health Unit, Transportation, X-Ray

Allowable PCPs:
-Nurse Practitioners
-Physician Assistants
-Nurse Midwives
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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
-Optional Categorically Needy

Subpopulations Excluded from Otherwise Included Populations:
-Refugee Assistance
-Adoption Assistance
-Eligibility Period that is only Retroactive
-Special Needs Children (BBA defined)
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medically Needy
-Foster Care

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

NORTH DAKOTA
North Dakota Access and Care Program

ADDITIONAL INFORMATION

AltruCare is only offered in Grand Forks, Pembina, and Walsh counties.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards
-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 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. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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)
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Asthma care - medication use
-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
-Diabetes management/care
-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 in first 15 months of life

Access/Availability of Care
-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
-Number of OB/GYN visits per adult female beneficiary

Health Plan Stability/ Financial/Cost of
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-State minimum reserve requirements

Health Plan/ Provider Characteristics
-Number and Type of Services Provided

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management/care
-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 Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-North Dakota Health Care Review

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Yet to be determined

EQRO Optional Activities
None

NORTH DAKOTA
North Dakota Access and Care Program

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Track Health Service provision

Consumer Self-Report Data
None

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:
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:
September 01, 1993

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Laboratory, Opthalmology, Outpatient Hospital, Outpatient Mental Health, Physician, Residential Treatment Centers, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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
-Blind/Disabled Adults and Related Populations

SOUTH DAKOTA
PRIME

-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
-Special Needs Children (BBA defined)

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Provider contacts - Medically fragile protocol
-Uses eligibility data to identify members of these

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

Quality Oversight Activities:
-Consumer Self-Report Data
-Focused Studies
-Performance Improvements Projects (see below for details)

Use of Collected Data:
-Beneficiary Provider Selection
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling

Consumer Self-Report Data
-Disenrollment Survey
-State-developed Survey

Performance Measures

Process Quality
-Adolescent well-care visits rates
-Asthma care - medication use

Health Status/Outcomes Quality
None

SOUTH DAKOTA
PRIME

-Performance Measures (see below for details) -Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners

Use of Services/Utilization
-Emergency room visits/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Diabetes management
-Pre-natal care

Non-Clinical Topics
None

WASHINGTON
Healthy Options

CONTACT INFORMATION

State Medicaid Contact:
MaryAnne Lindeblad
Division of Program Support
(360) 725-1786

State Website Address:
http://www.dshs.wa.gov

PROGRAM DATA

Program Service Area:
Statewide

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:
6 months guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 1993

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Vision, X-Ray

Allowable PCPs:
-Indian Health Service (IHS) Providers
-Physician Assistants
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

Populations Mandatorily Enrolled:
None

-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

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

MCO (Comprehensive Benefits) - 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:
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants
-Pediatricians
-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

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Retroactive Eligibility
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Asuris Northwest Health
Columbia United Providers
Group Health
Molina
BHP Plus
Community Health Plans of Washington
Healthy Options/PCCM
Regence Blue Shield

WASHINGTON
Healthy Options

ADDITIONAL INFORMATION

Health Options converted from a 1915(b) to 1932(a).

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO 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
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data
-CAHPS
Child Medicaid AFDC Questionnaire
Child with Special Needs Questionnaire

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Provided data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (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)

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID

State conducts general data completeness assessments
Yes

WASHINGTON
Healthy Options

-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-OMPRO

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct performance improvement projects

WASHINGTON
Healthy Options

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data
-CAHPS
Child Medicaid AFDC Questionnaire
Child with Special Needs Questionnaire

WISCONSIN
Medicaid HMO Program

CONTACT INFORMATION

State Medicaid Contact:
Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:
http://dhfs.wisconsin.gov

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

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

Guaranteed Eligibility:
12 months guaranteed eligibility for children

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers
-General Practitioners
-Pediatricians
-Family Practitioners
-Internists
-Obstetricians/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

WISCONSIN
Medicaid HMO Program

Subpopulations Excluded from Otherwise Included Populations:
-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
-Special Needs Children (BBA defined)
-Medicare Dual Eligible
-Pregnant Women

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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 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
Group Health Cooperative Of Eau Claire -- Medicaid
Health Tradition Health Plan -- Medicaid HMO
MercyCare Insurance Company -- Medicaid HMO
Security Health Plan -- Medicaid HMO
UnitedHealthcare of WI -- Medicaid HMO
Valley Health Plan -- Medicaid HMO
Dean Health Plan -- Medicaid HMO
Group Health Cooperative Of South Central WI -- Medicaid HMO
Managed Health Services -- Medicaid HMO
Network Health Plan -- Medicaid HMO
Touchpoint Health Plan -- Medicaid HMO
Unity Health Insurance -- 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 MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)

Use of Collected Data
-Beneficiary Plan Selection
-Contract Standard Compliance

WISCONSIN
Medicaid HMO Program

-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Health Services Research
-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

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
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-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
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Admission source
-Admission type
-Days supply
-Modifier codes
-Patient status code
-Place of service codes
-Quantity

State conducts general data completeness assessments
Yes

WISCONSIN
Medicaid HMO Program

Performance Measures

Process Quality
-Breast Cancer screening rate
-Cervical cancer screening rate
-Children with at least one comprehensive EPSDT well child visit in the look-back period at age 3-5 years, 6-14years, and 15-20 years
-Children with at least one non-EPSDT well-child visit in the look-back period at ages birth-1 year, 1-2 years, 3-5 years, 6-14years and 15-20 years
-Comprehensive EPSDT well-child visits for children age birth to two years for those receiving 5, 6 and 7 or more visits
-Dental services
-Diabetes management
-Follow-up after hospitalization for mental illness
-Hearing services for individuals of all ages
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals of all ages

Health Status/Outcomes Quality
-Breast malaignancies detected
-Cervix/uterus malignancies detected
-HPV infections detected
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP
-Provider network data on geographic distribution
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percent of beneficiaries with at least one PCP visit
-Percent of beneficiaries with at least one specialist visit
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Standards/Accreditation

MCO Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
-AAAHC (Accreditation Association for Ambulatory Health Care)
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name
-MetaStar

WISCONSIN
Medicaid HMO Program

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional 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

CALIFORNIA
Prepaid Health Plan Program

CONTACT INFORMATION

State Medicaid Contact:
Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

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:
1) Health Care Options for Marin County
2) HCO

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) - 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, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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

Populations
-Section 1931 (CALWORKS/TANF) Adults and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Dental PAHP - 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
-Section 1931 (CALWORKS/TANF) Children and Related Populations
-Section 1931 (CALWORKS/TANF) Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Populations residing outside plans service area defined by contract
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

CALIFORNIA
Prepaid Health Plan Program

PAHP (Only for Emotional Support) - Capitation

Service Delivery

Included Services:
Emotional Support

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Emotionally Disturbed 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
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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

Kaiser Foundation (North)
San Francisco City & CO/Family Mosiac
UHP Healthcare-Dental

ADDITIONAL INFORMATION

San Francisco City under this program only provides emotional support to severely emotionally disturbed children.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Not Applicable

Use of Collected Data
-Not Applicable

CALIFORNIA
Prepaid Health Plan Program

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
None

COLORADO
Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:
Jerry Smallwood
Dept. of Health Care Policy and Financing
(303) 866-5947

State Website Address:
http://www.CHCPF.state.co.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS, INC.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 1983

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

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, Pharmacy, Physician, Skilled Nursing Facility, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Populations Mandatorily Enrolled:
None

-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Foster Care Children
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

MCO (Comprehensive Benefits) - 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

Enrollment

Populations Voluntarily 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

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Foster Care Children
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

COLORADO
Managed Care Program

Medical-only PIHP (non-risk, comprehensive) - Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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:
-Developmental Disabilities Agency
-Mental Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Colorado Access
Primary Care Physician Program
Denver Health and Hospital Authority
Rocky Mountain HMO

COLORADO
Managed Care Program

ADDITIONAL INFORMATION

Program was converted from a 1915(b) to a 1915(a) on May 1, 2003. The Primary Care Physician Program is available statewide which provides beneficiaries the option of a fee-for service physician who acts as a gatekeeper and refers for specialty care. HMO options and PIHP options are available and varies by county.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO 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

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

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

COLORADO
Managed Care Program

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Standards/Accreditation

MCO Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Health Services Advisory Group, Inc.

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities
None

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting

COLORADO
Managed Care Program

-Performance Measures (see below for details)
-PIHP Standards

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

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

PIHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

COLORADO
Managed Care Program

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics
Not Applicable - PIHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - PIHPs are not required to conduct common project(s)

Standards/Accreditation

PIHP Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Health Services Advisory Group. Inc.

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of PIHP compliance with structural and operational standards established by the State

EQRO Optional Activities
None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

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

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Adult access to preventive/ambulatory health services
-Average wait time for an appointment with primary care case

Use of Services/Utilization
None

COLORADO
Managed Care Program

-Performance Measures (see below for details) manager
-Children's access to primary care practitioners

Provider Characteristics
None

Beneficiary Characteristics
None

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

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:
ACS, Inc

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 PIHP (non-risk, comprehensive) - Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Most Medicaid Services, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/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
-Special Needs Children (State defined)

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
-American Indian/Alaskan Native

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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 Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Services For Children with Special Needs

ADDITIONAL INFORMATION

This is no longer a demonstration program but a cost-base reimbursement program and there is no risk involved for providers. Program provides Emergency Transportation only and Skilled Nursing Facility for first 30 days. Special Needs Children (State-defined): Those Children who have, or are at risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond those required by children generally. This definition includes children on SSI or who are SSI-related eligibles.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards

Use of Collected Data
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement

-On-Site Reviews
-Performance Measures (see below for details)
-PIHP Standards
-Provider Data
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data
None

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across PIHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PIHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

STRICT OF COLUMBIA
Health Services for Children with Special Needs

Performance Measures

Process Quality
-Adolescent immunization rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Diabetes medication management
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
None

Standards/Accreditation

PIHP Standards
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Delmarva Foundation for Medical Care

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

-Validation of client level data, such as claims and encounters

ILLINOIS
Voluntary Managed Care

CONTACT INFORMATION

State Medicaid Contact:
Kelly Carter
Illinois Department of Public Aid
(217) 524-7478

State Website Address:
http://www.dpaillinois.com

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:
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) - Capitation

Service Delivery

Included Services:
Assistive/Augmentative Communication Devices, Audiology Services, Physical Therapy, Occupational Therapy, Speech Therapy, Behavioral Health, Blood and Blood Components, Case Management, Certified Hospice, Chiropractic, Clinic, Diagnosis and treatment of medical conditions of the eye, Disease Management, Durable and nondurable medical equipment and supplies, Emergency Services, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Psychiatric Care, Inpatient Substance Use Disorders, Laboratory and x-ray services, Medical procedures performed by a dentist, Nurse Midwives, Orthotic/Prosthetic Devices, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician services, Psychiatric Care, Podiatric, Skilled Nursing Facility, Transportation

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

ILLINOIS
Voluntary Managed Care

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

-TITLE XXI SCHIP
-Poverty-Level Pregnant Women

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Spenddown Eligibles
-Other Insurance - High Level
-Age 19 or older and eligible thru State Family and Children Assistance Program
-Medicaid Presumptive Eligibility for Pregnant Women
-Non-citizens only receiving emergency services
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Illinois Inc.
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 MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO 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
-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 generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

ILLINOIS
Voluntary Managed Care

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent well-care visit rates
-Asthma care- medication use
-Breast Cancer Screening Rate
-Cervical Cancer Screening Rate
-Check-ups after delivery
-Chlamydia screening in women
-Controlling high blood pressure
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Health history/physicals
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5 and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants
-Percentage of very low birth weight infants

ILLINOIS
Voluntary Managed Care

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at

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
-Languages Spoken (other than English)
-Provider license number
-Specialty of providers

Beneficiary Characteristics
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Standards/Accreditation

MCO Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-HealthSystems of Illinois

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Technical assistance to MCOs to assist them in conducting quality activities

MICHIGAN
Childrens Special Health Care Services

CONTACT INFORMATION

State Medicaid Contact:
Katherine Stiffler
Michigan Department of Community Health
(517) 241-7186

State Website Address:
http://www.michigan.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
Michigan Enrolls

For All Areas Phased-In:
Yes

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) - 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, 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) Adults and Related Populations

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

MICHIGAN
Childrens Special Health Care Services

-When Medically Eligible
-Section 1931 (AFDC/TANF) Children with CHCS coverage who may or may not have Medicaid or MiChild coverage

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR or incarcerated
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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

Children's Choice of Michigan

Kid's 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 MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-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 survey 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

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-Proprietary for Pharmacy

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-County
-Zip code

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Access to buildings
-Average wait time for an appointment with PCP

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

MICHIGAN
Childrens Special Health Care Services

Project Requirements
-MCOs are required to conduct a project(s) of their own choosing

Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Standards/Accreditation

MCO Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-None

EQRO Organization
-None

EQRO Mandatory Activities
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities
None

MINNESOTA
Minnesota Disability Health Options (MnDHO)

CONTACT INFORMATION

State Medicaid Contact:
Christine Bronson
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:
September 01, 2001

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
All Medicare Services Under Parts A & B, Case Management, Dental, Durable Medical Equipment, Family Planning, Hearing, Home and Community-Based Waiver, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nursing Facility Are Covered for 180 Days, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Blind or Disabled, age 18 through 64, dually or singly eligible

Populations Mandatorily Enrolled:
None

MINNESOTA
Minnesota Disability Health Options (MnDHO)

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Reside in Regional Treatment Center
-QMB or SLMB, Not Otherwise Eligible for Medicaid
-Eligible for Medicare Part A or Part B Only
-Medicare Dual Eligible
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

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:
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

UCARE

ADDITIONAL INFORMATION

Contractors are not required to identify PCPs. PCP provider types are designated by HMOs rather than State. Health plans have been encouraged to develop networks with professionals with disability experience.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Care System Reviews
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO 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 Questionaire
-Disenrollment Survey
-State-Developed Survey for Nursing Home Enrollees/Families

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

MINNESOTA
Minnesota Disability Health Options (MnDHO)

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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
-Ad hoc comparison to benchmarks and norms
-Ad hoc per member per month analysis and comparison across MCOs
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Limited analysis of encounter data submissions to help determine data completeness

MCO/HIO 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
-Cholesterol screening and management
-Diabetes management/care
-Influenza Vaccination Rate
-Timeliness of HCBS Reassessments
-Use of Home andCommunity-Based Services
-Use of Nursing Home Days

Health Status/Outcomes Quality
-Family Satisfaction with Care - Nursing Home Members
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP
-Number of PCP Ambulatory Visits

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
-Use of Home Health Care/1000 Beneficiaries

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Medical loss ratio

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)

MINNESOTA
Minnesota Disability Health Options (MnDHO)

-Net income
-State minimum reserve requirements
-Total revenue
-Provider turnover

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Congestive Heart Failure Management
-Diabetes management/care
-Optimal Medication Management
-Prevention of Influenza and Pneumonia

Non-Clinical Topics
None

Standards/Accreditation

MCO Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-FMAS (QIO-like)
-MetaStar (QIO)
-NCQA (Accreditation)
-PRS (QIO)
-Stratis Health (QIO)

EQRO Organization
-Private Accreditation Organization
-QIO-like entity
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Coordination of QSMIC Collaboratives Between MSHO Health Plans
-Validation of client level data, such as claims and encounters

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

CONTACT INFORMATION

State Medicaid Contact:
Christine Bronson
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) - 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 Use Disorders, Laboratory, Nursing Facility Are Covered for 180 Days, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Services Available Under The Home And Community-Based 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, or Eligible for Medicaid without Medicare
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

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.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Care System Reviews
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards
-Monitoring of MCO 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 Questionaire
-Disenrollment Survey
-State-Developed Survey for Nursing Home Enrollees/Families

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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
-Ad hoc comparison to benchmarks and norms
-Ad hoc per member per month analysis and comparison across MCOs
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Limited automated analysis of encounter data submissions to help determine data completeness

MCO/HIO 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
-Cholesterol screening and management
-Diabetes management/care
-Influenza Vaccination Rate
-Timeliness of HCBS Reassessments
-Use of Home and Community-Based Services
-Use of Nursing Home Days

Health Status/Outcomes Quality
-Family Satisfaction with Care - Nursing Home Members
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP
-Number of PCP Ambulatory Visits

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
-Use of Home Health Care/1000 Beneficiaries

Health Plan Stability/ Financial/Cost of
-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 are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Congestive Heart Failure Management
-Diabetes management/care
-Optimal Medication Management
-Prevention of Influenza and Pneumonia

Non-Clinical Topics
None

Standards/Accreditation

MCO Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-FMAS (QIO-like)
-MetaStar (QIO)
-NCQA (Accreditation)
-PRS (QIO)
-Stratis Health (QIO)

EQRO Organization
-Private Accreditation Organization
-QIO-like entity
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Validation of performance measures

EQRO Optional Activities
-Coordination of QSMIC Collaboratives Between MSHO Health Plans
-Special Federal Projects on Dual Medicare-Medicaid Eligibles

NEW YORK
Managed Long Term Care Program

CONTACT INFORMATION

State Medicaid Contact:
Linda Gowdy
Office of Managed Care, NY State Dept. of Health
(518) 408-1145

State Website Address:
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:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Long Term Care PIHP (risk, non-comprehensive) - Capitation

Service Delivery

Included Services:
Adult Day Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Meals, Medical Social Services, Nutrition, Occupational Therapy, Personal Care, Personal Emergency Response System, Pharmacy, Physical Therapy, Podiatry, Private Duty Nursing, Respiratory Therapy, Skilled Nursing Facility, Speech Pathology, Transportation, Vision

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

NEW YORK
Managed Long Term Care Program

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Medicare Dual Eligible

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Guildnet
Hebrew Hospital Home/CO-OP Care Plan
Independent Care Systems
Mohawk Valley Network/Senior Network Health
Senior Health Partners
VNS Choice
Health Advantage/Elant Choice
HomeFirst
Long Island Health Partners/Broadlawn Health Partners
Partners In Community Care
Total Aging in Place

ADDITIONAL INFORMATION

To be eligible for this program, a person must have a disability or chronic illness. Persons must be nursing home eligible to enroll and while enrolled they receive their services at home, but if someone is enrolled and he/she goes into a Nursing Home and the Nursing Home is in the plan network, the enrollee may stay in the plan and the plan pays for the Nursing Home services.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data
-Contract Standard Compliance
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
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

NEW YORK
Managed Long Term Care Program

Encounter Data

Collection: Requirements
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Deadlines for regular/ongoing encounter data submission(s)

Collection: Standardized Forms
None

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

PIHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Provider networks and updates are collected quarterly and reviewed for accuracy

Use of Services/Utilization
-Drug Utilization
-Number of home health visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)

Health Plan/ Provider Characteristics
-Languages Spoken (other than English)

Beneficiary Characteristics
-Upon enrollment DMS-1 assessment score that measures nursing home eligibility

Performance Improvement Projects

Project Requirements
-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics
Not Applicable - PIHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - PIHPs are not required to conduct common project(s)

NEW YORK
Managed Long Term Care Program

Standards/Accreditation

PIHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-IPRO - Island Peer Review Organization

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Validation of performance improvement projects

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

NEW YORK
Office of Mental Health/Partial Capitation Program

CONTACT INFORMATION

State Medicaid Contact:
Joe Kaiser
New York State Office of Mental Health
(518) 473-9582

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) PAHP - Capitation

Service Delivery

Included Services:
Mental Health Continuion Day Treatment, Mental Health Intensive Psychiatric Rehabilitation Treatment, Mental Health Outpatient

Allowable PCPs:
-Mental Health PCP
-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

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Receiving outpatient (Clinic, CDT, IPRT)
-Admitted to an outpatient psychiatric center program

Populations Mandatorily Enrolled:
None

NEW YORK
Office of Mental Health/Partial Capitation Program

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period Less Than 6 Months
-Participation in HCBS Waiver
-Special Needs Children (BBA defined)
-Enrolled in Another Managed Care Program
-Medicare Dual Eligible
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

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 PAHP

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-PAHP Standards
-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

NEW YORK
Office of Mental Health/Partial Capitation Program

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Number of encounters per provider

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Use of acute sector hospitalization

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Standards/Accreditation

PAHP Standards
-State-Developed/Specified Standards

Accreditation Required for Partcipation
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

Non-Duplication Based on Accreditation
None

PENNSYLVANIA
Long Term Care Capitated Assistance Program (PIHP)

CONTACT INFORMATION

State Medicaid Contact:
James Pezzuti
PA Department of Public Welfare
(717) 772-2525

State Website Address:
www.state.pa.us

PROGRAM DATA

Program Service Area:
Zip Code

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:
October 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PIHP (non-risk, comprehensive) - Capitation

Service Delivery

Included Services:
Adult Day Care, Case Management, Chiropractic, Dental, Durable Medical Equipment, Hearing, Hospice, Immunization, In-home Supportive Care, Institutional, Occupational Therapy, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

PENNSYLVANIA
Long Term Care Capitated Assistance Program (PIHP)

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

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LIFE - Beaver County
LIFE - Pittsburgh
LIFE - St. Agnes

ADDITIONAL INFORMATION

The three pre-PACE sites listed are identified as Medical-only PIHP. Program provides capitated institutional services not capitated inpatient hospital services.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards

Use of Collected Data
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
None

Use of HEDIS
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
None

PENNSYLVANIA
Long Term Care Capitated Assistance Program (PIHP)

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics
Not Applicable - PIHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - PIHPs are not required to conduct common project(s)

Standards/Accreditation

PIHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditataion
None

EQRO Name
-IPRO

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting quality activities

PENNSYLVANIA
Voluntary HMO Contracts

CONTACT INFORMATION

State Medicaid Contact:
Patricia 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:
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) - 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 Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility for First 30 Days, Vision, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives

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
-State Only Categorically Needy
-State Only Medically Needy
-Pregnant Women
-Special Needs Children (State defined)
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-State Blind Pension Recipients
-Monthly Spend Downs
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

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

AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan - VOL
ION Health Plan, Inc. - VOL
UPMC Health Plan, Inc./UPMC for You - VOL
Gateway Health Plan, Inc. -VOL
Three Rivers Health Plans, Inc./MedPlus - VOL

ADDITIONAL INFORMATION

Special Needs Children: (state defined) Broadly defined non-categorical to include all children.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines

Use of Collected Data
-Beneficiary Plan Selection
-Contract Standard Compliance

PENNSYLVANIA
Voluntary HMO Contracts

-Focused Studies
-MCO Standards
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-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 to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-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 in HEDIS measures
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-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

PENNSYLVANIA
Voluntary HMO Contracts

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for

Performance Improvement Projects

Project Requirements
-MCOs are required to conduct a project(s) of their own choosing
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Clinical Topics
None

Non-Clinical Topics
-Availability of language interpretation services

Standards/Accreditation

MCO Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-IPRO

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional 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 Plan

CONTACT INFORMATION

State Medicaid Contact:
Wendy Matos-Negron, PhD
PR Department of Health
(787) 250-0453

State Website Address:
http://www.ases.gobierno.pr

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) - Capitation

Service Delivery

Included Services:
Case Management, Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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

-Foster Care Children
-TITLE XXI SCHIP
-Individual/Families up to 200% of Puerto Rico poverty level
-Police
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

MH/SUD PIHP - Capitation

Service Delivery

Included Services:
Case Management, Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation

Allowable PCPs:
-Psychiatrists
-Psychologists

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
-TITLE XXI SCHIP
-Foster Care Children
-Individual/families up to 200% of the Puerto Rico poverty line
-Police

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Public Health Agency

PUERTO RICO
Puerto Rico Health Care Plan

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Alianza de Medicos de Sur Este, Inc.
FHC Healthcare
APS Healthcare
Humana Health Plans of Puerto Rico, Inc.
MCS Health Management Options, Inc.
Triple-S, Inc.
San Judas Medical Services

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. Mental Health and Abuse program is separated and handled by MBHOs. There are no QMBs dual eligibles in Puerto Rico.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Monitoring of MCO Standards
-Performance 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 uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Use of Medicaid Identification Number for beneficiaries

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)

Collection: Standardized Forms
None

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Payment
-Type of Service
-Diagnosis Codes
-Procedure Codes

State conducts general data completeness assessments
No

-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Pregnancy Prevention
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Number of children with diagnosis of rubella(measles)/1,000 children

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of 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
-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
-Total revenue

Health Plan/ Provider Characteristics
-Board Certification

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Asthma management
-Diabetes management
-Hypertension management

Non-Clinical Topics
None

Standards/Accreditation

MCO Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Quality Improvement Professional Research Organization

PUERTO RICO
Puerto Rico Health Care Plan

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Monitoring of PIHP Standards
-Performance Measures (see below for details)

Use of Collected Data
-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 DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality
None

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization
None

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
-Total revenue

Health Plan/ Provider Characteristics
-Board Certification

Beneficiary Characteristics
None

Standards/Accreditation

PIHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Administración de Servicios de Salud Mental y Contra la Adicción (ASSMCA)

PUERTO RICO
Puerto Rico Health Care Plan

EQRO Organization
-State entity

EQRO Mandatory Activities
-Review of PIHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Technical assistance to PIHPs to assist them in conducting quality activities

SOUTH CAROLINA
Health Maintenance Organization (HMO)

CONTACT INFORMATION

State Medicaid Contact:
Bruce Harbaugh
Division of Medical Services
(803) 898-2618

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:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
August 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Capitation

Service Delivery

Included Services:
Alcohol and Drug Screening, Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Interactive Psychiatric Interview Exam with other Mechanisms of Communication, Laboratory, Outpatient Hospital, Pharmacy, Physical Exam through the SC Department of Alcohol and other Drug Abuse Services, Physician, Psychiatric Diagnostic Interview Exam, 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

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

SOUTH CAROLINA
Health Maintenance Organization (HMO)

-Blind/Disabled Children 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
-Hospice Recipients
-Enrolled In An HMO Through Third Party Coverage
-Medically Fragile Children Program

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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

Select Health of South Carolina, Incorporated

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards
-Monitoring of MCO 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 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

SOUTH CAROLINA
Health Maintenance Organization (HMO)

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms
-NSF (National Standard Format)
-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
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Date of Admission Invalid
-Date of Discharge Invalid
-Dollar amount billed not greater than zero
-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 - medication use
-Check-ups after delivery
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

SOUTH CAROLINA
Health Maintenance Organization (HMO)

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

Health Plan Stability/ Financial/Cost of
-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
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements
-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Standards/Accreditation

MCO Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Carolina Medical Review

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Conduct performance improvement projects
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

SOUTH CAROLINA
Physicians Enhanced Program (PEP)

CONTACT INFORMATION

State Medicaid Contact:
Dee Hydrick
Department of Physician Services
(803) 898-4538

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:
None

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 PAHP (risk, non-comprehensive) - Capitation

Service Delivery

Included Services:
EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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 capitated for this program. All other services are fee-for-service.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Not applicable

Use of Collected Data
-Not applicable

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

PAHP Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation

None

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 PAHP - Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not Applicable

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
-TITLE XXI SCHIP
-Medicare Dual Eligibles
-American Indian/Alaskan Native
-Poverty-Level Pregnant Women
-Foster Care Children

Populations Mandatorily Enrolled:
None

SOUTH DAKOTA
Dental Program

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only QMB

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI

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

Delta Dental

ADDITIONAL INFORMATION

Most of the Medicaid eligibles are automatically included in the program except beneficiaries with limited benefits.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-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 PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements
-Requirements for PAHPs 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, definitions, sets of acceptable values, standards for data processing

SOUTH DAKOTA
Dental Program

Medicaid agency
-State Standards to ensure complete, accurate, timely encounter data submission

and editing
-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)

PAHP conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care

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 PAHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
Not Applicable - PAHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - PAHPs are not required to conduct common project(s)

Standards/Accreditation

PAHP Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

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://dhfs.wisconsin.gov

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:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1993

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Capitation

Service Delivery

Included Services:
Community Support Program (CSP), Crisis, Emergency Services, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Medical Day Treatment, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

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
-Medicare Dual Eligible

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Community Partnerships
-Dane County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
-Mental Health Agency
-Other Public And Private Agencies Are On The Statewide Children Come First Advisory Committee.
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Dane County Human Services Department -- CCF

ADDITIONAL INFORMATION

Program goal is to keep children with severe emotional disturbances out of institutions and to serve these children and their families in the community. 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 and substance abuse carve-out program does not designate a primary care provider for physical health care. All enrollees must have special needs to be eligible for enrollment.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards

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 DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

WISCONSIN
Children Come First (CCF)

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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, etc.

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PIHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-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

WISCONSIN
Children Come First (CCF)

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Other Demographic, Clinical, And Service System Characteristics Of Enrollees.
-PIHP/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics
Not Applicable - PIHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - PIHPs are not required to conduct common project(s)

Standards/Accreditation

PIHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-MetaStar

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

WISCONSIN
Independent Care Health Plan (iCare)

CONTACT INFORMATION

State Medicaid Contact:
Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:
http://dhfs.wisconsin.gov

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:
No

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) - Capitation

Service Delivery

Included Services:
Coordination With Non-Medicaid Services (Social & Vocational Services), Recreational & Wellness Prog, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Skilled Nursing Facility Only Covered Up To 90 Days, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/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
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

WISCONSIN
Independent Care Health Plan (iCare)

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
-Reside in Nursing Facility or ICF/MR
-Children Under Age 18
-Medicare Dual Eligible

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

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 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
Independent Care Health Plan (Voluntary, iCare)

ADDITIONAL INFORMATION

Humana/Wisconsin Health Organization (an HMO) and the Milwaukee Center for Independence (a community vocational services agency) were previously partners in a joint venture agreement to operate Independent Care (iCare). Effective June 18, 2003, iCare became an independently licensed HMO and changed its full name to Independent Care Health Plan. 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, iCare 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 Dental Services are included in this program. Optional Chiropractic Services and Targeted Case Management are

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards

Use of Collected Data
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

WISCONSIN
Independent Care Health Plan (iCare)

-Monitoring of MCO Standards

-Track Health Service provision

-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

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 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
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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
-Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Admission Source
-Admission Type
-Days Supply
-Modifier Codes
-Patient Status Code
-Place of Service Codes
-Quantity

State conducts general data completeness assessments
Yes

WISCONSIN
Independent Care Health Plan (iCare)

Performance Measures

Process Quality
-Breast cancer screening rate and malignancies detected
-Cervical cancer screening rate and malignancies and HPV detected
-Dental services
-Diabetes management/care
-Follow-up after hospitalization for mental illness and substance abuse at 7 and 30 days
-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
-Monitoring Voluntary Disenrollments
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Asthma prevalence, ED care and inpatient care
-Inpatient general and speciality care: surgery, medical, psychiatry, substance abuse
-Mental health/substance abuse evaluations and day and outpatient care
-Outpatient general and specialty care: ED without admit, primary care visits, vision care, audiology, general dental
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
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 are required to conduct a project(s) of their own choosing

Clinical Topics
Not Applicable - MCOs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs are not required to conduct common

project(s)

Standards/Accreditation

MCO Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-MetaStar

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State

-Validation of performance improvement projects

WISCONSIN
Independent Care Health Plan (iCare)

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

WISCONSIN
Wraparound Milwaukee

CONTACT INFORMATION

State Medicaid Contact:
Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:
http://dhfs.wisconsin.gov

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:
March 01, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Capitation

Service Delivery

Included Services:
Community Support Program (CSP), Crisis, Emergency Services, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Medical Day Treatment, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

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
Wraparound Milwaukee

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

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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 Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Milwaukee County Human Services Department --
Wraparound Milwaukee

ADDITIONAL INFORMATION
Program goal is to keep children with severe emotional disturbances out of institutions and to serve these children and their families in the community. 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 and substance abuse carve-out program does not designate a primary care provider for physical health care.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data
-Annual family satisfaction survey through Families United Inc. (advocacy agency)
-State-developed Survey

Use of HEDIS
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

WISCONSIN
Wraparound Milwaukee

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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, etc.

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

PIHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-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

WISCONSIN
Wraparound Milwaukee

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
-Internal Quality Assurance Review Of Sub-Contracted Providers

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Other Demographic, Clinical, And Service System Characteristics Of Enrollees.
-PIHP/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-PIHPs are required to conduct a project(s) of their own choosing

Clinical Topics
Not Applicable - PIHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - PIHPs are not required to conduct common project(s)

Standards/Accreditation

PIHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-MetaStar

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

FLORIDA
Florida Comprehensive Adult Day Health Care Program

CONTACT INFORMATION

State Medicaid Contact:
Sam Chaaban
Agency of Health Care Administration
(850) 487-2618

State Website Address:
http://www.fdhc.state.fl.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 24, 2003

Implementation Date:
April 01, 2004

Waiver Expiration Date:
March 23, 2006

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

Adult Day Health Care Facility - Other

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Medical direction, Nutrition, Personal care, Rehabilitation therapy, Skilled Nursing Facility, Social Services, Transportation

Allowable PCPs:
-Adult Day Health Care Center

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Other Insurance

Lock-In Provision:
No lock-in

FLORIDA
Florida Comprehensive Adult Day Health Care Program

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)
-Recipients less than 75 years of age

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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:
-Aging Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Adult Day Health Care

ADDITIONAL INFORMATION

The Adult Day Health Care facilities are not managed care entities, as defined by the state statutes. They are licensed persuant to Chapter 400 Part 5 of the Florida Statutes. Reimbursement is not FFS but via gross adjustment. R

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:
Sam Chabaan
Data Analyst
Agency for Health Care Administration
(850) 487-2618

State Operating Agency Contact:
Not Applicable

PROGRAM DATA

Program Service Area:
County

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

Initial Waiver Effective Date:
March 24, 2003

Waiver Expiration Date:
March 23, 2006

FLORIDA
Florida Comprehensive Adult Day Health Care Program

Service Delivery

Target Group:
Aged

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

The 1915(b) waiver enabled Florida to go through the selective contracting process to choose providers in select counties to provide 1915(c) waiver service.

Quality Activities for Adult Day Health Care Facility

Quality Oversight Activities:
-Does not perform any of the Quality Activities

Use of Collected Data:
None

Consumer Self-Report Data
None

MICHIGAN
Specialty Prepaid Inpatient Health Plans

CONTACT INFORMATION

State Medicaid Contact:
Irene Kazieczko
MDCH, Bureau of Community Mental Health Services
(517) 335-0252

State Website Address:
http://www.mdch.michigan.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b)/1915(c)

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 26, 1998

Implementation Date:
October 01, 1998

Waiver Expiration Date:
September 30, 2005

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

MH/SUD PIHP - Capitation

Service Delivery

Included Services:
Crisis, Durable Medical Equipment, Emergency Specialty DD, Home Health, Inpatient Mental Health, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, MH Clinic, Outpatient Mental Health (Partial Hospitalization), Outpatient Substance Use Disorders, Personal Care, Residential Substance Use Disorders Rehabilitation, Specialty Services and Supports for persons with DD, Targetted Case Management, Transportation

Allowable PCPs:
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Addictionologists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

MICHIGAN
Specialty Prepaid Inpatient Health Plans

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Residing in ICF/MR
-Children Enrolled in Childrens Waiver (Section 1915(c))
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

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

Bay Arenac CMH
Central Michigan CMH
Genesee County CMH
Kent County CMH
Macomb County CMH
Northern Lakes CMH
Oakland County CMH
Saginaw County CMH
Summit Pointe
CEI CMH
Detroit-Wayne CMH
Kalamazoo County CMH
Lifeways CMH
Muskegon County CMH
Northern Michigan CMH
Pathways CMH
St. Clair County CMH
Washtenaw County 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.

MICHIGAN
Specialty Prepaid Inpatient Health Plans

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Irene Kazieczko
Director
MDCH, Bureau of Community Mental Health Services
517 335-0252

State Operating Agency Contact:

Debra Ziegler
HSW Specialist
Bureau of Community Health Services
Michigan Department of Community Health
(517) 241-3044

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Effective Date:
October 02, 2000

Statutes Waived:
1902(a)(10)(B) Comparability of Services

Waiver Expiration Date:
September 30, 2005

Service Delivery

Target Group:
Developmental Disabled

Level of Care:
ICFMR

ADDITIONAL INFORMATION

Under the Michigan Managed Specialty Support and Services Program, PIHPs administer state plan alternatives and 1915(c) waiver services. This managed mental health services program provides supports and services to persons with serious mental illness, developmental disability and substance use disorders, and children with serious emotional disturbance. Persons served through the 1915(b) waiver use a combination of state plan and alternative services. Persons enrolled in the C waiver, called the Habilitation Supports Waiver (HSW), use a combination of C waiver services, state plan, and alternative services.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Measures (see below for details)
-PIHP Standards

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

MICHIGAN
Specialty Prepaid Inpatient Health Plans

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 PIHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of electronic file formats
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-Proprietary for Pharmacy

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

PIHP conducts data accuracy check(s) on specified data elements
None
-Provider ID
-Type of Service
-Medicaid Eligibility
-Diagnosis Codes
-Age-appropriate diagnosis/procedure
-Age
-Gender
-Race/Ethnicity
-Social Security

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
-Adults living in homes of their own
-Adults working in supported employment
-Children living with family
-Patient satisfaction with care
-Rates of rights complaints/1000 served
-Rates of sentinel events/1000 served
-Rates of suicide/1000 served

Access/Availability of Care
-Average wait time for first appointment with PCP
-Penetration rates for special populations
-Percent of denials of service
-Percent of persons in NHs who met OBRA criteria served
-Wait time for commencement of service(s)

Use of Services/Utilization
-Cost per case by population
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries

-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility

MICHIGAN
Specialty Prepaid Inpatient Health Plans

-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Standards/Accreditation

PIHP Standards
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
-CARF
-COA
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-The Council

Non-Duplication Based on Accreditation
None

EQRO Name
-Health Service Advisory Group, Phoenix, AZ

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of Performance Improvement Projects
-Validation of performance measures

EQRO Optional Activities
None

TEXAS
STAR+PLUS

CONTACT INFORMATION

State Medicaid Contact:
Pam Coleman
Health and Human Services Commission
(512) 685-3172

State Website Address:
http://www.hhsc.state.tx.us/starplus/starplus.htm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

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:
January 30, 1998

Implementation Date:
February 01, 1998

Waiver Expiration Date:
August 31, 2006

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) - Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Internists
-Physician Assistants
-Nurse Practitioners
-Nurse Midwives
-Rural Health Clinics (RHCs)
-Federally Qualified Health Centers (FQHCs)

TEXAS
STAR+PLUS

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

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 Use Disorders, Laboratory, Outpatient Hospital, Outpatient Substance Use Disorders, Physician, X-Ray

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Midwives
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

TEXAS
STAR+PLUS

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

Amerigroup- STAR+PLUS
Texas Health Network (Star+Plus)
Evercare- STAR+PLUS

ADDITIONAL INFORMATION

None

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Bill Farnsowth
Policy & Information Specialist
Health & Human Services Commission
512-491-1301

State Operating Agency Contact:

Not Applicable

PROGRAM DATA

Program Service Area:
County

Statutes Waived:
1902(a)(1) Statewideness
1902(a)(10)(B) Comparability of Services

Initial Waiver Effective Date:
February 01, 1998

Waiver Expiration Date:
August 31, 2005

Service Delivery

Target Group:
Aged and Disabled

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

Both b&c waivers are operating through the STAR+PLUS program which integrates acute and long term care services for SSI enrollees in Harris County.

TEXAS
STAR+PLUS

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-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 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)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-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

MCO/HIO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

TEXAS
STAR+PLUS

Standards/Accreditation

MCO Standards
None

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-Institute for Child Health Policy

EQRO Organization
-QIO-like entity

EQRO Mandatory Activities
-Review of MCO compliance with structural and operational standards established by the State

EQRO Optional Activities
None

WISCONSIN
Family Care

CONTACT INFORMATION

State Medicaid Contact:
Charles Jones
Wisconsin Department of Health and Family Services
(608) 266-0991

State Website Address:
http://dhfs.wisconsin.gov/LTCare/INDEX.HTM

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Southeastern Wisconsin Area Agency on Aging

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 01, 2004

Implementation Date:
January 01, 2004

Waiver Expiration Date:
December 31, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) Choice of PIHP

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

LTC PIHP - Capitation

Service Delivery

Included Services:
1915(c) Waiver Services, Case Management, Durable Medical Equipment, Home Health, ICF-MR, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Skilled Nursing, Skilled Nursing Facility, Transportation

Allowable PCPs:
-Not applicable, primary care is carved out

Enrollment

WISCONSIN
Family Care

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Under Age 60 in Milwaukee County
-Enrolled in Another Managed Care Program
-Have an Eligibility Period that Is Only Retroactive

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-All Target Groups Are Persons with Special Needs

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Mental Health Agency
-Protective Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Family Care

ADDITIONAL INFORMATION

Milwaukee County Department of Aging serves only persons age 60 and over.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:
Charles Jones
Lead Waiver/Policy Analyst
Department of Health and Family Services
(608) 266-0991

State Operating Agency Contact:
Not Applicable

PROGRAM DATA

WISCONSIN
Family Care

Program Service Area:
County

Initial Waiver Effective Date:
June 01, 2001

Statutes Waived:
1902(a)(1) Statewideness
1902(a)(10)(B) Comparability of Services
1902(a)(10)(C)(i)(III) Income and Resource Rules

Waiver Expiration Date:
December 31, 2004

Service Delivery

Target Group:
Aged and Disabled

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

Family Care is a capitated, full risk managed care program for the delivery of long-term care services. Family Care 1915b Long Term Care PIHP includes 1915c waiver services and Medicaid State Plan Long Term Care services. Primary and acute health care are carved out, but remain available to enrollees through the Medicaid State Plan. Every enrollee participates with an interdisciplinary care management team that, at minimum includes a nurse and a social worker, in a member-centered planning process to design an individualized service plan (ISP). The ISP is designed to identify the members long-term care needs and authorize services to achieve identified outcomes in relation to those needs. PIHP quality is evaluated on a performance-based QA/QI assessment of success in meeting identified outcomes. The assessment methodology uses: 1) a structured validated member interview tool to evaluate member perception of performance; 2) a structured review of a sample of ISPs by the States External Quality Review Organization; 3) annual State evaluation and certification of the PIHP network of providers to ensure adequate access and capacity; and 4) ongoing utlilization review and focus studies to identify areas for performance improvement projects and other quality improvement strategies. Aging and Disability Resource Centers are established in each county where Family Care is available to act as a single entry point for information and access to services for persons in need of long-term care.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Individualized Service Plan Reviews
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards
-Provider Data
-Structured Member Outcome Interviews

Use of Collected Data
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation

Consumer Self-Report Data
-Structured Member Outcome Interviews

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

Collections: Submission Specifications
-Data submission requirements including documentation

WISCONSIN
Family Care

Collection: Standardized Forms
None

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

PIHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Member LTC outcomes present
-Support for member LTC outcomes provided

Health Status/Outcomes Quality
-Member health and safety outcomes present
-Support for member health and safety outcomes provided

Access/Availability of Care
-State assessment of adequate network capacity

Use of Services/Utilization
-NF and ICF-MR utilization

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-State minimum reserve requirements

Health Plan/ Provider Characteristics
-Board Certification
-State review for cultural competency

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-PIHP/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-PIHPs are required to conduct a project(s) of their own choosing
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
Not Applicable - PIHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - PIHPs are not required to conduct common project(s)

WISCONSIN
Family Care

Standards/Accreditation

PIHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Non-Duplication Based on Accreditation
None

EQRO Name
-MetaStar, Inc.

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of PIHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

CALIFORNIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Della Cabrera
Contract Manager
Office of Long Term Care
(916) 440-7532

State Website Address: http://www.dhs.ca.gov

PACE Organization

Approved PACE Organization Name: Center for Elders Independence

Program Agreement Effective Date: November 01, 2003

PACE Contact:

Peter Szutu
1955 San Pablo Avenue
Oakland, CA 95612
(414) 902-2363

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a risk-adjusted payment rate and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. PACE organizations may charge a premium to individuals who do not have Medicaid eligibility.

The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplanary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

CALIFORNIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Louise Nava
Contract Manager
Office of Long Term Care
(916) 440-7538

State Website Address:

http://www.dhs.ca.gov

PACE Organization

Approved PACE Organization Name:

AltaMed Health Services Corporation

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Sohia Guel-Valenzuela
500 Citadel Drive - Suite 490
Los Angeles, CA 90040
(323) 725-8751

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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CALIFORNIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Louise Nava
Contract Manager
Office of Long Term Care
(916) 440-7538

State Website Address: http://www.dhs.ca.gov

PACE Organization

Approved PACE Organization Name: On Lok Senior Health Services

Program Agreement Effective Date: November 01, 2003

PACE Contact:

Eileen Kunz
1333 Bush Street
San Francisco, CA 94109
(415) 292-8888

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

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CALIFORNIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Della Cabrera
Contract Manager
Office of Long Term Care
(916) 440-7532

State Website Address: http://www.dhs.ca.gov

PACE Organization

Approved PACE Organization Name: Sutter Senior Care

Program Agreement Effective Date: November 01, 2003

PACE Contact:

Janet Tedesco
1234 U Street
Sacramento, CA 95818
(916) 446-3100

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

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COLORADO
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Beverly Barabara Dahan
Contract Administrator
Department of Health Care Policy and Financing
303-866-2148

State Website Address:

http://www.CHCPF.state.co.us

PACE Organization

Approved PACE Organization Name:

Total Long Term Care

Program Agreement Effective Date:

April 01, 2003

PACE Contact:

David Reyes
200 E. 9th Avenue
Denver, CO 80203
(303) 869-4664

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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FLORIDA
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Wendy Smith
Program Administrator
Agency for Health Care Administration
(850) 922-7348

State Website Address:

http://www.fdhc.state.fl.us

PACE Organization

Approved PACE Organization Name:

Florida PACE Centers, Inc.

Program Agreement Effective Date:

January 01, 2003

PACE Contact:

Daniel Brady
5200 NE 2nd Avenue
Miami, FL 33137
(305) 531-5341

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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KANSAS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Debra Bachmann
Manager, PACE Program
Department of Social and Rehabilitation Services - Health Care Policy
(785) 296-3667

State Website Address:

http://www.srskansas.org

PACE Organization

Approved PACE Organization Name:

Via Christi Healthcare Outreach Program for the Elders

Program Agreement Effective Date:

September 01, 2002

PACE Contact:

Gale Remington Smith
935 S. Glendale
Wichita, KS 67208
(316) 858-1111

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

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MARYLAND
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Katherine Tvaronas
Administrator
Department of Health and Mental Hygiene
410-767-1478

State Website Address:

http://www.dhmh.state.md.us

PACE Organization

Approved PACE Organization Name:

Hopkins Elder Plus

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Karen Armacost
4940 Eastern Ave.
Baltimore, MD 21224
410-550-7044

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

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MASSACHUSETTS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Diane Flanders
Director, Coordinated Care Systems
Division of Medical Assistance
(617) 222-7409

State Website Address:

http://www.mass.gov

PACE Organization

Approved PACE Organization Name:

Elder Service Plan of Cambridge Health Alliance

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Carol Murphy
270 Green Street
Cambridge, MA 02139
(617) 499-8366

Approved PACE Organization Name:

Elder Service Plan of Harbor Health Services Inc

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Carol Crawford
2216 Dorchester Avenue
Dorchester, MA 02124
(617) 296-5100

Approved PACE Organization Name:

Uphams Elder Service Plan

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Jay Trivedi
1140 Dorchester Avenue
Dorchester, MA 02125
(617) 288-0970

MASSACHUSETTS
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Elder Service Plan of East Boston

Program Agreement Effective Date: November 01, 2003

PACE Contact:
Diane Fischer
10 Gove Street
East Boston, MA 02128
(617) 568-6413

Approved PACE Organization Name: Elder Service Plan at Fallon Community Health Plan

Program Agreement Effective Date: November 01, 2002

PACE Contact:
Karen Longo
277 East Mountain Street
Worcester, MA 01605
(508) 852-2026

Approved PACE Organization Name: Elder Service Plan of the North Shore, Inc.

Program Agreement Effective Date: November 01, 2003

PACE Contact:
Carol Suleski
20 School Street
Lynn, MA 01901
781-581-7565

ADDITIONAL INFORMATION

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MISSOURI
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Susan Eggen
MC+ Operations Manager
Department of Social Services, Division of Medical Services
573-751-5178

State Website Address: www.state.mo.us

PACE Organization

Approved PACE Organization Name: Alexian Brothers Community Services

Program Agreement Effective Date: November 01, 2001

PACE Contact:

Deno Fabbre
3900 South Grand
St. Louis, MO 63118
314-771-5800

ADDITIONAL INFORMATION

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NEW MEXICO
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Consuelo Trujillo
Planning and Operation Bureau Chief
NM HSD/Medical Assistance Division
(505) 827-3164

State Website Address:

http://www.state.nm.us/hsd/mad/Index.html

PACE Organization

Approved PACE Organization Name:

Total Community Care

Program Agreement Effective Date:

July 01, 2004

PACE Contact:

Gina DeBlassie
904 A Los Lomas NE
Albuquerque, NM 87102
505-924-2606

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

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NEW YORK
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Linda Gowdy
Director, Bureau of Continuing Care Initiatives
Office of Managed Care, NYS Dept of Health
(518) 408-1248

State Website Address:

www.health.state.ny.us

PACE Organization

Approved PACE Organization Name:

PACE CNY

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Penny Abulencia
100 Malta Lane
North Syracuse, NY 13212
(315) 452-5800

Approved PACE Organization Name:

Eddy Senior Care

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Bernadette Hallam
504 State Street
Schenectady, NY 12305
(518) 382-3290

Approved PACE Organization Name:

Comprehensive Care Management Corporation

Program Agreement Effective Date:

November 01, 2003

PACE Contact:

Susan Aldrich
612 Allerton Avenue
Bronx, NY 10457
(718) 515-8600

NEW YORK
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Independent Living for Seniors, Inc.

Program Agreement Effective Date: November 01, 2003

PACE Contact: Joanne Tallinger
2066 Hudson Ave.
Rochester, NY 14617
(585) 922-2800

ADDITIONAL INFORMATION

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OHIO
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Lisa Walsh
Chief
Ohio Department of Job and Planning Services
(614) 387-7944

State Website Address:

http://www.state.oh.us/odjfs/index.stm

PACE Organization

Approved PACE Organization Name:

Concordia Care

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Janis Faenhrich, CEO
2373 Euclid Heights Blvd.
Cleveland Heights, OH 44106
(216) 791-3580

Approved PACE Organization Name:

TriHealth Senior Link

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Steve Mombach, Director
619 Oak St.
Cincinnati, OH 45206
(513) 531-5110

ADDITIONAL INFORMATION

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To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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OREGON
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

David Allm
PACE Coordinator
Oregon Dept. of Human Services
(503) 947-5247

State Website Address:

http://www.dhs.state.or.us

PACE Organization

Approved PACE Organization Name:

Providence Elder Care

Program Agreement Effective Date:

November 01, 2003

PACE Contact:

Don Keister
13007 NE Gleason
Portland, OR 97230
(503) 215-3612

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

James Pezzuti
Director, Division of Long Term Care Client Service
PA Department of Public Welfare
(717) 772-2525

State Website Address:

www.state.pa.us

PACE Organization

Approved PACE Organization Name:

LIFE - University of Pennsylvania

Program Agreement Effective Date:

January 01, 2002

PACE Contact:

Wayne Pendleton
4101 Woodland Avenue
Philadelphia, PA 19104
(215) 573-7200

Approved PACE Organization Name:

Community - LIFE

Program Agreement Effective Date:

March 01, 2004

PACE Contact:

Ransom Towsley
1305 Fifth Avenue
McKeesport, PA 15132
(412) 664-1448

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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SOUTH CAROLINA
Program of All-inclusive Care of the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

George Maky
Department Head, Division of CLTC-Waiver Mgt.
South Carolina Dept of Health and Human Services
803-898-2711

State Website Address:

www.dhhs.state.sc.us

PACE Organization

Approved PACE Organization Name:

Palmetto SeniorCare

Program Agreement Effective Date:

November 01, 2003

PACE Contact:

Judy Baskins
Palmetto SeniorCare, 5 Richland Medical Park
Columbia, SC 29203
(803) 434-3770

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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TENNESSEE
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

J D Hickey
Deputy Commissioner
TennCare
(615) 741-0213

State Website Address: http://www.state.tn.us/tenncare

PACE Organization

Approved PACE Organization Name: Alexian Brothers Community Services

Program Agreement Effective Date: November 01, 2002

PACE Contact:

Viston Taylor
425 Cumberland Street Suite 110
Chattanooga, TN 37404
(423) 698-0802

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a risk-adjusted payment rate and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. PACE organizations may charge a premium to individuals who do not have Medicaid eligibility.

The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplanary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

TEXAS
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Susan Syler
Program Manager
Department of Aging and Disability
(512) 438-3693

State Website Address:

http://www.dads.state.tx.us/business/pace/index.html

PACE Organization

Approved PACE Organization Name:

Bienvivir Senior Health Services

Program Agreement Effective Date:

November 01, 2003

PACE Contact:

Rosemarie Castillo
2300 McKinley Avenue
El Paso, TX 79930
(512) 438-3693

Approved PACE Organization Name:

The Basics at Jan Werner

Program Agreement Effective Date:

March 01, 2004

PACE Contact:

Alana J. Chilcote
3108 S. Fillmore
Amarillo, TX 79110
(806) 374-5516

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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WASHINGTON
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Kristi Knudsen
Program Manager
ADSA
(360) 586-0615

State Website Address:

www.dshs.wa.gov

PACE Organization

Approved PACE Organization Name:

Providence Elderplace - Seattle

Program Agreement Effective Date:

July 27, 2000

PACE Contact:

Ellen Garcia
5900 Martin Luther King Way South
Seattle, WA 98118
(206) 760-6300

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a risk-adjusted payment rate and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. PACE organizations may charge a premium to individuals who do not have Medicaid eligibility.

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WISCONSIN
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Cecilia Chathas
Project Manager
Wisoncsin Department of Health and Family Services
(608) 267-2923

State Website Address:

http://dhfs.wisconsin.gov

PACE Organization

Approved PACE Organization Name:

Community Care Organization

Program Agreement Effective Date:

November 01, 2003

PACE Contact:

Paul F. Soczynski
1555 South Layton Boulevard
Milwaukee, WI 53215
(414) 385-6600

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplanary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

COLORADO
Primary Care Physician Program

CONTACT INFORMATION

State Medicaid Contact:
Jerry Smallwood
Dept. of Health Care Policy and Financing
303-866-5947

State Website Address:
http://www.CHCPF.state.co.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1905(t)

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus, INC.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
June 30, 2003

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Disease Management, EPSDT, Hearing, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Indian Health Service (IHS) Providers
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-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

-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

COLORADO
Primary Care Physician Program

-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Medicare Dual Eligibles
-Foster Care Children
-Special Needs Children (BBA defined)
-Poverty-Level Pregnant Women
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI

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
-Maternal and Child Health Agency
-Mental Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Primary Care Physician Program

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Self-Report Data
-Performance Improvements Projects (see below for details)

Use of Collected Data:
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
-Consumer/beneficiary Focus Groups
-Disenrollment Survey
-State-developed Survey

Performance Improvement Projects

COLORADO
Primary Care Physician Program

Clinical Topics
None

Non-Clinical Topics
-Adults access to preventive/ambulatory health services

Operating Authorities by State as of June 30, 2004							
State	1915(b)	1115(a)	1932(a)	1915(a), voluntary	Concurrent 1915(b)/(c)	PACE	1905(t)
Alabama			✓				
*Alaska							
Arizona		✓					
Arkansas	✓						
California	✓	✓	✓	✓		✓	
Colorado	✓			✓		✓	✓
Connecticut	✓						
Delaware		✓					
District of Columbia	✓			✓			
Florida	✓				✓	✓	
Georgia	✓		✓				
Hawaii		✓					
Idaho	✓						
Illinois				✓			
Indiana	✓						
Iowa	✓		✓				
Kansas			✓			✓	
Kentucky	✓	✓	✓				
Louisiana	✓						
Maine			✓				
Maryland		✓				✓	
Massachusetts		✓				✓	
Michigan	✓			✓	✓		
Minnesota		✓		✓			
Mississippi			✓				
Missouri	✓	✓				✓	
Montana	✓						
Nebraska	✓		✓				
Nevada			✓				
*New Hampshire							
New Jersey	✓		✓				
New Mexico	✓					✓	
New York		✓		✓		✓	
North Carolina			✓				
North Dakota			✓				
Ohio	✓					✓	
Oklahoma		✓					
Oregon		✓				✓	
Pennsylvania	✓			✓		✓	
Puerto Rico				✓			
Rhode Island		✓					
South Carolina				✓		✓	
South Dakota			✓	✓			
Tennessee		✓				✓	
Texas	✓				✓	✓	
Utah	✓	✓					
Vermont		✓					
*Virgin Islands							
Virginia	✓						
Washington	✓		✓			✓	
West Virginia	✓						
Wisconsin		✓	✓	✓	✓	✓	
*Wyoming							

*These States do not have managed care.

Medicaid Programs that include Dental services as of June 30, 2004

State	Program Name	Managed Care Entity	Operating Authority
ARIZONA	Arizona Health Care Cost Containment System (AHCCCS)	MCO (Comprehensive Benefits)	1115(a)
CALIFORNIA	Senior Care Action Network	Social HMO	1115(a)
CALIFORNIA	Prepaid Health Plan Program	Dental PAHP	1915(a), voluntary
CALIFORNIA	Sacramento Geographic Managed Care	Dental PAHP	
CONNECTICUT	HUSKY A	MCO (Comprehensive Benefits)	1915(b)
DELAWARE	Diamond State Partners	Enhanced Fee for Service Model	1115(a)
DIST. OF COLUMBIA	District of Columbia Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1915(b)
DIST. OF COLUMBIA	Health Services for Children with Special Needs	Medical-only PIHP (non-risk, comprehensive)	1915(a), voluntary
FLORIDA	Managed Health Care	MCO (Comprehensive Benefits)	1915(b)
FLORIDA	Managed Health Care	PCCM Provider	1915(b)
HAWAII	Hawaii QUEST	MCO (Comprehensive Benefits)	1115(a)
IDAHO	Healthy Connections	PCCM Provider	1915(b)
INDIANA	Hoosier Healthwise	PCCM Provider	1915(b)
KENTUCKY	Kentucky Health Care Partnership Program	MCO (Comprehensive Benefits)	1115(a)
KENTUCKY	Kentucky Patient Access and Care (KENPAC) Program	PCCM Provider	1932(a)
MARYLAND	HealthChoice	MCO (Comprehensive Benefits)	1115(a)
MASSACHUSETTS	Mass Health	MCO (Comprehensive Benefits)	1115(a)
MASSACHUSETTS	Mass Health	PCCM Provider	1115(a)
MICHIGAN	Childrens Special Health Care Services	MCO (Comprehensive Benefits)	1915(a), voluntary
MINNESOTA	Minnesota Disability Health Options (MnDHO)	MCO (Comprehensive Benefits)	1915(a), voluntary
MINNESOTA	Minnesota Senior Health Options Program (MSHO)	MCO (Comprehensive Benefits)	1915(a), voluntary
MINNESOTA	MinnesotaCare Program For Families And Children	MCO (Comprehensive Benefits)	1115(a)
MINNESOTA	Prepaid Medical Assistance Program	MCO (Comprehensive Benefits)	1115(a)
MISSOURI	MC+ Managed Care/1115	MCO (Comprehensive Benefits)	1115(a)
MISSOURI	MC+ Managed Care/1915b	MCO (Comprehensive Benefits)	1915(b)
MONTANA	Passport To Health	PCCM Provider	1915(b)
NEVADA	Mandatory Health Maintenance Program	MCO (Comprehensive Benefits)	1932(a)
NEW JERSEY	New Jersey Care 2000+ (1932)	MCO (Comprehensive Benefits)	1932(a)
NEW MEXICO	SALUD!	MCO (Comprehensive Benefits)	1915(b)
NEW YORK	Managed Long Term Care Program	LTC PIHP (risk, non-comprehensive)	1915(a), voluntary
NEW YORK	Partnership Plan - Family Health Plus	MCO (Comprehensive Benefits)	1115(a)
NEW YORK	Partnership Plan - Family Health Plus	PPO (Comprehensive Benefits)	1115(a)
NEW YORK	Partnership Plan Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1115(a)

Medicaid Programs that include Dental services as of June 30, 2004

State	Program Name	Managed Care Entity	Operating Authority
NEW YORK	Partnership Plan Medicaid Managed Care Program	PCCM Provider	1115(a)
NORTH DAKOTA	North Dakota Access and Care Program	PCCM Provider	1932(a)
OHIO	PremierCare	MCO (Comprehensive Benefits)	1915(b)
OKLAHOMA	SoonerCare	PCCM Provider	1115(a)
OREGON	Oregon Health Plan	Dental PAHP	
PENNSYLVANIA	Family Care Network	PCCM Provider	1915(b)
PENNSYLVANIA	HealthChoices	MCO (Comprehensive Benefits)	1915(b)
PENNSYLVANIA	Long Term Care Capitated Assistance Program (PIHP)	Medical-only PIHP (non-risk, comprehensive)	1915(a), voluntary
PENNSYLVANIA	Voluntary HMO Contracts	MCO (Comprehensive Benefits)	1915(a), voluntary
PUERTO RICO	Puerto Rico Health Care Plan	MCO (Comprehensive Benefits)	1915(a), voluntary
SOUTH DAKOTA	Dental Program	Dental PAHP	1915(a), voluntary
TENNESSEE	TennCare	MCO (Comprehensive Benefits)	1115(a)
TEXAS	STAR	MCO (Comprehensive Benefits)	1915(b)
TEXAS	STAR	PCCM Provider	1915(b)
UTAH	Primary Care Network (PCN)	PCCM Provider	1115(a)
VIRGINIA	MEDALLION	PCCM Provider	1915(b)
VIRGINIA	Medallion II	MCO (Comprehensive Benefits)	1915(b)
WEST VIRGINIA	Mountain Health Trust	MCO (Comprehensive Benefits)	1915(b)
WISCONSIN	BadgerCare [SCHIP]	MCO (Comprehensive Benefits)	1115(a)
WISCONSIN	Independent Care Health Plan (iCare)	MCO (Comprehensive Benefits)	1915(a), voluntary
WISCONSIN	Medicaid HMO Program	MCO (Comprehensive Benefits)	1932(a)
WISCONSIN	Wisconsin Partnership Program	MCO (Comprehensive Benefits)	1115(a)

Medicaid Programs that include Pharmacy as of June 30, 2004

State	Program Name	Managed Care Entity	Operating Authority
ARIZONA	Arizona Health Care Cost Containment System (AHCCCS)	MCO (Comprehensive Benefits)	1115(a)
ARIZONA	Arizona Health Care Cost Containment System (AHCCCS)	MH/SUD PIHP	1115(a)
CALIFORNIA	AIDS Healthcare Foundation	Managed Care Organization (MCO)	1932(a)
CALIFORNIA	Caloptima	HIO	1915(b)
CALIFORNIA	Central Coast Alliance for Health	HIO	1915(b)
CALIFORNIA	Health Plan of San Mateo	HIO	1915(b)
CALIFORNIA	Medi-Cal Mental Health Care Field Test (San Mateo County)	Mental Health plan	1915(b)
CALIFORNIA	Partnership Health Plan of California	HIO	1915(b)
CALIFORNIA	Prepaid Health Plan Program	MCO (Comprehensive Benefits)	1915(a), voluntary
CALIFORNIA	Sacramento Geographic Managed Care	MCO (Comprehensive Benefits)	1915(b)
CALIFORNIA	San Diego Geographic Managed Care	MCO (Comprehensive Benefits)	1915(b)
CALIFORNIA	Santa Barbara Health Initiative	HIO	1915(b)
CALIFORNIA	Senior Care Action Network	Social HMO	1115(a)
CALIFORNIA	Two-Plan Model Program	MCO (Comprehensive Benefits)	1915(b)
COLORADO	Managed Care Program	MCO (Comprehensive Benefits)	1915(a), voluntary
COLORADO	Managed Care Program	Medical-only PIHP (non-risk, comprehensive)	1915(a), voluntary
COLORADO	Managed Care Program	PCCM Provider	1915(a), voluntary
COLORADO	Primary Care Physician Program	PCCM Provider	1905(t)
CONNECTICUT	HUSKY A	MCO (Comprehensive Benefits)	1915(b)
DELAWARE	Diamond State Partners	Enhanced Fee for Service Model	1115(a)
DIST. OF COLUMBIA	District of Columbia Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1915(b)
DIST. OF COLUMBIA	Health Services for Children with Special Needs	Medical-only PIHP (non-risk, comprehensive)	1915(a), voluntary
FLORIDA	Managed Health Care	PCCM Provider	1915(b)
HAWAII	Hawaii QUEST	MCO (Comprehensive Benefits)	1115(a)
HAWAII	Hawaii QUEST	MH/SUD PIHP	1115(a)
IDAHO	Healthy Connections	PCCM Provider	1915(b)
ILLINOIS	Voluntary Managed Care	MCO (Comprehensive Benefits)	1915(a), voluntary
INDIANA	Hoosier Healthwise	MCO (Comprehensive Benefits)	1915(b)
INDIANA	Hoosier Healthwise	PCCM Provider	1915(b)
INDIANA	Medicaid Select	PCCM Provider	1915(b)
KANSAS	HealthConnect Kansas	PCCM Provider	1932(a)
KANSAS	HealthWave 19	MCO (Comprehensive Benefits)	1932(a)
KENTUCKY	Kentucky Health Care Partnership Program	MCO (Comprehensive Benefits)	1115(a)

Medicaid Programs that include Pharmacy as of June 30, 2004

State	Program Name	Managed Care Entity	Operating Authority
KENTUCKY	Kentucky Patient Access and Care (KENPAC) Program	PCCM Provider	1932(a)
MARYLAND	HealthChoice	MCO (Comprehensive Benefits)	1115(a)
MASSACHUSETTS	Mass Health	MCO (Comprehensive Benefits)	1115(a)
MASSACHUSETTS	Mass Health	PCCM Provider	1115(a)
MICHIGAN	Childrens Special Health Care Services	MCO (Comprehensive Benefits)	1915(a), voluntary
MICHIGAN	Comprehensive Health Plan	MCO (Comprehensive Benefits)	1915(b)
MINNESOTA	Minnesota Senior Health Options Program (MSHO)	MCO (Comprehensive Benefits)	1915(a), voluntary
MINNESOTA	MinnesotaCare Program For Families And Children	MCO (Comprehensive Benefits)	1115(a)
MINNESOTA	Prepaid Medical Assistance Program	MCO (Comprehensive Benefits)	1115(a)
MISSOURI	MC+ Managed Care/1115	MCO (Comprehensive Benefits)	1115(a)
MISSOURI	MC+ Managed Care/1915b	MCO (Comprehensive Benefits)	1915(b)
MONTANA	Passport To Health	PCCM Provider	1915(b)
NEVADA	Mandatory Health Maintenance Program	MCO (Comprehensive Benefits)	1932(a)
NEW JERSEY	New Jersey Care 2000+ (1932)	MCO (Comprehensive Benefits)	1932(a)
NEW MEXICO	SALUD!	MCO (Comprehensive Benefits)	1915(b)
NEW YORK	Managed Long Term Care Program	LTC PIHP (risk, non-comprehensive)	1915(a), voluntary
NEW YORK	Partnership Plan - Family Health Plus	MCO (Comprehensive Benefits)	1115(a)
NEW YORK	Partnership Plan - Family Health Plus	PPO (Comprehensive Benefits)	1115(a)
NORTH DAKOTA	North Dakota Access and Care Program	PCCM Provider	1932(a)
OHIO	PremierCare	MCO (Comprehensive Benefits)	1915(b)
OKLAHOMA	SoonerCare	PCCM Provider	1115(a)
OREGON	Oregon Health Plan	MCO (Comprehensive Benefits)	1115(a)
PENNSYLVANIA	Family Care Network	PCCM Provider	1915(b)
PENNSYLVANIA	HealthChoices	MCO (Comprehensive Benefits)	1915(b)
PENNSYLVANIA	Long Term Care Capitated Assistance Program (PIHP)	Medical-only PIHP (non-risk, comprehensive)	1915(a), voluntary
PENNSYLVANIA	Voluntary HMO Contracts	MCO (Comprehensive Benefits)	1915(a), voluntary
PUERTO RICO	Puerto Rico Health Care Plan	MCO (Comprehensive Benefits)	1915(a), voluntary
PUERTO RICO	Puerto Rico Health Care Plan	MH/SUD PIHP	1915(a), voluntary
RHODE ISLAND	Rite Care	MCO (Comprehensive Benefits)	1115(a)
SOUTH CAROLINA	Health Maintenance Organization (HMO)	MCO (Comprehensive Benefits)	1915(a), voluntary
TEXAS	STAR	PCCM Provider	1915(b)
UTAH	Primary Care Network (PCN)	PCCM Provider	1115(a)
VERMONT	Vermont Health Access	PCCM Provider	1115(a)

Medicaid Programs that include Pharmacy as of June 30, 2004

State	Program Name	Managed Care Entity	Operating Authority
VIRGINIA	MEDALLION	PCCM Provider	1915(b)
VIRGINIA	Medallion II	MCO (Comprehensive Benefits)	1915(b)
WASHINGTON	Healthy Options	MCO (Comprehensive Benefits)	1932(a)
WASHINGTON	Healthy Options	PCCM Provider	1932(a)
WISCONSIN	BadgerCare [SCHIP]	MCO (Comprehensive Benefits)	1115(a)
WISCONSIN	Independent Care Health Plan (iCare)	MCO (Comprehensive Benefits)	1915(a), voluntary
WISCONSIN	Medicaid HMO Program	MCO (Comprehensive Benefits)	1932(a)
WISCONSIN	Wisconsin Partnership Program	MCO (Comprehensive Benefits)	1115(a)

Medicaid Programs that Enroll Adult Populations as of June 30, 2004

State	Program Name	Aged Adults	Section 1931 (AFDC/TANF) Adults	Blind/Disabled Adults	Managed Care Entity Type	Operating Authority
AL	Partnership Hospital Program	x	x	x	Medical-only PIHP	1932(a)
AL	Maternity Care Program		x		*Contracted Global Fee	1932(a)
AR	Primary Care Physician	x	x	x	PCCM	1915(b)
AR	Non-Emergency Transportation	x	x	x	Transportation PAHP	1915(b)
AZ	Arizona Health Care Cost Containment System (AHCCCS)	x	x	x	MCO (Comprehensive Benefits)	1115(a)
AZ	Arizona Health Care Cost Containment System (AHCCCS)	x	x	x	MH/SUD PIHP	1115(a)
CA	Medi-Cal Mental Health Care Field Test (San Mateo County)	x	x	x	Mental Health plan	1915(b)
CA	Med-Cal Specialty Mental Health Services Consolidation	x	x	x	Mental Health plan	1915(b)
CA	Caloptima	x	x	x	HIO	1915(b)
CA	Prepaid Health Plan Program	x	x	x	MCO (Comprehensive Benefits)	1915(a), voluntary
CA	Prepaid Health Plan Program	x	x	x	Dental PAHP	1915(a), voluntary
CA	Senior Care Action Network	x		x	*Social HMO	1115(a)
CA	Partnership Health Plan of California		x	x	HIO	1915(b)
CA	Health Plan of San Mateo	x	x	x	HIO	1915(b)
CA	Sacramento Geographic Managed Care	x	x	x	Dental PAHP	1915(b)
CA	Sacramento Geographic Managed Care	x	x	x	MCO (Comprehensive Benefits)	1915(b)
CA	Two-Plan Model Program	x		x	MCO (Comprehensive Benefits)	1915(b)
CA	Central Coast Alliance for Health	x	x	x	HIO	1915(b)
CA	Santa Barbara Health Initiative	x	x	x	HIO	1915(b)
CA	AIDS Healthcare Foundation	x	x	x	*Managed Care Organization	1932(a)
CA	San Diego Geographic Managed Care	x	x	x	MCO (Comprehensive Benefits)	1915(b)
CO	Mental Health Capitation Program	x	x	x	Mental Health PIHP	1915(b)
CO	Managed Care Program	x	x	x	PCCM	1915(a), voluntary
CO	Managed Care Program	x	x	x	Medical-only PIHP	1915(a), voluntary
CO	Managed Care Program	x	x	x	MCO (Comprehensive Benefits)	1915(a), voluntary
CO	Primary Care Physician Program	x	x	x	PCCM	1905(t)
CT	Husky A		x		MCO (Comprehensive Benefits)	1915(b)
DC	District of Columbia Medicaid Managed Care Program		x		MCO (Comprehensive Benefits)	1915(b)
DE	Delaware Physicians Care, Inc.	x	x	x	MCO (Comprehensive Benefits)	1115(a)
DE	Diamond State Partners	x	x	x	*Enhanced Fee For Service Model	1115(a)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Adult Populations as of June 30, 2004

State	Program Name	Aged Adults	Section 1931 (AFDC/TANF) Adults	Blind/Disabled Adults	Managed Care Entity Type	Operating Authority
FL	Prepaid Mental Health Plan	x	x	x	Mental Health PIHP	1915(b)
FL	Managed Care Program	x	x	x	Disease Management PAHP	1915(b)
FL	Managed Care Program	x	x	x	PCCM	1915(b)
FL	Managed Care Program	x	x	x	MCO (Comprehensive Benefits)	1915(b)
GA	Georgia Better Health Care		x	x	PCCM	1932(a)
GA	Non-Emergency Transportation Broker Program	x	x	x	Transportation PAHP	1915(b)
GA	Preadmission Screening and Annual Resident Review (PASARR)	x		x	Mental Health PIHP	1915(b)
HI	Hawaii Quest		x		MCO (Comprehensive Benefits)	1115(a)
HI	Hawaii Quest	x	x	x	MH/SUD PIHP	1115(a)
IA	Iowa Medicaid Managed Health Care		x		MCO (Comprehensive Benefits)	1932(a)
IA	Iowa Medicaid Managed Health Care		x		PCCM	1932(a)
IA	Iowa Plan for Behavioral Health		x	x	MH/SUD PIHP	1915(b)
ID	Healthy Connections	x	x	x	MH/SUD PIHP	1115(a)
IL	Voluntary Managed Care		x		MCO (Comprehensive Benefits)	1915(a), voluntary
IN	Medicaid Select	x		x	PCCM	1915(b)
IN	Hoosier Healthwise		x		PCCM	1915(b)
IN	Hoosier Healthwise		x		MCO (Comprehensive Benefits)	1915(b)
IN	Hoosier Healthwise	x	x	x	Disease Management PCCM	1915(b)
KS	HealthWave 19		x		MCO (Comprehensive Benefits)	1932(a)
KS	HealthConnect Kansas		x	x	PCCM	1932(a)
KY	Kentucky Health Care Partnership Program	x	x	x	MCO (Comprehensive Benefits)	1115(a)
KY	Human Service Transportation	x	x	x	Transportation PAHP	1915(b)
KY	Kentucky Patient Access and Care (KENPAC) Program		x		PCCM	1932(a)
LA	Community Care		x	x	PCCM	1915(b)
MA	MassHealth		x	x	PCCM	1115(a)
MA	MassHealth		x	x	MH/SUD PIHP	1115(a)
MA	MassHealth		x	x	MCO (Comprehensive Benefits)	1115(a)
MD	HealthChoice		x	x	MCO (Comprehensive Benefits)	1115(a)
ME	MaineCare Primary Care Case Management		x		PCCM	1932(a)
MI	Specialty Prepaid Inpatient Health Plans	x	x	x	MH/SUD PIHP	1915(b)/(c)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Adult Populations as of June 30, 2004

State	Program Name	Aged Adults	Section 1931 (AFDC/TANF) Adults	Blind/Disabled Adults	Managed Care Entity Type	Operating Authority
MI	Childrens Special Health Care Services		x	x	MCO (Comprehensive Benefits)	1915(a), voluntary
MI	Comprehensive Health Plan	x	x	x	MCO (Comprehensive Benefits)	1915(b)
MN	MinnesotaCare Program for Families and Children		x		MCO (Comprehensive Benefits)	1115(a)
MN	Prepaid Medical Assistance Program	x	x		MCO (Comprehensive Benefits)	1115(a)
MN	Consolidated Chemical Dependency Treatment Fund	x		x	*County Case Manager	1915(b)
MO	MC+ Managed Care/1915(b)		x		MCO (Comprehensive Benefits)	1915(b)
MT	Passport to Health	x	x	x	PCCM	1915(b)
NC	Access II/III - 1932(a)	x	x	x	PCCM	1932(a)
NC	Carolina ACCESS 1932(a)	x	x	x	PCCM	1932(a)
NC	Health Care Connection 1932(a)	x	x	x	MCO (Comprehensive Benefits)	1932(a)
ND	North Dakota Access and Care Program		x		PCCM	1932(a)
ND	North Dakota Access and Care Program		x		MCO (Comprehensive Benefits)	1932(a)
NE	Nebraska Health Connection Combined Waiver Program	x	x	x	PCCM	1932(a)
NE	Nebraska Health Connection Combined Waiver Program	x	x	x	MCO (Comprehensive Benefits)	1932(a)
NJ	New Jersey Care 2000+ (1932)	x	x	x	MCO (Comprehensive Benefits)	1932(a)
NM	SALUD!	x	x	x	MCO (Comprehensive Benefits)	1915(b)
NV	Mandatory Health Maintenance Program		x		MCO (Comprehensive Benefits)	1932(a)
NY	Managed Long Term Care Program			x	Long Term Care PIHP	1915(a), voluntary
NY	Partnership Plan - Medicaid Managed Care Program		x		MCO (Comprehensive Benefits)	1115(a)
NY	Partnership Plan - Medicaid Managed Care Program	x	x	x	PCCM - Fee-For-Service	1115(a)
NY	Partnership Plan - Medicaid Managed Care Program	x	x	x	PCCM - Capitation	1115(a)
NY	Non-Emergency Transportation	x	x	x	Transportation PAHP	1915(b)
NY	Office of Mental Health/Partial Capitation Program	x	x	x	Mental Health PIHP	1915(a), voluntary
OH	PremierCare		x		MCO (Comprehensive Benefits)	1915(b)
OK	SoonerCare	x	x	x	Medical-only PIHP	1115(a)
OR	Oregon Health Plan	x	x	x	MH/SUD PIHP	1115(a)
OR	Oregon Health Plan	x	x	x	PCCM	1115(a)
OR	Oregon Health Plan	x	x	x	Dental PAHP	1115(a)
OR	Oregon Health Plan	x	x	x	MCO (Comprehensive Benefits)	1115(a)
PA	HealthChoices	x	x	x	MCO (Comprehensive Benefits)	1915(b)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Adult Populations as of June 30, 2004

State	Program Name	Aged Adults	Section 1931 (AFDC/TANF) Adults	Blind/Disabled Adults	Managed Care Entity Type	Operating Authority
PA	HealthChoices	x	x	x	MH/SUD PIHP	1915(b)
PA	Long Term Care Capitated Assistance Program (PIHP)	x		x	Medical-only PIHP	1915(a), voluntary
PA	Voluntary HMO Contracts	x	x	x	MCO (Comprehensive Benefits)	1915(a), voluntary
PR	Puerto Rico Health Care Plan	x	x	x	MCO (Comprehensive Benefits)	1915(a), voluntary
PR	Puerto Rico Health Care Plan	x	x	x	MH/SUD PIHP	1915(a), voluntary
RI	Rite Care		x		MCO (Comprehensive Benefits)	1115(a)
SC	Physicians Enhanced Program (PEP)		x	x	Medical-only PIHP	1915(a), voluntary
SC	Health Maintenance Organization (HMO)		x	x	MCO (Comprehensive Benefits)	1915(a), voluntary
SD	Dental Program	x	x	x	Dental PAHP	1915(a), voluntary
SD	Prime		x	x	PCCM	1932(a)
TN	TennCare	x	x	x	MCO (Comprehensive Benefits)	1115(a)
TN	TennCare	x	x	x	MH/SUD PIHP	1115(a)
TX	STAR+PLUS	x		x	MCO (Comprehensive Benefits)	1915(b)/(c)
TX	STAR+PLUS	x		x	PCCM	1915(b)/(c)
TX	NorthSTAR	x	x	x	MH/SUD PIHP	1915(b)
TX	STAR		x	x	PCCM	1915(b)
TX	STAR		x	x	MCO (Comprehensive Benefits)	1915(b)
UT	Choice of Health Care Delivery	x	x	x	Medical-only PIHP	1915(b)
UT	Choice of Health Care Delivery	x		x	PCCM	1915(b)
UT	Primary Care Network (PCN)		x		Mental Health PIHP	1115(a)
UT	Primary Care Network (PCN)		x		Medical-only PIHP	1115(a)
UT	Non-Emergency Transportation	x	x	x	Transportation PAHP	1915(b)
UT	Prepaid Mental Health Program	x	x	x	Mental Health PIHP	1915(b)
VA	Medallion II	x	x	x	MCO (Comprehensive Benefits)	1915(b)
VA	MEDALLION	x	x	x	PCCM	1915(b)
VT	Vermont Health Access	x	x	x	PCCM	1115(a)
WA	Healthy Options		x		PCCM	1932(a)
WA	Healthy Options		x		MCO (Comprehensive Benefits)	1932(a)
WA	The Integrated Mental Health Services	x	x	x	Mental Health PIHP	1915(b)
WI	Family Care	x		x	Long Term Care PIHP	1915(b)/(c)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Adult Populations as of June 30, 2004

State	Program Name	Aged Adults	Section 1931 (AFDC/TANF) Adults	Blind/Disabled Adults	Managed Care Entity Type	Operating Authority
WI	Medicaid HMO Program		x		MCO (Comprehensive Benefits)	1932(a)
WI	Independent Care Health Plan (iCare)			x	MCO (Comprehensive Benefits)	1915(a), voluntary
WI	Wisconsin Partnership Program	x		x	MCO (Comprehensive Benefits)	1115(a)
WV	Mountain Health Trust		x		MCO (Comprehensive Benefits)	1915(b)
WV	Physician Assured Access System		x	x	PCCM	1915(b)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Dual Eligibles as of June 30, 2004

State	Program Name	QMB Plus, SLMB Plus, and Medicaid-only	QMB	SLMB, QI, and QDWI	Managed Care Entity Type	Operating Authority
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	X	X	X (only SLMB)	MCO (Comprehensive Benefits)	1115(a)
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	X	X	X (only SLMB)	MH/SUD PIHP	1115(a)
California	AIDS Healthcare Foundation	X			MCO (Comprehensive Benefits)	1932(a)
California	Caloptima	X			HIO	1915(b)
California	Central Coast Alliance for Health	X			HIO	1915(b)
California	Health Plan of San Mateo	X			HIO	1915(b)
California	Partnership Health Plan of California	X			HIO	1915(b)
California	Prepaid Health Plan Program	X			Dental PAHP	1915(a), voluntary
California	Prepaid Health Plan Program	X			MCO (Comprehensive Benefits)	1915(a), voluntary
California	Prepaid Health Plan Program	X			*PAHP (Emotional Support)	1915(a), voluntary
California	Sacramento Geographic Managed Care	X			Dental PAHP	1915(b)
California	Sacramento Geographic Managed Care	X			MCO (Comprehensive Benefits)	1915(b)
California	San Diego Geographic Managed Care	X			MCO (Comprehensive Benefits)	1915(b)
California	Santa Barbara Health Initiative	X			HIO	1915(b)
California	Senior Care Action Network	X			*Social HMO	1115(a)
California	Two-Plan Model Program	X			MCO (Comprehensive Benefits)	1915(b)
Colorado	Managed Care Program	X	X	X	MCO (Comprehensive Benefits)	1915(a), voluntary
Colorado	Managed Care Program	X	X	X	PCCM	1915(a), voluntary
Colorado	Managed Care Program	X	X	X	Medical-only PIHP	1915(a), voluntary
Colorado	Primary Care Physician Program	X			PCCM	1915(t)
Florida	Managed Health Care	X	X	X	MCO (Comprehensive Benefits)	1915(b)
Florida	Managed Health Care	X	X	X	PCCM	1915(b)
Idaho	Healthy Connections	X			PCCM	1915(b)
Indiana	Hoosier Healthwise	X	X	X	*Disease Management PCCM	1915(b)
Indiana	Medicaid Select	X	X	X (only SLMB)	PCCM	1915(b)
Iowa	Iowa Plan For Behavioral Health	X	X	X	MH/SUD PIHP	1915(b)
Kentucky	Human Service Transportation	X	X	X	Transportation PAHP	1915(b)
Kentucky	Kentucky Health Care Partnership Program	X			MCO (Comprehensive Benefits)	1115(a)
Minnesota	Consolidated Chemical Dependency Treatment Fund	X			*County Case Manager	1915(b)
Minnesota	Minnesota Disability Health Options (MnDHO)	X			MCO (Comprehensive Benefits)	1915(a), voluntary
Minnesota	Minnesota Senior Health Options Program (MSHO)	X			MCO (Comprehensive Benefits)	1915(a), voluntary
Minnesota	Prepaid Medical Assistance Program	X			MCO (Comprehensive Benefits)	1115(a)
New Jersey	New Jersey Care 2000+ (1915 {b})	X			MCO (Comprehensive Benefits)	1932(a)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Dual Eligibles as of June 30, 2004

State	Program Name	QMB Plus, SLMB Plus, and Medicaid-only	QMB	SLMB, QI, and QDWI	Managed Care Entity Type	Operating Authority
New Jersey	New Jersey Care 2000+ (1932)	X			MCO (Comprehensive Benefits)	1932(a)
New Jersey	Managed Long Term Care Program	X			*Long Term Care PIHP	1915(b)
New York	Non-Emergency Transportation	X			Transportation PAHP	1932(a)
New York	Office of Mental Health/Partial Capitation Program	X			Mental Health PAHP	1915(a), voluntary
New York	Partnership Plan Medicaid Managed Care Program	X			PCCM - Capitated	1915(a), voluntary
North Carolina	Access II/III - 1932(a)	X (Only Medicaid-only)			PCCM	1115(a)
North Carolina	Carolina ACCESS 1932(a)	X (Only Medicaid-only)			PCCM	1115(a)
Oregon	Oregon Health Plan	X	X	X	Dental PAHP	1115(a)
Oregon	Oregon Health Plan	X	X	X	MCO (Comprehensive Benefits)	1115(a)
Oregon	Oregon Health Plan	X	X	X	MH/SUD PIHP	1115(a)
Oregon	Oregon Health Plan	X	X	X	PCCM	1115(a)
Pennsylvania	Family Care Network	X			PCCM	1915(b)
Pennsylvania	HealthChoices	X			MCO (Comprehensive Benefits)	1915(b)
Pennsylvania	HealthChoices	X			MH/SUD PIHP	1915(b)
Pennsylvania	Long Term Care Capitated Assistance Program (PIHP)	X	X	X	Medical-only PIHP	1915(a), voluntary
Pennsylvania	Voluntary HMO Contracts	X			MCO (Comprehensive Benefits)	1915(a), voluntary
Puerto Rico	Puerto Rico Health Care Plan	X	X	X	MCO (Comprehensive Benefits)	1915(a), voluntary
Puerto Rico	Puerto Rico Health Care Plan	X	X	X	MH/SUD PIHP	1915(a), voluntary
South Dakota	Dental Program	X	X		Dental PAHP	1915(a), voluntary
Tennessee	TennCare	X	X	X	MCO (Comprehensive Benefits)	1115(a)
Tennessee	TennCare	X	X	X	MH/SUD PIHP	1115(a)
Texas	NorthSTAR	X (Only individuals on SSI and QMB Plus)			MH/SUD PIHP	1915(b)
Texas	STAR+PLUS	X			PCCM	1915b/c
Texas	STAR+PLUS	X			MCO (Comprehensive Benefits)	1915b/c
Utah	Choice Of Health Care Delivery	X			Medical-only PIHP	1915(b)
Utah	Choice Of Health Care Delivery	X			PCCM	1915(b)
Utah	Non-Emergency Transportation	X			Transportation PAHP	1915(b)
Utah	Prepaid Mental Health Program	X			Mental Health PIHP	1915(b)
Utah	Primary Care Network (PCN)	X			Medical-only PIHP	1115(a)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Dual Eligibles as of June 30, 2004

State	Program Name	QMB Plus, SLMB Plus, and Medicaid-only	QMB	SLMB, QI, and QDWI	Managed Care Entity Type	Operating Authority
Utah	Primary Care Network (PCN)	X			Mental Health PIHP	1115(a)
Utah	Primary Care Network (PCN)	X			PCCM	1115(a)
Wisconsin	Family Care	X			*LTC PIHP	1915b/c
Wisconsin	Independent Care Health Plan (iCare)	X			MCO (Comprehensive Benefits)	1915(a), voluntary
Wisconsin	Wisconsin Partnership Program	X			MCO (Comprehensive Benefits)	1115(a)

*Indicates MCE Type is "Other".

States that incorporate SCHIP into their Medicaid programs as of June 30, 2004

	Managed Care Entity Type				
State	**MCO**	**PCCM**	**PIHP**	**PAHP**	**Program Name(s)**
AR		✓		✓	Primary Care Physician, Non-Emergency Transportation
DC	✓			✓	Health Services for Children with Special Needs (PIHP) DC Medicaid Managed Care Program (MCO)
FL	✓	✓		✓	Managed Health Care
ID		✓			Healthy Connections
IL	✓				Voluntary Managed Care
IN	✓	✓			Hoosier Healthwise
KY		✓		✓	Human Service Transportation, KENPAC program
LA		✓			Community Care
MA	✓	✓	✓		MassHealth
MD	✓				Health Choices
ME		✓			MaineCare Primary Care Case Management
MI	✓				Children's Special Health Care Services
MN	✓				MinnesotaCare Program for Families and Children, Prepaid Medical Assistance Program
MO	✓				MC+ Managed Care/1115
NE	✓	✓			NE Health Care Connection Combined Waiver Program
NJ	✓				New Jersey Care 2000+ (1932)
NM	✓				SALUD!
OH	✓				PremierCare
OK				✓	SoonerCare
OR	✓	✓	✓	✓	Oregon Health Plan
PR	✓		✓		Puerto Rico Health Care Plan
RI	✓				Rite Care
SC				✓	Physicians Enhanced Program
SD		✓		✓	PRIME (PCCM), Dental Program (PAHP)
TN	✓		✓		TennCare
TX	✓	✓			STAR
VA		✓			MEDALLION
VT		✓			Vermont Health Access
WI	✓		✓		Children Come First (CCF) and Wraparound Milwaukee (PIHPs) BadgerCare - SCHIP (MCO)

Note: For all of our statistical charts, we do <u>not</u> collect separate SCHIP enrollment figures from the States. If the State incorporates SCHIP into their Medicaid program, the SCHIP enrollment is included in the total Medicaid, Managed care, and plan-level figures.

Medicaid Programs that Enroll Foster Care Children as of June 30, 2004

State	Program Name	Managed Care Entity Type	Operating Authority
Alabama	Partnership Hospital Program	Medical-only PIHP	1932(a)
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	MCO (Comprehensive Benefits)	1115(a)
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	MH/SUD PIHP	1115(a)
Arkansas	Non-Emergency Transportation	Transportation PAHP	1915(b)
Arkansas	Primary Care Physician	PCCM	1915(b)
California	AIDS Healthcare Foundation	Managed Care Organization	1932(a)
California	Caloptima	HIO	1915(b)
California	Central Coast Alliance for Health	HIO	1915(b)
California	Partnership Health Plan of California	HIO	1915(b)
California	Prepaid Health Plan Program	Dental PAHP	1915(a), voluntary
California	Prepaid Health Plan Program	MCO (Comprehensive Benefits)	1915(a), voluntary
California	Sacramento Geographic Managed Care	Dental PAHP	1915(b)
California	Sacramento Geographic Managed Care	MCO (Comprehensive Benefits)	1915(b)
California	Santa Barbara Health Initiative	HIO	1915(b)
California	Two-Plan Model Program	MCO (Comprehensive Benefits)	1915(b)
Colorado	Managed Care Program	Medical-only PIHP	1915(a), voluntary
Colorado	Mental Health Capitation Program	Mental Health PIHP	1915(b)
Colorado	Primary Care Physician Program	PCCM	1905(t)
Connecticut	HUSKY A	MCO (Comprehensive Benefits)	1915(b)
Delaware	Delaware Physicians Care , Inc.	MCO (Comprehensive Benefits)	1115(a)
Delaware	Diamond State Partners	*Enhanced Fee for Service Model	1115(a)
Dist. of	District of Columbia Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1915(b)
Florida	Managed Health Care	Disease Management PAHP	1915(b)
Florida	Managed Health Care	MCO (Comprehensive Benefits)	1915(b)
Florida	Managed Health Care	PCCM	1915(b)
Florida	Prepaid Mental Health Plan	Mental Health (MH) PIHP	1915(b)
Hawaii	Hawaii QUEST	MCO (Comprehensive Benefits)	1115(a)
Idaho	Healthy Connections	PCCM	1915(b)
Indianna	Hoosier Healthwise	Disease Management PCCM	1915(b)
Indianna	Hoosier Healthwise	MCO (Comprehensive Benefits)	1915(b
Indianna	Hoosier Healthwise	PCCM	1915(b)
Iowa	Iowa Plan For Behavioral Health	MH/SUD PIHP	1915(b)
Kentucky	Human Service Transportation	Transportation PAHP	1915(b)
Kentucky	Kentucky Health Care Partnership Program	MCO (Comprehensive Benefits)	1115(a)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Foster Care Children as of June 30, 2004

State	Program Name	Managed Care Entity Type	Operating Authority
Maine	MaineCare Primary Care Case Management	PCCM	1932(a)
Maryland	HealthChoice	MCO (Comprehensive Benefits)	1115(a)
Massachusetts	Mass Health	MCO (Comprehensive Benefits)	1115(a)
Massachusetts	Mass Health	MH/SUD PIHP	1115(a)
Massachusetts	Mass Health	PCCM	1115(a)
Michigan	Childrens Special Health Care Services	MCO (Comprehensive Benefits)	1915(a), voluntary
Michigan	Specialty Prepaid Inpatient Health Plans	MH/SUD PIHP	1915b/c
Minnesota	MinnesotaCare Program For Families And Children	MCO (Comprehensive Benefits)	1115(a)
Minnesota	Prepaid Medical Assistance Program	MCO (Comprehensive Benefits)	1115(a)
Missouri	MC+ Managed Care/1915b	MCO (Comprehensive Benefits)	1915(b)
Montana	Passport To Health	PCCM	1915(b)
Nebraska	Nebraska Health Connection Combined Waiver Program	MCO (Comprehensive Benefits)	1932(a)
Nebraska	Nebraska Health Connection Combined Waiver Program	PCCM	1932(a)
New Jersey	New Jersey Care 2000+ (1932)	MCO (Comprehensive Benefits)	1932(a)
New Mexico	SALUD!	MCO (Comprehensive Benefits)	1915(b)
New York	Non-Emergency Transportation	Transportation PAHP	1915(b)
New York	Partnership Plan Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1115(a)
New York	Partnership Plan Medicaid Managed Care Program	PCCM - Capitated	1115(a)
New York	Partnership Plan Medicaid Managed Care Program	PCCM - Fee-For-Service	1115(a)
North Carolina	Access II/III - 1932(a)	PCCM	1932(a)
North Carolina	Carolina ACCESS 1932(a)	PCCM	1932(a)
North Carolina	Health Care Connection 1932(a)	MCO (Comprehensive Benefits)	1932(a)
Ohio	PremierCare	MCO (Comprehensive Benefits)	1915(b)
Oregon	Oregon Health Plan	Dental PAHP	1115(a)
Oregon	Oregon Health Plan	MCO (Comprehensive Benefits)	1115(a)
Oregon	Oregon Health Plan	MH/SUD PIHP	1115(a)
Oregon	Oregon Health Plan	PCCM	1115(a)
Pennsylvania	HealthChoices	MCO (Comprehensive Benefits)	1915(b)
Pennsylvania	HealthChoices	MH/SUD PIHP	1915(b)
Puerto Rico	Puerto Rico Health Care Plan	MCO (Comprehensive Benefits)	1915(a), voluntary
Puerto Rico	Puerto Rico Health Care Plan	MH/SUD PIHP	1915(a), voluntary
Rhode Island	Rite Care	MCO (Comprehensive Benefits)	1115(a)
South Carolina	Physicians Enhanced Program (PEP)	Medical-only PAHP	1915(a), voluntary

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Foster Care Children as of June 30, 2004

State	Program Name	Managed Care Entity Type	Operating Authority
South Dakota	Dental Program	Dental PAHP	1915(a), voluntary
Tennessee	TennCare	MCO (Comprehensive Benefits)	1115(a)
Tennessee	TennCare	MH/SUD PIHP	1115(a)
Utah	Choice Of Health Care Delivery	Medical-only PIHP	1915(b)
Utah	Choice Of Health Care Delivery	PCCM	1915(b)
Utah	Non-Emergency Transportation	Transportation PAHP	1915(b)
Vermont	Vermont Health Access	PCCM	1115(a)
Virginia	MEDALLION	PCCM	1915(b)
Washington	The Integrated Mental Health Services	Mental Health PIHP	1915(b)
West Virginia	Physician Assured Access System	PCCM	1915(b)
Wisconsin	Children Come First (CCF)	MH/SUD PIHP	1915(a), voluntary
Wisconsin	Wraparound Milwaukee	MH/SUD PIHP	1915(a), voluntary

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Section 1931 (AFDC/TANF) Children as of June 30, 2004

State	Program Name	Managed Care Entity Type	Operating Authority
Alabama	Maternity Care Program	*Contracted Global Fee	1932(a)
Alabama	Partnership Hospital Program	Medical-only PIHP	1932(a)
Arkansas	Non-Emergency Transportation	Transportation PAHP	1915(b)
Arkansas	Primary Care Physician	PCCM	1915(b)
California	AIDS Healthcare Foundation	MCO (Comprehensive Benefits)	1932(a)
California	Caloptima	HIO	1915(b)
California	Central Coast Alliance for Health	HIO	1915(b)
California	Health Plan of San Mateo	HIO	1915(b)
California	Medi-Cal Mental Health Care Field Test (San Mateo County)	Mental health plan	1915(b)
California	Medi-Cal Specialty Mental Health Services Consolidation	Mental health plans	1915(b)
California	Partnership Health Plan of California	HIO	1915(b)
California	Santa Barbara Health Initiative	HIO	1915(b)
California	Two-Plan Model Program	MCO (Comprehensive Benefits)	1915(b)
Colorado	Managed Care Program	MCO (Comprehensive Benefits)	1915(a), voluntary
Colorado	Managed Care Program	Medical-only PIHP	1915(a), voluntary
Colorado	Managed Care Program	PCCM	1915(a), voluntary
Colorado	Mental Health Capitation Program	Mental Health (MH) PIHP	1915(b)
Colorado	Primary Care Physician Program	PCCM	1905(t)
Connecticut	HUSKY A	MCO (Comprehensive Benefits)	1915(b)
Delaware	Delaware Physicians Care , Inc.	MCO (Comprehensive Benefits)	1115(a)
Delaware	Diamond State Partners	*Enhanced Fee for Service Model	1115(a)
Dist. of Columbia	District of Columbia Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1915(b)
Dist. of Columbia	Health Services for Children with Special Needs	Medical-only PIHP	1915(a), voluntary
Florida	Managed Health Care	Disease Management PAHP	1915(b)
Florida	Managed Health Care	MCO (Comprehensive Benefits)	1915(b)
Florida	Managed Health Care	PCCM	1915(b)
Florida	Prepaid Mental Health Plan	Mental Health (MH) PIHP	1915(b)
Georgia	Georgia Better Health Care	PCCM	1932(a)
Georgia	Non-Emergency Transportation Broker Program	Transportation PAHP	1915(b)
Hawaii	Hawaii QUEST	MCO (Comprehensive Benefits)	1115(a)
Idaho	Healthy Connections	PCCM	1915(b)
Illinois	Voluntary Managed Care	MCO (Comprehensive Benefits)	1915(a), voluntary
Indiana	Hoosier Healthwise	Disease Management PCCM	1915(b)
Indiana	Hoosier Healthwise	MCO (Comprehensive Benefits)	1915(b)
Indiana	Hoosier Healthwise	PCCM	1915(b)
Iowa	Iowa Medicaid Managed Health Care	MCO (Comprehensive Benefits)	1932(a)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Section 1931 (AFDC/TANF) Children as of June 30, 2004

State	Program Name	Managed Care Entity Type	Operating Authority
Iowa	Iowa Medicaid Managed Health Care	PCCM	1932(a)
Iowa	Iowa Plan For Behavioral Health	MH/SUD PIHP	1915(b)
Kansas	HealthConnect Kansas	PCCM	1932(a)
Kansas	HealthWave 19	MCO (Comprehensive Benefits)	1932(a)
Kentucky	Human Service Transportation	Transportation PAHP	1915(b)
Kentucky	Kentucky Health Care Partnership Program	MCO (Comprehensive Benefits)	1115(a)
Kentucky	Kentucky Patient Access and Care (KENPAC) Program	PCCM	1932(a)
Louisiana	Community Care	PCCM	1915(b)
Maine	MaineCare Primary Care Case Management	PCCM	1932(a)
Maryland	HealthChoice	MCO (Comprehensive Benefits)	1115(a)
Massachusetts	Mass Health	MCO (Comprehensive Benefits)	1115(a)
Massachusetts	Mass Health	MH/SUD PIHP	1115(a)
Massachusetts	Mass Health	PCCM	1115(a)
Michigan	Comprehensive Health Plan	MCO (Comprehensive Benefits)	1915(b)
Michigan	Specialty Prepaid Inpatient Health Plans	MH/SUD PIHP	1915b/c
Minnesota	MinnesotaCare Program For Families And Children	MCO (Comprehensive Benefits)	1115(a)
Minnesota	Prepaid Medical Assistance Program	MCO (Comprehensive Benefits)	1115(a)
Missouri	MC+ Managed Care/1915b	MCO (Comprehensive Benefits)	1915(b)
Montana	Passport To Health	PCCM	1915(b)
Nebraska	Nebraska Health Connection Combined Waiver Program	MCO (Comprehensive Benefits)	1932(a)
Nebraska	Nebraska Health Connection Combined Waiver Program	PCCM	1932(a)
Nevada	Mandatory Health Maintenance Program	MCO (Comprehensive Benefits)	1932(a)
New Jersey	New Jersey Care 2000+ (1932)	MCO (Comprehensive Benefits)	1932(a)
New Mexico	SALUD!	MCO (Comprehensive Benefits)	1915(b)
New York	Non-Emergency Transportation	Transportation PAHP	1915(b)
New York	Office of Mental Health/Partial Capitation Program	Mental Health PAHP	1915(a), voluntary
New York	Partnership Plan Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1115(a)
New York	Partnership Plan Medicaid Managed Care Program	PCCM - Capitated	1115(a)
New York	Partnership Plan Medicaid Managed Care Program	PCCM- Fee-for-Service	1115(a)
North Carolina	Access II/III - 1932(a)	PCCM	1932(a)
North Carolina	Carolina ACCESS 1932(a)	PCCM	1932(a)
North Carolina	Health Care Connection 1932(a)	MCO (Comprehensive Benefits)	1932(a)
North Dakota	North Dakota Access and Care Program	MCO (Comprehensive Benefits)	1932(a)
North Dakota	North Dakota Access and Care Program	PCCM	1932(a)
Ohio	PremierCare	MCO (Comprehensive Benefits)	1915(b)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Section 1931 (AFDC/TANF) Children as of June 30, 2004

State	Program Name	Managed Care Entity Type	Operating Authority
Oklahoma	SoonerCare	Medical-only PAHP	1115(a)
Oregon	Oregon Health Plan	Dental PAHP	1115(a)
Oregon	Oregon Health Plan	MCO (Comprehensive Benefits)	1115(a)
Oregon	Oregon Health Plan	MH/SUD PIHP	1115(a)
Oregon	Oregon Health Plan	PCCM	1115(a)
Pennsylvania	Family Care Network	PCCM	1915(b)
Pennsylvania	HealthChoices	MCO (Comprehensive Benefits)	1915(b)
Pennsylvania	HealthChoices	MH/SUD PIHP	1915(b)
Pennsylvania	Voluntary HMO Contracts	MCO (Comprehensive Benefits)	1915(a), voluntary
Puerto Rico	Puerto Rico Health Care Plan	MCO (Comprehensive Benefits)	1915(a), voluntary
Puerto Rico	Puerto Rico Health Care Plan	MH/SUD PIHP	1915(a), voluntary
Rhode Island	Rite Care	MCO (Comprehensive Benefits)	1115(a)
South Carolina	Health Maintenance Organization (HMO)	MCO (Comprehensive Benefits)	1915(a), voluntary
South Carolina	Physicians Enhanced Program (PEP)	Medical-only PAHP	1915(a), voluntary
South Dakota	Dental Program	Dental PAHP	1915(a), voluntary
South Dakota	PRIME	PCCM	1932(a)
Tennessee	TennCare	MCO (Comprehensive Benefits)	1115(a)
Tennessee	TennCare	MH/SUD PIHP	1115(a)
Texas	NorthSTAR	MH/SUD PIHP	1915(b)
Texas	STAR	MCO (Comprehensive Benefits)	1915(b)
Texas	STAR	PCCM	1915(b)
Utah	Choice Of Health Care Delivery	Medical-only PIHP	1915(b)
Utah	Choice Of Health Care Delivery	PCCM Provider	1915(b)
Utah	Non-Emergency Transportation	Transportation PAHP	1915(b)
Utah	Prepaid Mental Health Program	Mental Health PIHP	1915(b)
Vermont	Vermont Health Access	PCCM	1115(a)
Virginia	MEDALLION	PCCM	1915(b)
Virginia	Medallion II	MCO (Comprehensive Benefits)	1915(b)
Washington	Healthy Options	MCO (Comprehensive Benefits)	1932(a)
Washington	Healthy Options	PCCM	1932(a)
Washington	The Integrated Mental Health Services	Mental Health PIHP	1915(b)
West Virginia	Mountain Health Trust	MCO (Comprehensive Benefits)	1915(b)
West Virginia	Physician Assured Access System	PCCM	1915(b)
Wisconsin	Children Come First (CCF)	MH/SUD PIHP	1915(a), voluntary
Wisconsin	Medicaid HMO Program	MCO (Comprehensive Benefits)	1932(a)
Wisconsin	Wraparound Milwaukee	MH/SUD PIHP	1915(a), voluntary

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Blind/Disabled Children as of June 30, 2004

State	Program Name	Managed Care Entity Type	Operating Authority
Alabama	Partnership Hospital Program	Medical-only PIHP	1932(a)
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	MCO (Comprehensive Benefits)	1115(a)
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	MH/SUD PIHP	1115(a)
Arkansas	Non-Emergency Transportation	Transportation PAHP	1915(b)
Arkansas	Primary Care Physician	PCCM	1915(b)
California	AIDS Healthcare Foundation	MCO (Comprehensive Benefits)	1932(a)
California	Caloptima	HIO	1915(b)
California	Central Coast Alliance for Health	HIO	1915(b)
California	Health Plan of San Mateo	HIO	1915(b)
California	Medi-Cal Mental Health Care Field Test (San Mateo County)	Mental health plan	1915(b)
California	Medi-Cal Specialty Mental Health Services Consolidation	Mental health plans	1915(b)
California	Partnership Health Plan of California	HIO	1915(b)
California	Prepaid Health Plan Program	Dental PAHP	1915(a), voluntary
California	Prepaid Health Plan Program	MCO (Comprehensive Benefits)	1915(a), voluntary
California	Prepaid Health Plan Program	*PAHP (Emotional Support)	1915(a), voluntary
California	Sacramento Geographic Managed Care	Dental PAHP	1915(b)
California	Sacramento Geographic Managed Care	MCO (Comprehensive Benefits)	1915(b)
California	San Diego Geographic Managed Care	MCO (Comprehensive Benefits)	1915(b)
California	Santa Barbara Health Initiative	HIO	1915(b)
California	Two-Plan Model Program	MCO (Comprehensive Benefits)	1915(b)
Colorado	Managed Care Program	MCO (Comprehensive Benefits)	1915(a), voluntary
Colorado	Managed Care Program	Medical-only PIHP	1915(a), voluntary
Colorado	Managed Care Program	PCCM	1915(a), voluntary
Colorado	Mental Health Capitation Program	Mental Health PIHP	1915(b)
Colorado	Primary Care Physician Program	PCCM	1905(t)
Delaware	Delaware Physicians Care , Inc.	MCO (Comprehensive Benefits)	1115(a)
Delaware	Diamond State Partners	*Enhanced Fee for Service Model	1115(a)
Florida	Managed Health Care	Disease Management PAHP	1915(b)
Florida	Managed Health Care	MCO (Comprehensive Benefits)	1915(b)
Florida	Managed Health Care	PCCM	1915(b)
Florida	Prepaid Mental Health Plan	Mental Health PIHP	1915(b)
Georgia	Georgia Better Health Care	PCCM	1932(a)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Blind/Disabled Children as of June 30, 2004

State	Program Name	Managed Care Entity Type	Operating Authority
Georgia	Non-Emergency Transportation Broker Program	Transportation PAHP	1915(b)
Idaho	Healthy Connections	PCCM	1915(b)
Indiana	Hoosier Healthwise	Disease Management PCCM	1915(b)
Indiana	Hoosier Healthwise	MCO (Comprehensive Benefits)	1915(b)
Indiana	Hoosier Healthwise	PCCM	1915(b)
Indiana	Medicaid Select	PCCM	1915(b)
Iowa	Iowa Plan For Behavioral Health	MH/SUD PIHP	1915(b)
Kansas	HealthConnect Kansas	PCCM	1932(a)
Kentucky	Human Service Transportation	Transportation PAHP	1915(b)
Kentucky	Kentucky Health Care Partnership Program	MCO (Comprehensive Benefits)	1115(a)
Louisiana	Community Care	PCCM	1915(b)
Maryland	HealthChoice	MCO (Comprehensive Benefits)	1115(a)
Massachusetts	Mass Health	MCO (Comprehensive Benefits)	1115(a)
Massachusetts	Mass Health	MH/SUD PIHP	1115(a)
Massachusetts	Mass Health	PCCM	1115(a)
Michigan	Childrens Special Health Care Services	MCO (Comprehensive Benefits)	1915(a), voluntary
Michigan	Comprehensive Health Plan	MCO (Comprehensive Benefits)	1915(b)
Michigan	Specialty Prepaid Inpatient Health Plans	MH/SUD PIHP	1915b/c
Minnesota	Consolidated Chemical Dependency Treatment Fund	*County Case Manager	1915(b)
Montana	Passport To Health	PCCM	1915(b)
Nebraska	Nebraska Health Connection Combined Waiver	MCO (Comprehensive Benefits)	1932(a)
Nebraska	Nebraska Health Connection Combined Waiver	PCCM	1932(a)
New Mexico	SALUD!	MCO (Comprehensive Benefits)	1915(b)
New York	Non-Emergency Transportation	Transportation PAHP	1915(b)
New York	Office of Mental Health/Partial Capitation Program	Mental Health PAHP	1915(a), voluntary
New York	Partnership Plan Medicaid Managed Care Program	MCO (Comprehensive Benefits)	1115(a)
New York	Partnership Plan Medicaid Managed Care Program	PCCM - fee-for-service	1115(a)
New York	Partnership Plan Medicaid Managed Care Program	PCCM - capitated	1115(a)
North Carolina	Access II/III - 1932(a)	PCCM	1932(a)
North Carolina	Carolina ACCESS 1932(a)	PCCM	1932(a)
North Carolina	Health Care Connection 1932(a)	MCO (Comprehensive Benefits)	1932(a)
Oklahoma	SoonerCare	Medical-only PAHP	1115(a)
Oklahoma	SoonerCare	PCCM	1115(a)
Oregon	Oregon Health Plan	Dental PAHP	1115(a)
Oregon	Oregon Health Plan	MCO (Comprehensive Benefits)	1115(a)

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Blind/Disabled Children as of June 30, 2004

State	Program Name	Managed Care Entity Type	Operating Authority
Oregon	Oregon Health Plan	MH/SUD PIHP	1115(a)
Oregon	Oregon Health Plan	PCCM	1115(a)
Pennsylvania	Family Care Network	PCCM	1915(b)
Pennsylvania	HealthChoices	MCO (Comprehensive Benefits)	1915(b)
Pennsylvania	HealthChoices	MH/SUD PIHP	1915(b)
Pennsylvania	Voluntary HMO Contracts	MCO (Comprehensive Benefits)	1915(a), voluntary
Puerto Rico	Puerto Rico Health Care Plan	MCO (Comprehensive Benefits)	1915(a), voluntary
Puerto Rico	Puerto Rico Health Care Plan	MH/SUD PIHP	1915(a), voluntary
South Carolina	Health Maintenance Organization (HMO)	MCO (Comprehensive Benefits)	1915(a), voluntary
South Carolina	Physicians Enhanced Program (PEP)	Medical-only PAHP	1915(a), voluntary
South Dakota	Dental Program	Dental PAHP	1915(a), voluntary
Tennessee	TennCare	MCO (Comprehensive Benefits)	1115(a)
Tennessee	TennCare	MH/SUD PIHP	1115(a)
Texas	NorthSTAR	MH/SUD PIHP	1915(b)
Texas	STAR	MCO (Comprehensive Benefits)	1915(b)
Texas	STAR	PCCM	1915(b)
Texas	STAR+PLUS	MCO (Comprehensive Benefits)	1915b/c
Texas	STAR+PLUS	PCCM	1915b/c
Utah	Choice Of Health Care Delivery	Medical-only PIHP	1915(b)
Utah	Choice Of Health Care Delivery	PCCM	1915(b)
Utah	Non-Emergency Transportation	Transportation PAHP	1915(b)
Utah	Prepaid Mental Health Program	Mental Health PIHP	1915(b)
Vermont	Vermont Health Access	PCCM	1115(a)
Virginia	MEDALLION	PCCM	1915(b)
Virginia	Medallion II	MCO (Comprehensive Benefits)	1915(b)
Washington	The Integrated Mental Health Services	Mental Health PIHP	1915(b)
West Virginia	Physician Assured Access System	PCCM	1915(b)
Wisconsin	Children Come First (CCF)	MH/SUD PIHP	1915(a), voluntary
Wisconsin	Independent Care Health Plan (iCare)	MCO (Comprehensive Benefits)	1915(a), voluntary
Wisconsin	Wraparound Milwaukee	MH/SUD PIHP	1915(a), voluntary

*Indicates MCE Type is "Other".

Medicaid Programs that Enroll Special Needs Children as of June 30, 2004

State	Program Name	State Defined	BBA Defined	Managed Care Entity Type	Operating Authority
Arkansas	Non-Emergency Transportation	X		Transportation PAHP	1915(b)
Colorado	Primary Care Physician Program		X	PCCM	1905(t)
Delaware	Delaware Physicians Care , Inc.	X	X	MCO (Comprehensive Benefits)	1115(a)
Delaware	Diamond State Partners		X	*Enhanced Fee for Service Model	1115(a)
District of Columbia	Health Services for Children with Special Needs	X		Medical-only PIHP	1915(a), voluntary
Indiana	Hoosier Healthwise	X	X	Disease Management PCCM	1915(b)
Indiana	Hoosier Healthwise	X	X	MCO (Comprehensive Benefits)	1915(b)
Indiana	Hoosier Healthwise	X	X	PCCM	1915(b)
Missouri	MC+ Managed Care/1915b	X		MCO (Comprehensive Benefits)	1915(b)
Nebraska	Nebraska Health Connection Combined Waiver Program	X		MCO (Comprehensive Benefits)	1915(b)
Nebraska	Nebraska Health Connection Combined Waiver Program	X		PCCM	1915(b)
Nebraska	Nebraska Health Connection Combined Waiver Program	X		*Specialty Physician Case	1915(b)
North Carolina	Access II/III - 1913(a)		X	PCCM	1932(a)
North Carolina	Carolina ACCESS 1932(a)		X	PCCM	1932(a)
North Carolina	Health Care Connection 19132(a)		X	MCO (Comprehensive Benefits)	1932(a)
Ohio	PremierCare	X	X	MCO (Comprehensive Benefits)	1915(b)
Oregon	Oregon Health Plan		X	Dental PAHP	1115(a)
Oregon	Oregon Health Plan		X	MCO (Comprehensive Benefits)	1115(a)
Oregon	Oregon Health Plan		X	MH/SUD PIHP	1115(a)
Oregon	Oregon Health Plan		X	PCCM	1115(a)
Pennsylvania	HealthChoices	X		MCO (Comprehensive Benefits)	1915(b)
Pennsylvania	HealthChoices	X		MH/SUD PIHP	1915(b)
Pennsylvania	Voluntary HMO Contracts	X		MCO (Comprehensive Benefits)	1915(a), voluntary
Rhode Island	Rite Care	X		MCO (Comprehensive Benefits)	1115(a)
Utah	Choice Of Health Care Delivery	X		Medical-only PIHP	1915(b)
Utah	Choice Of Health Care Delivery	X		PCCM	1915(b)
Utah	Non-Emergency Transportation	X	X	Transportation PAHP	1915(b)

*Indicates MCE Type is "Other".

National Summary of State Medicaid Managed Care Programs
Glossary as of June 30, 2004

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.

National Summary of State Medicaid Managed Care Programs
Glossary as of June 30, 2004

1902(a)(23)

Freedom of Choice. This section of the Act requires State Medicaid plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted.

Section: Service Delivery--Managed Care Entity Terms

PCCM

Primary Care Case Management (PCCM) Provider is usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants who contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category include PCCMs and those PIHPs which act as PCCMs.

PIHP

Prepaid Inpatient Health Plan (PIHP) – A PIHP is a prepaid **inpatient** health plan that provides less than comprehensive services on an at-risk or other than state plan reimbursement basis; and provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are define in 42 CFR 438.2} There are several types of PIHPs that States use to deliver a range of services. For example, a Mental Health (MH) PIHP is a managed care entity that provides only mental health services**.**

PAHP

Prepaid Ambulatory Health Plan (PAHP) – A PAHP is a prepaid **ambulatory** health plan that provides less than comprehensive services on an at-risk or other than state plan reimbursement basis, and does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are defined in 42 CFR 438.2} There are several types of PAHPs that States use to deliver a range of services. For example, a Dental PAHP is a managed care entity that provides only dental services.

National Summary of State Medicaid Managed Care Programs
Glossary as of June 30, 2004

MCO	***Managed Care Organization*** is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare-Choice organization, a provider sponsored organization or any other private or public organization which meets the requirements of §1902 (w) to provide comprehensive services.
HIO	***Health Insuring Organization*** is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

Section: Service Delivery--Reimbursement Arrangement Terms

Fee-For-Service	The 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, PIHP, or PAHP. The survey may be conducted by the State or a contractor to the State.
Encounter Data	Detailed data about individual services provided to individual beneficiaries at the point of the beneficiary's interaction with a MCO, PIHP, PAHP institutional or practitioner provider. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims".
Enrollee Hotlines	Toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their MCO, PIHP, PAHP. The people who staff hotlines are knowledgeable about program policies and may play an "intake and triage" role or may assist in resolving the problem.
Focused Studies	State required studies that examine a specific aspect of health care (such as prenatal care) for a defined point in time. These projects are usually based on information extracted from medical records or MCO, PIHP, PAHP administrative data such as enrollment files and encounter /claims data. State staff, EQRO staff, MCO, PIHP, PAHP staff or more than one of these entities may perform such studies at the discretion of the State.
MCO/PIHP/PAHP	These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each MCO/PIHP/PAHP must have in order to participate in the Medicaid program.
Monitoring of Standards	Activities related to the monitoring of standards that have been set for plan structure, operations, and quality improvement/assurance to determine that standards have been established, implemented, adhered to, etc.
Ombudsman	An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PIHP/PAHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PIHP/PAHP, and the provider (as appropriate) to resolve individual enrollee problems.

National Summary of State Medicaid Managed Care Programs
Glossary as of June 30, 2004

On-Site Reviews	Reviews performed on-site at the MCO/PIHP/PAHP health care delivery system sites to assess the physical resources and operational practices in place to deliver health care.
Performance Improvement Projects	Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MCO/PIHP/PAHPs choosing or prescribed by the State.
Performance Measures	Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PIHP/PAHP.
Provider Data	Data collected through a survey or focus group of providers who participate in the Medicaid program and have provided services to enrolled Medicaid beneficiaries. The State or a contractor of the State may conduct survey.
HEDIS Measures from Encounter Data	*Health Plan Employer Data and Information Set (HEDIS)* measures from encounter data as opposed to having the plans generate HEDIS measures. HEDIS is a collection of performance measures and their definitions produced by the National Committee for Quality Assurance (NCQA).
EQRO	Federal law and regulations require States to use an *External Quality Review Organization (EQRO)* to review the care provided by capitated managed care entities. EQROs

may be Peer Review Organizations (PROs), another entity that meets PRO requirements, or a private accreditation body.