MCO Administrative Interview Guide

2005 Review
Results

Prepared by

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University of Florida

For the Florida Healthy Kids Corporation

Submitted January 2006
Updated March 2006

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Section 1. Organizational Structure

Plan Name	Program - Model Type[1]	Multiplan	University/ Hospital Affiliation	Other Low Income Enrollees	Years in Business Anywhere	Years in Florida Overall	Years in Florida Healthy Kids Program	Years in Commercial in Florida	Total Enrollees National Medicaid Members	Total Enrollees National SCHIP Members	Total Enrollees National Commercial Members	Total Enrollees Florida Commercial Members	Total Enrollees Florida Healthy Kids Program	Ownership Status	Publicly Traded
	S1.1.	S1.2.	S1.3.	S.1.4.	S1.5.				S1.6.					S1.7.	S1.8.
Plan 1	MMH & PCCM	No-Florida Yes-nationally	No	Yes*	11	3.5	3.5	N/A	876,000	194,000	N/A	N/A	53,041	For-profit	Yes
Plan 2	EPO	No	No	No	64	5	5	N/A	N/A	N/A	N/A	N/A	14,500	For-profit	Yes – parent company
Plan 3	MMH	No	Yes*	Yes*	31	31	14	31	N/A	N/A	N/A	40,350	7,520	Non-profit	No
Plan 4	IPA	No	No	No	54	54	9	25 since consolidation; 50 overall*	N/A	N/A	N/A	525,597	1,512	For-profit	No
Plan 5	MMH	Yes	No	Yes*	13 or 20?+	13 or 20?	4	0	707,652	83,654	0	0	73,289	For-profit	Yes
Plan 6	MMH	No	No	Yes*	28	11	7	11	1.2 million	600,000	1 million	380,000	11,300	For-profit	Yes
Plan 7	GMH IPA MMH PPO (but not for HK)	Yes*	No	Yes*	18	18	9	18	45,118 (Florida only)	N/A	N/A	148,715	35,108	For-profit	No

*Throughout this summary, an asterisk (*) indicates that additional verbal explanation was provided.
+Throughout this summary, highlighted items indicate that additional information or clarification has been requested from the plan.

[1] GMH = Group Model HMO, IPA = Independent Practice, MMH = Mixed Model HMO, EPO = Exclusive Provider Organization, PPO = Preferred Provider Organization

Section 2. Children's Programs

Plan Name	Primary Responsibility for Coordinating Child's Care	Clinical Guidelines for Preventive Care						
		American Academy of Pediatrics / Bright Futures	Child Health Check Up, EPSDT, USPSTF	American Academy of Family Physicians	Center for Disease Control and Prevention/ ACIP for Immunizations	Other	Ensure Providers are Following Guidelines?	Are these effective?
	S2.1.	S2.2.					S2.3.	
Plan 1	PCP	X	X			Florida Medicaid guidelines	Random sample medical records review against guidelines and claims data analysis	Yes
Plan 2	PCP	X	X		X		Initial communication of requirements during provider program training. Ongoing communication between Care Management Department staff and the providers.	Yes
Plan 3	PCP	X					Reviews medical charts of each PCP periodically. Indicators that are subject to review are described.	Yes
Plan 4	PCP	X (immunization)	X		X		Not applicable, but practitioners are monitored on an ongoing basis through the use of sanctions, member complaints and incidents, and monitoring of adherence to Care Guidelines to determine whether the services provided meet established criteria and are eligible for coverage under the member's policy.	Yes
Plan 5	PCP		X		X		Annual medical records audits, HEDIS, and CHCU quality indicators.	Yes
Plan 6	PCP	X	X	X (immunization)	X		Internal database that identifies which members have not received preventive services; providers receive data and letter on a quarterly basis. Network management staff meets with providers to discuss results; corrective action plans implemented for providers not meeting the expected rates.	Yes
Plan 7	PCP	X		X			Monthly analysis of claims and encounter data to identify children out of compliance with immunizations and well child visits. PCPs receive monthly reports that identify members out of compliance and these reports are monitored for high volume non-compliance. On-site PCP staff training on outreach and encounter coding. DM programs that improve pharmacologic interventions.	Yes

Section 2. Children's Programs, Continued

Special Programs for Parents for Well-Child Care and Immunizations?								
Plan Name	**Program?**	**Birthday Other Reminders**	**Newsletter / Other Mailings**	**Member Incentives**	**Phone Reminder**	**PCP Sent Reminder or Reports of Non-Compliant Children**	**Other**	**What would you like to change?**
	S2.4							
Plan 1	Yes			X	X	X		None.
Plan 2	Yes						Initial program orientation and education; Member Manual education materials	None.
Plan 3	Yes		X				Kid-Care magazine	None.
Plan 4	Yes	X	X				Health record included in mailing to help parent keep track of immunization	None.
Plan 5	Yes	X				X	New enrollment welcome calls and reminder letter.	Obtain feedback from members when they have completed the well child preventive requirements
Plan 6	No	N/A	N/A	N/A	N/A	N/A		N/A
Plan 7	Yes		X		X	X		Greatest challenge is the instability of FHK membership – often, children lose eligibility by the time follow-up calls are made.

Section 2. Children's Programs, Continued

	Screening Mechanism for Domestic Violence and Child Abuse?					
Plan Name	**Screening Mechanism?**	**Provider Manual**	**Screening Tool Guidelines Used**	**Screening for DV and CA required as part of Standard Patient Screening Process**	**Case Management Interview**	**Claims Data / Medical Records Review**
	S2.5					
Plan 1	Yes*		X - American College of Obstetricians and Gynecologists		X	X
Plan 2	Yes*					
Plan 3	Yes*					
Plan 4	No	N/A	N/A	N/A	N/A	N/A
Plan 5	Yes*	X	X			
Plan 6	Yes*		X – American College of Obstetricians & Gynecologists	X		X
Plan 7	Yes*	X		X		

Section 2. Children's Programs, Continued...

	Screening Mechanism for Domestic Violence and Child Abuse, Continued					
Plan Name	**Provider Education/Training**	**Provider Contractually Required to Screen**	**Suspected or Confirmed Cases are Reported to Appropriate Agency**	**Providers are Encouraged to Make Referrals to or Cooperate with Community Organizations**	**Other**	**What would you like to change?**
	S2.5					
Plan 1	X				All pregnant members are screened for DV. Pediatric assessment tool completed for those enrollees referred to case management includes evaluation questions for potential child abuse (e.g., ER/hospital visits).	None.
Plan 2			X		Nurse and advocate reviewers are trained to screen for potential violence or abuse as a component of their patient or provider contact.	None.
Plan 3	X (Annual in-service required of all health care providers)		X			None.
Plan 4	N/A	N/A	N/A	N/A	N/A	N/A
Plan 5	X (annual)				Provider adherence to DV screening recommendations is monitored via medical record review. Plan's customer service representatives are trained on DV	Continued reinforcement with providers is needed.
Plan 6	X (annual training packets)	X		X	Providers are encouraged to post domestic violence hotline numbers in examination rooms.	Would like to enhance annual training by making it more in-depth.
Plan 7				X		None.

Section 2. Children's Programs, Continued

	Substance Abuse Screening among Children/Adolescents and Program Features							
Plan Name	**Screening Mechanism?**	**Screening as Part of Standard Patient Screening Process**	**Require SA History to be Documented in Medical Record**	**Use of Screening Tool**	**Clinical Guidelines and/or Standards of Care**	**Providers Contractually Required to Screen**	**Provider Manual**	**PCP Training**
	S2.6.							
Plan 1	Yes*				X (Interqual and ASAM)			X
Plan 2	Yes*			X (HRA)				
Plan 3	Yes*	X	X		X			
Plan 4	Yes*				X (Adopted from APA Behavioral Health Guidelines)			X
Plan 5	Yes*		X		X (Substance Abuse & Mental Health Services Admin)		X	X (annual)
Plan 6	Yes*							X (annual training packets)
Plan 7	Yes*	X				X		

Section 2. Children's Programs, Continued

	Substance Abuse Screening among Children/Adolescents and Program Features, Continued				
Plan Name	**Referral to Appropriate Community Organizations and Agencies**	**Referral to Behavioral Entity**	**Care Coordination with Behavioral Health Provider**	**Other**	**What would you like to change?**
	S2.6.				
Plan 1				Case managers on staff who specialize in behavioral health. Network includes behavioral specialists and plan ensures child/adolescent is referred to appropriate provider.	None.
Plan 2		X	X		The development of improved provider integrated programs and communication between PCP and BHP so that member is better clinically managed and has improved clinical and functional outcomes.
Plan 3					None.
Plan 4					None.
Plan 5				SA screening recommendations are incorporated into health history recommendations. Adherence to SA screening recommendations is monitored via annual medical record review.	Continued reinforcement with providers is needed.
Plan 6	X	X		Recommended screening guidelines adapted from Brown, RL. *Identification and Office Management of Alcohol and Drug Disorders* and from *Physician's Guide to Helping Patients with Alcohol Problems*, NIAAA	Would like to enhance annual training by making it more in-depth.
Plan 7	X	X			Plan would like to have greater interaction with the schools to assist PCPs in early detection; barriers to interaction are patient privacy and other issues.

	Special Programs for Providing a Medical Home and Program Features			
Plan Name	**Special programs to encourage providers to serve as medical home?**	**Enrollees Required to select PCP or assigned one**	**Integrated Facilities**	**Case Managers working with families**
	S2.7.			
Plan 1	Yes*	X		
Plan 2	Yes*			X
Plan 3	Yes*		X	
Plan 4	No	N/A	N/A	N/A
Plan 5	Yes	X		
Plan 6	No	N/A	N/A	N/A
Plan 7	No, not a special program, but PCP is gatekeeper and child's medical home; Providers are required to meet AAP definition of medical home by contract	X	N/A	N/A

Section 2. Children's Programs, Continued

	Special Programs for Providing a Medical Home and Program Features, Continued			
Plan Name	**Family Orientation and/or Education**	**Provider Education (EPSDT, etc)**	**Other**	**What would you like to change?**
	S2.7.			
Plan 1				None.
Plan 2	X	X		None.
Plan 3	X		Periodic incentives to providers who meet specific goals related to wellness, patient satisfaction, timely care, and ER/Urgent Care utilization.	None.
Plan 4	N/A	N/A	N/A	N/A
Plan 5			Providers are sent a monthly list of membership including indication of those who haven't received targeted preventive visits, screening, and chronic disease interventions.	None.
Plan 6	N/A	N/A	N/A	N/A
Plan 7	N/A	N/A	Providers are required to meet AAP definition of medical home by contract.	N/A

	Other Special Programs for Children/Adolescents for Florida Healthy Kids Enrollees								
Plan Name	**Other Special Programs?**	**Asthma Education**	**Pediatric Case management**	**Maternity Case Management**	**Maternity Education**	**Obesity Education**	**Diabetes Education**	**Outreach for Blood Lead Testing**	**What would you like to change?**
	S2.8								
Plan 1	Yes*							X	None.
Plan 2	Yes*	X			X		X		To have medical home and specialty providers adopt National Practice Standards that are incorporated into care coordination programs to improve quality management.
Plan 3	Yes*					X			None.
Plan 4	No								N/A
Plan 5	Yes		X						None.
Plan 6	No								N/A
Plan 7	Yes*		X	X					None.

Section 3. Care Coordination and Disease Management Programs for Those with Chronic Conditions or Special Health Care Needs

Coordination – Disease Management					
Plan Name	**General Care Coordination Program**	**General Care Coordination Other**	**Disease Management/ with the following chronic condition(s)**		
			Asthma	**Diabetes**	**Other DM Programs**
	S3.1.		**S3.2.**		
Plan 1	Yes	-Pediatric Case Mgmt -Integrated Behavioral and Physical Health Care Mgmt -Eating Disorder Mgmt	X (IH/PH)	X (IH/PH)	CHF (IH) HIV (IH) Depression (IH/PH)
Plan 2	Yes	No	X (IH)	X (IH)	Maternity (IH)
Plan 3	Yes*	No	X(IH)		Childhood Obesity (IH)
Plan 4	Yes – overall population based, but member outreach addressing care gaps is included in program design	No	X (IH)	X (IH)	
Plan 5	Yes	No	X (IH)	X (IH)	
Plan 6[2]	Yes	Personal Care Model (PCM) Case Mgmt Programs	PCM includes case management for asthma	PCM includes case mgmt for diabetes	Personal Care Model Case Mgmt Programs (IH) – includes programs for HIV/AIDS, CHF and other special care needs
Plan 7	No	-Pediatric Care Coordination program -Diabetes Care Coordination	No – but one is under development (IH)	Yes (IH), but does not specifically target HK enrollees although there are a few HK participants	

Key: IH = developed in-house; PH = pharmaceutical company; OEC = Other Externally contracted.

[2] This plan does not have population-based disease management programs, but it does have a personal case management (PCM) program in which cases with special care needs are identified and referred to the PCM program. The PCM activities and processes are similar to DM processes as they include assessment, planning, implementation/intervention, and evaluation. The PCM intervention also emphasizes patient education.

Section 3. Care Coordination and Disease Management Programs for Those with Chronic Conditions or Special Health Care Needs (SHCN), Continued

	Identification Strategies of Enrollees[3]								
Plan Name	**Review of Medical Claims Data for High Cost and Use**	**Review of Pharmacy Claims Data**	**Review of Claims / Encounter Data for Certain ICD-9 Diagnoses**	**Review of Patient Databases for Certain ICD-9 Diagnoses**	**Physician Referral**	**Use of Enrollee or Parent of Enrollee Report on Health Surveys**	**Review of Calls & Requests to health plan by enrollees or Parents of Enrollees**	**Dual Eligibility Status**	**Other**
	S3.3.								
Plan 1	R – Asthma, Diabetes, CHF, HIV; M - Depression	R – Asthma, Diabetes, CHF, HIV; M - Depression	R – Asthma, Diabetes, CHF, HIV; M - Depression	R – Asthma, Diabetes, CHF, HIV; M - Depression	R – Asthma, Diabetes, CHF, HIV, Depression	R – Asthma, Diabetes, CHF, HIV	R – Asthma, Diabetes, CHF, HIV, Depression	R – Asthma, Diabetes, CHF, HIV	Outside referrals: R – Asthma, Diabetes, CHF, HIV
Plan 2	M	M	M	M	R	N/A	R	N/A	
Plan 3	R	R	R	R	R	R	N/A	N/A	
Plan 4	M – Asthma & Diabetes; Variable – Other complex case mgmt.	M – Asthma & Diabetes;	M – Asthma & Diabetes; Variable – Other complex case mgmt	M – Asthma & Diabetes;	R – Asthma & Diabetes & other complex case mgmt.;	M – Asthma & Diabetes;	R – Asthma & Diabetes;	R – Asthma & Diabetes;	Other triggers for other complex case management include re-admission, frequent ER visits, extended acute LOS, trauma admissions
Plan 5	M	M	M	M	R	R	R	O - ?	
Plan 6[4]	M	M	R	M	R	M	R	R	Other quarterly re-admission reports; real-time referrals from onsite nurses, providers and other sources; Real time referrals from Compliance and Customer Service units
Plan 7	M	M	M	M	R	N/A	R	N/A	

[3] R = as enrollees referred, W = Weekly Review, M = Monthly Review, O = Other frequency, A = Annually, Q = Quarterly
[4] Reported numbers are for the plans personal case management program; this plan does not have DM programs.

Section 3. Care Coordination and Disease Management Programs for Those with Chronic Conditions or Special Health Care Needs (SHCN), Continued

			If Yes...[5]								
Plan Name	**Health Plan Data System Have a DM Component?**	**Health Plan Measure Member Participation Rates?**	**Asthma**			**Diabetes**			**Other**		
			F	**#**	**%**	**F**	**#**	**%**	**F**	**#**	**%**
	S3.4	**S3.5**	**S3.5.1.**								
Plan 1	Yes*	Yes*	M	7,952	2.5	M	224	4.5	M	CHF: 15 HIV:23	CHF:0 HIV: 8.7
Plan 2	Yes*	No	N/A	N/A	N/A	N/A	N/A	N/A			
Plan 3	Yes*	Yes for pediatric membership, but FHK membership not segregated	R	No separate breakout for HK; 35 pediatric members overall		N/A	N/A	N/A	Obesity: Frequency = R; No separate breakout for HK		
Plan 4	Yes*	Yes	M	86	99.54%	M	5	99.11%	N/A	N/A	N/A
Plan 5	Yes*	Yes	M	2963	16.1%	M	289	18.3%			
Plan 6	No but the case management program has a health plan data system that stores case management related data	No – no disease management program; PCM participation rates are not currently available because participation rates vary rapidly due to frequent eligibility transition of members.	N/A	N/A	N/A	N/A	N/A	N/A			
Plan 7	Yes*	Yes, in general; No, for FHK – too much fluctuation in FHK membership and very small participation by pediatric enrollees generally in DM programs; initiating pediatric asthma DM program in 2006.	N/A	N/A	N/A	N/A	N/A	N/A			

Participation Formula: # of enrollees participating in DM program/# of enrollees eligible to participate.

[5] Participation rates were calculated by dividing the members who are under active disease management (and not, for example, just receiving general educational intervention) by the number of members eligible for participation in the DM programs where eligible members are those who have undergone some type of screening to identify them as potential participants in the particular DM program.

Section 3. Care Coordination and Disease Management Programs for Those with Chronic Conditions or Special Health Care Needs (SHCN), Continued

Plan Name	Guidelines for Staffing Levels in DM	Eligible Members Provided with Written Information	Written Materials for Opt-Out of DM	Practitioners Educated Regarding DM Programs
	S3.6.	S3.7.	S3.7.2.	S3.8.
Plan 1	Yes*	Yes	No	Yes*
Plan 2	Yes*	Yes	Yes	Yes*
Plan 3	No	Yes*	No	Yes*
Plan 4	No	Yes*	Yes*	Yes*
Plan 5	No	Yes	No	Yes*
Plan 6	Yes*	No DM, but Yes for PCM program	No, but members can give verbal consent to proceed with PCM program and those participating can disenroll if they choose to do so.	DM-N/A; PCM – Yes*
Plan 7	Yes*	Yes*	No - members receive a phone call during which the program is explained and member can indicate whether they do or do not want to participate	Yes*

Plan Name	How do you define individuals with special health care needs?
	S3.9.
Plan 1	"…children (and adults) who face daily physical, mental, or environmental challenges that place at risk their health and ability to fully function in society…" Source: Florida Medicaid HMO Contract and Centers for Medicaid and Medicare Services in November 2000 Report to Congress.
Plan 2	". . . individuals who may have an ongoing, chronic physical or behavioral condition that may limit or hamper their physical or emotional functioning and well-being, particularly in comparison to accepted benchmarks for growth and development…"
Plan 3	"Serious and complex conditions by definition are persistent, substantially disabling or life threatening and require treatment and intervention across a broad scope of medical, social, and mental health services." Claims, lab results and pharmacy prescription data are used to identify at risk populations.
Plan 4	"Special care needs include: complex cases, high cost claims, specific diagnosis, coordination of care needs and member in need of information about diagnosis or care options"
Plan 5	"Adults and children who daily face physical, mental, or environmental challenges that place at risk their health and ability to fully function in society." Source: Florida Medicaid HMO Contract and Centers for Medicaid and Medicare Services in November 2000 Report to Congress.
Plan 6	"..members with complex and special needs i.e. disabilities. The following diagnoses assist us in identifying members with potential special health care needs: [includes long list]."
Plan 7	"…those with chronic conditions, multiple co-morbidities or environmental issues that put them at risk"

Section 3. Care Coordination and Disease Management Programs for Those with Chronic Conditions or Special Health Care Needs (SHCN), Continued

Plan Name	Allow a specialist to serve as PCP for an enrollee with chronic or SHCN	Nurse Coordinators who work with the enrollees' PCP	Telephone follow-up and monitoring by a nurse with the PCP	Telephone follow-up & monitoring by a nurse with the enrollee or parent	Waive prior authorization for those with chronic or SHCN	Special Program to coordinate physical & mental health services	Written treatment plan for enrollees identified with chronic or SHCN	Monitor adherence to treatment plans when they are required	Keep Care Coordination records
	S3.10.	S3.11.	S3.12.	S3.13.	S3.14.	S3.15.	S3.16.	S3.16.2.	S3.17.
Plan 1	Yes*	Yes	Yes	Yes	No *	Yes*	Yes*	Yes	Yes – standard medical record documentation; nothing specific to DM programs*
Plan 2	Yes*	Yes	Yes	Yes	No	Yes*	Yes*	Yes	Yes*
Plan 3	Yes*	Yes	Yes	Yes	No	No - but there is a department that is dedicated to coordinating complex care and DM cases more generally.	No – but complex care cases are referred to the care coordination department and a dedicated nurse who responsible for developing a treatment plan is assigned to each case.	Yes	Yes*
Plan 4	No	Yes	Yes	Yes	No	Yes*	No – verbal treatment plan is acceptable	Yes	Yes*
Plan 5	Yes*	Yes	Yes	Yes	Yes* - additional info requested	Yes*	No – requested but not required	Yes	Yes*
Plan 6	No	Yes	Yes	Yes	No	Yes*	No – no standardized treatment plan; treatment plan is provided by the PCP and shared with the case managers	Yes	Yes*
Plan 7	Yes*	Yes	Yes	Yes	No	No	No – plan is maintained by the provider; health plan may request treatment plan to make a determination on approval or authorization requests.	N/A*	Yes*

Section 3. Care Coordination and Disease Management Programs for Those with Chronic Conditions or Special Health Care Needs (SHCN), Continued

Plan Name	Other Features Regarding Care Coordination or DM
	S3.18
Plan 1	Member-centered case management approached customized to the individual; Early case identification and intervention; Needs assessment by case manager within 48 hours of referral to program; Individualized care plans developed within one week of needs assessment by case manager using Case Management Society of America approach; Regular review and periodic reassessment of care plans
Plan 2	See attached description of Care Management Program.
Plan 3	The plan has an on-going relationship with the pediatric specialists through hospital partners.
Plan 4	None.
Plan 5	?
Plan 6	Description of personal care management program is included in S3.2. and case management policies and procedures provided.
Plan 7	Pediatric Case Management Program and educational materials provided.

Section 4. Quality Assessment and Performance Improvement (QAPI)

Plan Name	Calculate HEDIS Measures	Performance Measures that address DM program	Specific quality of care indicators that address CSHCN	Use Specific Clinical Guidelines for Care (Y/N)	If yes, organization from which guidelines were adopted		
					Asthma	Diabetes	Other
	S4.1.	S4.2.	S4.3.	S4.4.	S4.4.1.		
Plan 1	No*	Yes	No (but have case mgmt program)	Yes	2002 Guidelines for the Diagnosis and Management of Asthma. Nat'l Heart & Lung Institute/Nat'l Asthma Education and Prevention Program	2004 Clinical Practice Recommendations, ADA, AHCA Contract, AAP, Standards of Care for Patients with Diabetes Mellitus	**Well Child & Preventive:** ADA, AHCA Contract, AAP **CHF:** American College of Cardiology/American Heart Association Guidelines for the evaluation and management of chronic heart failure, 2001 **HIV:** Nat'l Institute of Health, 2004 Guidelines for the use of Antiretroviral Agents in HIV-1 infected adults and adolescents
Plan 2	No*	No	No	Yes	NHLBI	American Diabetes Association	Milliman Care Guidelines – applied to almost all conditions encountered through the Care Coordination program; **COPD:** NHLBI **High-risk OB:** ACOG
Plan 3	Not for HK specifically - pediatric population overall*	Yes*	Yes*	Yes	National Asthma Guidelines	American Diabetes Association	**Preventive:** AAP **CHF:** American College of Cardiology **Immunization:** CDC
Plan 4[6]	No* (HEDIS measures for HMO overall, which are broken out by age range)	Yes*	Yes*	Yes	Nat'l Institutes of Health	American Diabetes Association, Standard of Medical Care for Patients with Diabetes Mellitus	Immunizations -AAP
Plan 5	Yes*	Yes	Yes	Yes	19997 Guidelines for the Diagnosis and treatment of Asthma, National Heart, Lung and Blood Institute/NIH	2005 Clinical Practice Recommendations, American Diabetes Association	

[6] Quality improvement plan itself was not submitted by this health plan on the basis that it is proprietary information.

Plan Name	Calculate HEDIS Measures	Performance Measures that address DM program	Specific quality of care indicators that address CSHCN	Use Specific Clinical Guidelines for Care (Y/N)	If yes, organization from which guidelines were adopted		
					Asthma	Diabetes	Other
	S4.1.	S4.2.	S4.3.	S4.4.	S4.4.1.		
Plan 6	No – use internal database to track receipt of well-child visits and preventive care; providers receive quarterly data , and meet with network management staff to discuss results	No	No	Yes	NIH/ Nat'l Heart, Lung and Blood Institute	American Diabetes Association Inc.	**Pediatric Immunization:** CDC/ACIP; AAP; AAFP. **Overweight/Obesity:** AAP
Plan 7	Not for HK, but calculate HEDIS measures for other pediatric populations excluding HK	No – DM programs are newly developed; quality indicators and performance measures are in development	No	Not currently; plan directs providers to national guidelines; Beginning in 2006, clinical practice guidelines will be adopted for certain high-volume diagnoses.	AAP and AAFP Effective 2006: NIH for Asthma	AAP and AAFP Effective 2006: National Association of Endocrinology	Effective 2006 for CHF: American Heart Association

Section 4. Quality Assessment and Improvement (QAPI), Continued

Plan Name	Organizational Component Responsible for Adoption of Clinical Practice Guidelines				
	Quality Committee/ Management/ Improvement	Medical Advisory Committee	Other (list)	Modify Guidelines to Meet the Needs of Enrollees	Frequency Review and Update Clinical Practice Guidelines
	S4.5.			S4.6.	S4.7.
Plan 1	X	X		Currently, no modifications; but would modify guidelines if appropriate.	Annually
Plan 2	X		Plan's internal Healthy Kids Executive Committee	No	Annually or upon any substantive changes
Plan 3	X*			Yes (based on medical necessity on a case-by-case basis)	Annually
Plan 4			Medical Policy and Coverage	No	Annually
Plan 5		X		No	At least annually
Plan 6		X	National Clinical Practice Guidelines Committee	No	At least bi-annually
Plan 7	X (as of 2006)		N/A prior to 2006 – Contracted providers are independent contractors, so plan has not been involved with clinical decisions and practices; Plan has provided copies of published guidelines for physicians to make their own judgments.	No	N/A – PCPs are referred to appropriate national guidelines

Section 4. Quality Assessment and Improvement (QAPI), Continued

	How Practice Guidelines are Disseminated to Providers						
Plan Name	**Newsletter, Updates and Mailers**	**Provider Manual**	**Health Plan Website**	**During Care Coordination and Oversight**	**Fax (e.g., broadcast fax, blast fax)**	**Other (List)**	**Monitor Provider Use of Practice Guidelines**
	S4.8.						**S4.9.**
Plan 1	X	X	X		X	One-on-one education	Yes*
Plan 2				X		When Requested	Yes*
Plan 3					X	Lunch and Learn sessions	Yes*
Plan 4	X	X				Provider education	Yes*
Plan 5		X	X				Yes*
Plan 6			X				No
Plan 7		X				Will use mailings and in-person reinforcement for guidelines effective 2006.	No – but reports compliance with check ups, immunizations, and disease appropriate treatment plans through targeted reports and communicates the results of those reports to providers.

Section 4. Quality Assessment and Improvement (QAPI), Continued

	Financial Incentives	Strategies to Provide QAPI Information to Providers							
Plan Name	**Offer Financial Incentives or Penalties**	**Provide QAPI Information in Provider Newsletters**	**Direct Mailing**	**Broadcast Email / Website**	**QAPI Meetings for Providers**	**Required Attendance at QAPI Meetings**	**Educational Programs**	**Other: Provider Manual**	**Other**
	S4.10.	**S4.11.**							
Plan 1	No	X	X				X		Provider visits
Plan 2	No								One-on-one communications with providers during the Care Management Process; in writing when necessary
Plan 3	No	X	X	X			X		PCP & Specialty Staff meetings
Plan 4	No	X	X	X			X		
Plan 5	No	X	X	X					
Plan 6	No		X	X			X		
Plan 7	No	X		X			X		

Section 4. Quality Assessment and Improvement (QAPI), Continued

Plan Name	Financial Incentives or Penalties to Encourage Compliance with QA Activities	Distribute Member Satisfaction Survey	Distribute Provider Satisfaction Survey	How do you monitor quality in facilities and other vendors?
	S4.12.	S4.13.	S4.14.	S.4.15
Plan 1	No*	No	Yes*	Vendors submit quarterly reports and participate in Vendor and Oversight Committee calls; annual vendor delegation survey; facilities monitored through credentialing process, complaints to call center and issues reported through reviews
Plan 2	No	Yes – those participating in care coordination programs*	No* (but monitor grievances, appeals, and complaints)	Analysis of grievances and appeals during care oversight process and care coordination to identify potential quality of care issues. Care management nurses also are encouraged to look for potential quality of care issues. Potential quality of care issues are reviewed by Director of Quality Management, CMO, and if substantiated, by the Clinical Peer Quality Committee and the plan's internal HK Executive Committee.
Plan 3	No	Yes – pediatric satisfaction survey; sample includes FHK enrollees*	Yes*	Site and chart reviews. Licensing, liability/malpractice coverage, and accreditation of external facilities are monitored. Risk management personnel initiate reviews of protocols, procedures, and other areas related to identified risks.
Plan 4	No	No	No	Monitors and evaluates the accreditation of all network facilities. Ancillary health care entities that include independent laboratories are reviewed through an internal credentialing process that includes monitoring of quality of services.
Plan 5	No	Yes – pediatric survey conducted on behalf of AHCA with survey segregated for HK.*	No	Complaint data, site inspections, and delegation audits.
Plan 6	No	Not independently; CAHPS survey conducted annually by AHCA	Yes- 1st survey conducted in October 2005; Targets Medicaid providers, the majority of which also serve HK enrollees	Quality concerns are primarily identified by on-site nurses, case managers, and customer service personnel, but can be identified by any health plan department, customer, or practitioner. Data related to quality of care is collected and entered into a database. Data analysis is presented to the appropriate committee for review and recommended actions for improvement.
Plan 7	No	No – Conduct CAHPS survey annually as part of AHCA surveys; results are not segregated for HK population.	Yes*	Potential quality of care issues may be identified or initiated by anyone inside or outside of the plan, including members, employees, and providers. Issues may be identified through reported hospital complications, direct observation through onsite liaisons and case management, medical or legal issues reported to Risk Management, medical record audit and evaluation of medical record documentation, member complaints and grievances, and member satisfaction survey (CAHPS). Quality of care issues are investigated by the Quality Improvement staff, with reviews and determinations by the Medical Director and Peer Review Committee.

Section 5. Utilization and Referral Management – Control the Use of Specialty Services and Hospitalization

Plan Name	Require Pre-Authorization for Specialty Referrals	Effective		Require Pre-Authorization for Tests	Effective		Require Pre-Authorization for Hospitalization	Effective		Profiling of Physician Utilization Patterns for Hospitalizations	Effective
					S5.1.						
Plan 1	No	N/A		Some*	Very		Yes	Very		Yes	Very
Plan 2	No	N/A		No	N/A		Yes	Very		Yes	Very
Plan 3	Yes	Very		Yes	Very		Yes	Very		Yes	Very
Plan 4	Yes	Moderate		Yes	Moderate		Yes	Moderate		Yes	Moderate
Plan 5	Yes	Very		Yes - for certain services	Very		Yes	Very		No	N/A
Plan 6	Yes – for all out-of-network referrals	Moderate		Yes – certain tests identified in the prior authorization list and experimental tests	Moderate		Yes	Very		Yes	Moderate
Plan 7	Yes – by PCP	Very		Yes – most by PCP, a few by plan	Very		Yes	Very		Yes	N/A (just initiated)

Plan Name	Profiling of Physician Utilization Patterns for Ambulatory Care Services	Effective		Requires Adherence to Clinical Practice Guidelines	Effective		Educational Programs to Providers about Cost Effective Utilization of Services	Effective
				S5.1.				
Plan 1	Yes	Very		No	N/A		Yes	Moderate
Plan 2	No	N/A		Yes	Very		Yes	Very
Plan 3	Yes	Very		Yes	Moderate		Yes	Moderate
Plan 4	Yes	Moderate		No	N/A		Yes	Moderate
Plan 5	No	N/A		No	N/A		No	N/A
Plan 6	Yes	Moderate		No	Not very		Yes	Moderate
Plan 7	Yes	N/A (just initiated)		No – providers directed to national guidelines	N/A		No	**N/A**

Section 5. Utilization and Referral Management – Control the Use of Specialty Services and Hospitalization, Continued

		Physician Profiling			Staff Handling Referral Request				
Plan Name	**Discharge Planning Program**	**Used**	**Accurate**	**Adjust for Case Mix**	**Clerical Staff**	**Registered Nurse**	**Licensed Practical Nurse**	**Physician**	**Other Personnel with Medical Training**
	S5.2.	**S.5.3.**			**S5.4.**				
Plan 1	Yes*	Yes	Somewhat	No	X*	X(majority)*	X(majority)*		
Plan 2	Yes*	Yes	Somewhat	No	N/A	N/A	N/A	N/A	N/A – Referral authorizations are not required.
Plan 3	Yes*	Yes	Very	Yes*	X	X	X (majority)	X	X
Plan 4	Yes*	Yes	Very	Yes*	X (majority of initial contact calls)	X	X		
Plan 5	Yes*	No	N/A	N/A	X (non-clinical – majority)	X	X		
Plan 6	Yes*	Yes	Very	No		X	X		X (majority)
Plan 7	Yes*	Yes	Very	No		X – facility requests for referrals		PCPs issue referrals on their own without contacting plan	X (majority) – facility requests for referral

Section 5. Utilization and Referral Management – Control the Use of Specialty Services and Hospitalization, Continued

	Problems with PCPs During the Referral Process				Problems with Specialists During the Referral Process			
Plan Name	**Insufficient Clinical Medical Information**	**Lack of Knowledge Regarding Provider Network**	**Referral Requests Received while Member is Already in the Specialist's Office**	**Untimely Submission of Service Authorization Requests**	**Insufficient Clinical/Medical Information**	**Providing Issued Authorization Number**	**Lack of Coordination with Member's PCP**	**Lack of Knowledge Regarding Provider Network**
		S5.5			**S5.6.**			
Plan 1	X				X			
Plan 2	N/A – RA not required.	N/A	N/A	N/A	N/A – RA not required.	N/A	N/A	N/A
Plan 3	N/A-No problems	N/A	N/A	N/A	N/A – No problems*	N/A	N/A	N/A
Plan 4	N/A – No problems	N/A	N/A	N/A	N/A – No problems	N/A	N/A	N/A
Plan 5	N/A – No problems	N/A	N/A	N/A		X		
Plan 6	X				X			
Plan 7	N/A – PCPs issue referrals directly	N/A	N/A	N/A	N/A – PCPs issue referrals directly	N/A	N/A	N/A

Section 6. Provider Network and Contractual Relationships (Pediatric Enrollees)

Plan Name	Pediatrician (Generalist)	Pediatric Specialist[7] (Serving as PCP)	Family Practitioner/GP	Adult Specialist[8] (Serving as PCP)	Physician Assistant	Registered Nurse Practitioner	Other
	S6.0						
Plan 1	635	0	220	0	0	0	0
Plan 2[9]	211	100[10]	154	1,832[11]	0	0	0
Plan 3	8	16	12	0	1	2	1 (Internal Medicine)
Plan 4	44	26	85	4	N/A	N/A	N/A
Plan 5	1550	327	1051	0	0	0	5609 – additional information requested
Plan 6	656	0	407	0	0	0	0
Plan 7	461	205	295	2966	0	0	4

[7] Actively Serving as PCP for Pediatrics
[8] Actively Serving as PCP for Pediatrics
[9] Enrollees in this plan are encouraged but not required to select a PCP, nor are they automatically assigned one.
[10] This indicates the number of all pediatric specialists in the plan. These specialists could serve as a medical home to enrollees if enrollees so choose.
[11] This indicates the number of all adult specialists in the plan. These specialists could serve as a medical home to enrollees if enrollees so choose.

Section 6. Provider Network and Contractual Relationships, Continued

Methods of Recruiting Primary Care Providers									
Plan Name	Geographic Needs Analysis	Panel Size Capacity Analysis	Participating Provider Referrals	Commercial Network Providers	Provider Completes Application – Self-referral	Little Blue Book / Review of Provider Lists	Member Referrals/ Requests	Visit to Providers Office with Recruitment Package	Other
S6.1.									
Plan 1	X	X	X		X	X		X	
Plan 2									No designated PCPs; research counties where members reside; contact potential new providers by phone
Plan 3			X				X		Provider Relations Personnel identifies and contacts potential providers; providers are evaluated based on services, location, and waiting times.
Plan 4					X				
Plan 5							X		Network need identification
Plan 6				X		X			
Plan 7					X		X		Look for PCPs who care for entire person and take a preventive approach to medicine. Currently, network is over capacity so not a priority at present time.

	Problems recruiting primary care providers				
Plan Name	None	Reimbursement Issues	Provider Not Board Certified	Provider Lacks Sufficient Malpractice Coverage	Other (list)
S6.2.					
Plan 1		X	X	X	
Plan 2		X			Lack of providers of certain types in some rural areas served
Plan 3	X				
Plan 4		X			
Plan 5			X (members requesting plan to recruit non-BC PCPs)		
Plan 6	X				
Plan 7	N/A – Not presently recruiting; over capacity				

Section 6. Provider Network and Contractual Relationships, Continued

	Selection Criteria				
Plan Name	**Board Certified**	**Able to Treat Children**	**Specialty of Pediatrics, Family Practice, or GP**	**Meet All Credentialing Criteria**	**Other (list)**
	S6.3				
Plan 1	X	X	X	X	
Plan 2	X (may be waived with appropriate approvals if necessary to provide access)			X	
Plan 3	X			X	
Plan 4			X	X	-Office location -Practice size and staffing -Services provided -Request for reimbursement
Plan 5	X			X	
Plan 6	X			X	
Plan 7	X			X	-Site reviews at the PCPs' offices

	Providers Subject to Credentialing Process[12]					
Plan Name	**Physicians**	**Nurse Practitioners / PAs**	**Facilities (Hospitals, LTC, etc)**	**Ancillary Services (Labs, radiology, etc)**	**Home Health Agencies**	**PTs/OTs**
	S6.4					
Plan 1	Yes	Yes	Yes	Yes	Yes	Yes, individuals are credentialed
Plan 2	Yes	Yes – includes CNMs, CRNAs	Yes	Yes	Yes	Yes – also includes STs, SLPs, RTs
Plan 3	Yes	Yes	No	Yes-free standing; No-hospital-based	No	Yes
Plan 4	Yes	N/A	N/A	Yes	Yes	Yes
Plan 5	Yes	Yes	Yes	Yes	Yes	Yes
Plan 6	Yes	No	No, JACHO accredited	No	Yes	No
Plan 7	Yes	Yes	Yes	Yes – delegated	Yes - delegated	Yes - delegated

[12] A blank cell indicates that the plan did not address this category of provider in its open-ended response.

Section 6. Provider Network and Contractual Relationships, Continued

	Providers Subject to Credentialing Process, Continued					
Plan Name	**Psychologist/ Psychiatrists**	**Other Mental/Behavioral Health Specialists**	**Chiropractors**	**Podiatrists**	**Dentists**	**Other**
			S6.4			
Plan 1	Yes	Yes, all licensed providers	Yes	Yes	Yes, delegated to dental vendor	
Plan 2	Yes	Yes	Yes	Yes	N/A	
Plan 3	Yes	Yes	Yes	Yes	Yes	
Plan 4	Yes	Yes	Yes	Yes	Yes	
Plan 5	Yes	Yes	Yes	Yes	Yes-delegated	
Plan 6	Yes	Yes	Yes	Yes	Yes	
Plan 7	Yes - delegated	Yes - delegated	Yes - delegated	Yes - delegated	Yes – delegated; HK has a direct contract with dental plans for preventive and routine services	Facility-based practitioners who practice only in the inpatient setting such as pathologists, radiologists and emergency department physicians are excluded from credentialing process.

Plan Name	**Steps to Ensure Providers Who Serve High Risk or Costly Populations are Not Discriminated Against in the Selection Process and When Considering Reimbursement**
	S6.6.
Plan 1	Providers who serve high risk/costly populations are integral part of network and are recruited to ensure that members who require such care are able to obtain that care. Providers are required to meet credentialing criteria; if they do not, there is a process in place to consider case-by-case exceptions. The contract process allows for comparison of reimbursement rates between like providers and favors higher reimbursement rates for those serving high risk/costly populations if necessary.
Plan 2	Populations served by provider are not considered as part of the credentialing and re-credentialing process. Providers are reimbursed at 100% of Medicaid Fee Schedule. If request is made for a higher reimbursement rate, decision is based on access and availability needs of network and not on service to high risk or costly populations.
Plan 3	Reimbursements are established through the contracting process; therefore claims are adjudicated using the same time-frames as any other claim. Contract process allows for reimbursements that vary by provider and population served. Sub-specialists and other providers who care for high risk or costly populations are paid higher rates. Plan also contracts with sub-specialty groups affiliated with tertiary care centers.
Plan 4	Provider applications are reviewed independently by contracts who serve a provider specialty type for a given region. The contractor interviews the physician about his/her practice and unique service attributes. This information is documented for the network evaluation, which is conducted by a cross-specialty contract review team.
Plan 5	Plan's credentialing policy providers for non-discrimination.
Plan 6	"Providers are recruited and credentialing based on network needs, regardless of their specialty or the population they serve."
Plan 7	Plan conducts uniform credentialing activities that comply with anti-discrimination requirements which prohibit discrimination in terms of participation, reimbursement or indemnification against any health care provider acting within the scope of his/her license or certification under state law.

Section 6. Provider Network and Contractual Relationships, Continued

Plan Name	Criteria to Deny Participation					Pediatric Staffing Ratio
	Not Meeting Credentialing Criteria	Licensure Sanctions	Malpractice Issues	Inability to Meet Geographic Access and Service Access Needs of Enrollees	Other (list)	
	S6.7.					S6.8.
Plan 1	X			X		15 PCPs/1000 children
Plan 2	X	X	X		If history indicates a pattern of poor quality or adverse effect on member satisfaction.	25.29 physician providers per 1000 children (not including non-physician providers)
Plan 3				X	Excluded from participation in Federal health care programs.	3 PCPs/1000 children
Plan 4	X				Not meeting plan's selection criteria (demographics, practice size and staffing, services provided, and reimbursement).	20 PCPs/1000 children
Plan 5	X				Applications by applicants who have diminished clinical privileges, an unusually large number of malpractice occurrences, licensure sanctions, criminal action, or other adverse concerns are referred by the Medical Director to the Credentialing Committee for review and recommendation.	?? Need clarification
Plan 6	X				Providers may be denied participation if the network access is already satisfied.	1 PCP/1000 children
Plan 7					Adverse information obtained or evidence of behavior that could jeopardize the health and well-being of members.	19.1 PCPs/1000 children

Plan Name	Board Certification for PCP	PCP Board Certification at some point	PCP turnover rate in last calendar year	AVG PCP turnover in last three years
	S6.9.	S6.10	S6.11.	
Plan 1	Yes	N/A	11.10%	20.8%
Plan 2	Yes	No – not for non-certified providers who are included for access reasons with appropriate approvals and waivers	2.2%	4.1%
Plan 3	Yes	N/A	0.06%	5%
Plan 4	Yes	N/A	<1%	<1%
Plan 5	Yes	N/A	<10% - requested more precise estimate	<10% - requested more precise estimate
Plan 6	Yes	N/A	20%	10%
Plan 7	Yes	N/A	Data not available due to change in data systems; overall, network has been stable with low turnover	Not available.

Section 6. Provider Network and Contractual Relationships, Continued

	Factors Contributing to PCP Turnover						
Plan Name	**Failure to Maintain Board Certification; Not Meeting Credentialing Guidelines**	**Relocation**	**Retirement or Death**	**Decrease in Plan's Network Size Due to Decrease in HK Enrollment**	**Staff Physicians Left for Private Practice**	**Reimbursement Issues**	**Other**
	S6.12						
Plan 1	X						
Plan 2		X	X				Close their practices
Plan 3				X	X		
Plan 4		X	X			X	-Disinterest in managed care -Administrative issues
Plan 5		X					-Practice overflow?
Plan 6							-Recent network consolidation – PCPs with very small memberships were terminated.
Plan 7				X			

Plan Name	Overall Specialists Pediatrics	Pediatric Specialist - Pediatrics	Adult Specialist - Pediatrics
	S6.13.		
Plan 1	1,877	399	1,478
Plan 2	1,932	100	1,832
Plan 3	1,888	220	1668
Plan 4	209	40	169
Plan 5	?	?	?
Plan 6	3272	245	3027
Plan 7	3,171	205	2,966

Section 6. Provider Network and Contractual Relationships, Continued

	Methods for Recruiting Specialists								
Plan Name	Analysis of Referrals to Out of Network Providers	Draw from Commercial Network Providers	Participating Provider Referrals	Geographic Needs Analysis	Little Blue Book / Review of Provider Lists	Provider Completes Application/ Self-referral	Visit to Provider's Office with Recruitment Package	Panel Size/ Capacity Analysis	Other
	S6.14.								
Plan 1	X		X	X		X	X	X	
Plan 2									Research counties where members reside; Contact potential new provider by phone
Plan 3			X						Provider Relations Personnel identifies and contacts potential providers; providers are evaluated based on services, location, and waiting times
Plan 4						X			Generally, do not need to solicit providers for participation. Providers are evaluated on credentialing criteria, practice size, staffing and location, services provided, and request for reimbursement.
Plan 5									Contract with all specialty groups in the state.
Plan 6		X			X				
Plan 7									Currently not recruiting – network has excess capacity.

	Problems Recruiting Specialists			
Plan Name	None	Reimbursement	Provider Lacks Sufficient Malpractice Coverage	Other (list)
	S6.15.			
Plan 1		X	X	
Plan 2		X		Lack of providers of certain types in some rural areas served
Plan 3	X			
Plan 4		X		
Plan 5		X		
Plan 6		X		
Plan 7	X			None historically. Not recruiting currently.

Section 6. Provider Network and Contractual Relationships, Continued

Plan Name	Board Certification for Specialist	Specialist Board Certification at some point	Specialist turnover rate in last calendar year	AVG Specialist turnover in last three years
	S6.16.	S6.17.	S6.18.	
Plan 1	No	No	23.3%	20.9%
Plan 2	No	No	3.4%	4.0%
Plan 3	No	No	0.17%	11%
Plan 4	Yes	N/A	<1%	<1%
Plan 5	?	?	?	?
Plan 6	No	No	10%	30%
Plan 7	Yes	N/A	Data not available. Generally, network has been stable with low turnover.	Not available.

	Factors Contributing to Specialist Turnover						
Plan Name	Relocation	Retirement or Death	Reimbursement Issues	Unable to Meet Credentialing Requirements	No Longer Want to Treat Medicaid/FHK Patients	Closed or Switched Practices	Other (List)
	S6.19.						
Plan 1			X	X	X		
Plan 2	X	X				X	
Plan 3	X					X	
Plan 4			X				
Plan 5							More stringent malpractice rules.
Plan 6			X				
Plan 7							A few specialists have been terminated due to excess capacity within the network.

Section 6. Provider Network and Contractual Relationships, Continued

	Strategies to Ensure Network is Adequate					
Plan Name	**Complaint Data/Member Feedback**	**Access / Availability Study / Reports**	**GeoAccess Maps / Geographic Needs Analysis**	**Panel Size / Capacity Analysis**	**Monitor Use of Out-of-Network Providers and Recruit to Fill Gaps**	**Other (List)**
	S6.20					
Plan 1			X	X	X	
Plan 2	X		X		X	
Plan 3				X		Member surveys that ask about experiences scheduling appointments, waiting times, and satisfaction.
Plan 4				X		Monthly monitoring reports of participating providers by specialty relative to eligible providers.
Plan 5				X		
Plan 6			X			Medicaid providers are also offered participation in FHK product.
Plan 7		X	X	X		Analyze access by specialty type also.

	Assumptions/Methodologies			
Plan Name	**Software GeoAccess**	**Time & Distance Standards**	**Panel Size - PCP/Member Ratio**	**Other**
	S6.21.			
Plan 1		X (FHKC)		Evaluate FHKC membership listings to identify membership shifts Evaluate network capacity
Plan 2	X	X (FHKC)		Review out-of-network utilization to determine network needs.
Plan 3			X	Review patient access statistics, wait times for appointments. Consider results of member and provider surveys.
Plan 4		X	X (1PCP/200members) 1spec./400 members)	Contract with all acute care facilities in a marketable county to cover members for emergency services.
Plan 5		X (AHCA & FHKC guidelines)		
Plan 6	X		X (AHCA standards – 1PCP/1500 members)	Specialists based on county availability; all pediatric sub-specialties available in a county are contracted.
Plan 7	X	X	X	Conduct annual access review and create annual access plan that includes assessment of the ratio of members to PCPs and to high volume specialists using claims and encounter data. Measure panel size on a monthly basis to ensure appropriate access..

Section 6. Provider Network and Contractual Relationships, Continued

	Procedures to Ensure Up-to-Date Provider Panel List		
Plan Name	**Providers Asked to Review and Update Data Sheet**	**In-House Review (Periodicity)**	**Other (list)**
	S6.22.		
Plan 1		X (monthly)	PCPs can review listing on website and report problems online
Plan 2		X (monthly)	
Plan 3		X (monthly)	
Plan 4			Dedicated Administrative Team for updating and maintaining Provider Database. Providers can submit changes to Provider Relations Field Team, Provider Contractors, and Provider Support Call unit; changes are submitted to provider data system team for verification and entry.
Plan 5			Changes from field reps are tracked through a database. Directories are updated quarterly.
Plan 6		X (quarterly)	All changes received from providers, provider relations representatives, customer service, and health services are submitted to centralized data gathering department with updates made within 15 days of receipt.
Plan 7	X (annually)		Letters and phone calls from members and providers indicating a change – verified and then updated in the system.

	Method of Communicating General Information to Participating Providers									
Plan Name	**Website**	**Training / Educational Programs**	**Newsletters**	**Mailings**	**Faxes**	**Provider Manual**	**Phone Line**	**On-Site Visits**	**Provider Relations Representative**	**Other (list)**
	S6.23.									
Plan 1	X				X			X	X	-E-mail -Phone calls to provider
Plan 2				X						
Plan 3		X	X		X	X				-Quarterly referral instruction updates
Plan 4			X				X		X	-Bulletins -News seminars
Plan 5			X		X					
Plan 6	X	X		X						
Plan 7	X			X		X				

Section 6. Provider Network and Contractual Relationships, Continued

	Information/Resources for Out of Network Providers			
Plan Name	**Website**	**Provider Relations / Services Representatives**	**800 line/ Telephone Number/Customer Service**	**Other (list)**
	S6.24.			
Plan 1	X	X	X	
Plan 2		X		
Plan 3	X		X	
Plan 4	X			-Onsite training -Claims administrative portal/tool
Plan 5	X		X	
Plan 6			X	
Plan 7	X		X	

Section 7. Provider Reimbursement & Incentives

Reimbursement Mechanisms for Pediatric PCPs						
Plan Name	**Salary**	**Negotiated FFS**	**Capitation Rate to IPA**	**Capitation Rate to Individual Providers**	**Cap Rate for Case Management Only**	**Other**
S7.1.						
Plan 1	No	Yes	No	Yes	Yes	
Plan 2	No	Yes	No	No	No	
Plan 3	Yes	Yes	No	Yes	No	
Plan 4[13]	No	No	Yes	No	No	Global capitation to an IPA, which in turn reimburses PCPs.
Plan 5	No	Yes	Yes	Yes	No	Additional information requested.
Plan 6	No	Yes	No	No	No	
Plan 7	No	Yes	Yes	Yes	Yes	

Percentage of PCPs Paid by Different Reimbursement Mechanisms				
Plan Name	**Salary**	**Negotiated FFS**	**Capitation**	**Mixed FFS and Capitation**
Plan 1	0%	75%	2%	23%
Plan 2	0%	100%	0%	0%
Plan 3	29%	18%	0%	53%
Plan 4	0%	0%	100%[14]	0%
Plan 5	?	?	?	Additional information requested.
Plan 6	0%	100%	0%	0%
Plan 7	0%	25%	60%	15%

[13] This plan has a provider network arrangement that is unique to the part of the state where it currently has Florida Healthy Kids enrollees (as well as commercial enrollees). Responses in other parts of the state would have been different, but were not included because the plan currently does not have Healthy Kids enrollment outside of this area.
[14] The health plan pays a global capitation to an IPA comprised of both PCPs and specialty physicians. The IPA may then pay individual physicians FFS or capitated payments. Information about the payments from the IPA to the individual physicians is not available.

Section 7. Provider Reimbursements & Incentives, Continued

	Contract with to Establish Network				
Plan Name	**Individual Physicians**	**Single Specialty Groups**	**Multiple Specialty Groups**	**Academic Health Centers**	**Payment to Group (G) Individual (I)**
	S7.2.				**S.7.3.**
Plan 1	Yes	Yes	Yes	Yes	G and I
Plan 2	Yes	Yes	Yes	No	I
Plan 3	Yes	Yes	Yes	Yes	G
Plan 4	Yes	Yes	Yes	Yes	G
Plan 5	Yes	Yes	Yes	No	G and I
Plan 6	Yes	Yes	Yes	Yes	G
Plan 7	Yes	Yes	Yes	No	G and I depending on contract

	Dispersed to Individual Physician					
Plan Name	**Know how payment is disbursed to individual in a group**	**How payment is dispersed**				**Factors Developing Capitation Rate (besides age, sex, and geographical area)**
		Salary	**FFS**	**Capitation**	**Other**	
	S7.4.	**S7.4.1.**				**S7.5.**
Plan 1	Yes	No	No	Yes		Benchmark against Medicaid rates
Plan 2	N/A	N/A	N/A	N/A		N/A
Plan 3	No	N/A	N/A	N/A		Actual utilization value
Plan 4	No	N/A	N/A	N/A		Utilization and specialty type; specialty and patient population mix.
Plan 5	No	N/A	N/A	N/A		Market dynamics
Plan 6	Yes	Yes	Yes	No		N/A
Plan 7	Yes	Yes	Yes	No	Yes	Paid claims data

	Tiers or Adjustments in Capitation Rate			
Plan Name	**Age Variable**	**Sex Variable**	**Benefit Plan Variable Rates**	**Other (List)**
	S.7.6.			
Plan 1	Yes	Yes	Yes	
Plan 2	N/A	N/A	N/A	
Plan 3	Yes	Yes	Yes	
Plan 4	N/A	N/A	N/A	
Plan 5	Yes	No?	No?	
Plan 6	N/A	N/A	N/A	
Plan 7	Yes	Yes	Yes	Paid claims data

Section 7. Provider Reimbursements & Incentives, Continued

			Capitation with FFS—what services are billed FFS?		
Plan Name	**PCPs All Paid Same Paid Cap Rate**	**Mixed Model for Reimbursement**	**Immunizations**	**Laboratory & radiology**	**Other**
	S7.7	**S7.8.**			
Plan 1	No	Yes	X		Varies depending on contract, but examples include immunizations and well-child check-ups.
Plan 2	N/A	N/A	N/A	N/A	
Plan 3	No	Yes	X		Minor excisions, ear wax removal, minor suturing, and cryotherapy
Plan 4	N/A[15]	N/A			
Plan 5	No	No		X	
Plan 6	N/A	N/A	N/A	N/A	All services reimbursed on FFS basis
Plan 7	No	Yes	X		No standardized FFS procedures –agreed to during contract negotiations. Customary FFS items include vaccinations/immunizations, preventive well child visits, and stat clinical lab procedures.

Plan Name	**PCP Ordered Labs—Part of Capitation?**	**PCP Expected to Meet Spending Targets?**	**If yes, how is risk distributed**		
	S.7.10	**S7.11.**	Individual	All Providers	Across Medical Subgroups
Plan 1	Yes/No (as necessary)*	No	N/A	N/A	N/A
Plan 2	N/A	N/A	N/A	N/A	N/A
Plan 3	No	No	N/A	N/A	N/A
Plan 4	Yes	No	N/A	N/A	N/A
Plan 5	No	No	N/A	N/A	N/A
Plan 6	N/A	No	N/A	N/A	N/A
Plan 7	Yes – Stat lab only; lab tests sent to health plan's contracting lab are paid directly to that lab.	No	N/A	N/A	N/A

[15] The health plan pays a global capitation to an IPA comprised of both PCPs and specialty physicians. The IPA may then pay individual physicians FFS or capitated payments. Information about the payments from the IPA to the individual physicians is not available.

Section 7. Provider Reimbursements & Incentives, Continued

	Reimbursement of Specialists					
Plan Name	**Salary**	**Negotiated FFS**	**Capitation Rate to IPA**	**Cap Rate to Individual Provider**	**Capitation Rate for Case Management Only**	**Other**
	S7.12.					
Plan 1	No	Yes	No	No	No	
Plan 2	No	Yes	No	No	No	
Plan 3	Yes	Yes	Yes	Yes	No	
Plan 4[16]	No	No	Yes	No	No	Global capitation to an IPA, which in turn reimburses specialists with exception of podiatric and chiropractic providers. The chiropractic network is contracted under a capitated arrangement.
Plan 5	No	Yes	Yes	Yes	No	
Plan 6	No	Yes	No	No	No	
Plan 7	No	Yes	No	No	No	Capitation to specialty networks

	Percentage of Specialists Paid by Different Reimbursement Mechanisms			
Plan Name	**Salary**	**Negotiated FFS**	**Capitation**	**Mixed FFS and Capitation**
Plan 1	0%	100%	0%	0%
Plan 2	0%	100%	0%	0%
Plan 3	21%	63%	6%	10%
Plan 4	0%	0%	100%[17]	0%
Plan 5	?	?	?	Additional information requested.
Plan 6	0%	100%	0%	0%
Plan 7	0%	50%	45%	5%

[16] This plan has a provider network arrangement that is unique to the part of the state where it currently has Florida Healthy Kids enrollees (as well as commercial enrollees). Responses in other parts of the state would have been different, but were not included because the plan currently does not have Healthy Kids enrollment outside of this area.

[17] The health plan pays a global capitation to an IPA comprised of both PCPs and specialty physicians. The IPA may then pay individual physicians FFS or capitated payments. Information about the payments from the IPA to the individual physicians is not available.

Section 7. Provider Reimbursements & Incentives, Continued

Plan Name	All Specialists Paid Same Capitation Rate?	Different (list)	Use Commercial Enrollees' Network?	Why/Why Not	Specialist Fund	Hospital Fund	Providers Assume Ancillary Risk
	S7.13	S7.13.1.	S7.14.	S7.14.1.	S7.15	S7.16	S7.17.
Plan 1	N/A	N/A	N/A	No commercial product offered.	No	No	No
Plan 2	N/A	N/A	No	There may be some overlap, but there are different networks for the plans various programs, which often operate in separate counties.	No	No	No
Plan 3	No	Historical utilization calculated at a percentage of the Medicare fee schedule	No	"Specialists are the same; however, we only permit Board Certified family practitioners, internal medicine, or pediatricians to act as Healthy Kids PCP's."	No	No	No
Plan 4	No[18]	N/A	No	"PCP's are restricted by FHK to only include Board Certified Pediatrics or Family Practice. All other providers are same as commercial enrollees providing choice and selection to our members"	No	No	No
Plan 5	No	Market dynamics?	N/A	No commercial product offered.	No	No	No
Plan 6	N/A	N/A	When possible	When possible, the commercial network is used to ensure that credentialing requirements are met and to allow for better negotiation position with the provider who anticipates greater volume of membership. Network differences may occur if a commercial provider is considered not to be needed for HK membership or if the rate negotiated is not reasonable for HK product.	No	No	No
Plan 7	No	Population mix, scope, duration, and type of services provided	No for PCPs, yes for specialists	Board Certification required for HK for the Pediatricians and Family Practitioners.	No	No	No

[18] The health plan pays a global capitation to an IPA comprised of both PCPs and specialty physicians. The IPA negotiates different payment arrangements with individual physicians and practices. Information about these payment arrangements is not available.

Section 7. Provider Reimbursements & Incentives, Continued

Plan Name	Physician Bonuses Paid	Bonus based on		How Bonus is Calculated
		Performance evaluations	Other (list)	
	S7.18.	S7.18.1.		S7.18.2.
Plan 1	No	N/A	N/A	N/A
Plan 2	No	N/A	N/A	N/A
Plan 3	Yes*	Yes (performance quality)	Member satisfaction	Part of individual performance
Plan 4	No	N/A	N/A	N/A
Plan 5	No	N/A	N/A	N/A
Plan 6	No	N/A	N/A	N/A
Plan 7	No	N/A	N/A	N/A

Plan Name	Describe how you pay Out-of-Network Providers			Claims & Encounter Data Received for Out-of-Network
	According to Medicaid Fee Schedule	Negotiate rate of payment with out-of-network provider	Other (list)	
	S7.19.			S7.20
Plan 1	Yes	Yes		Yes
Plan 2		Yes	In negotiations, strive for 100% Medicaid Fee Schedule.	Yes
Plan 3			Discounted FFS based on participation in national network; full charges if not in national network.	Yes
Plan 4			120% of Medicare	Yes
Plan 5	Yes – allowable for non-participating providers			Yes
Plan 6		Yes	One-on-one negotiations with baseline reimbursement 100% Medicaid fee schedule or up to 200% of Medicare fee schedule for certain specialties.	Yes
Plan 7		Yes	Based on letter of agreement; reimbursement rate is generally a % of Medicaid/Medicare allowable	Yes

Section 8. Enrollee Rights

	Privacy and Confidentiality of Information					Monitoring Compliance with Enrollee Rights		
Plan Name	Training/ Orientation	HIPAA Training	Provider Manual/ Handbook	Provider Offices Must Post Enrollee Rights	Other (list)	Monitor Member Inquiries/ Complaints	Site Visits	Other (list)
	S8.1.					S8.2.		
Plan 1	X		X		X (member handbooks, new member enrollment packets, member newsletters and website)	X		
Plan 2	X				Provider contract	X		
Plan 3	X		X	X	Newsletters	X	X	-Provider offices required to post enrollee rights -Monitor responses to member surveys.
Plan 4	X (employees, not providers)				Enrollees are notified of their privacy rights.	X		Providers are obligated to provide patients with Notice of Privacy Practices
Plan 5	X		X		Enrollees also are informed in member handbook.	X		
Plan 6	X	X	X	X	Member handbooks;		X	Contractual obligation; Offices must post enrollee rights
Plan 7			X		Member handbook.	X		

	Steps taken to ensure enrollees receive information about available treatment options and alternatives							
Plan Name	Case Managers	Member Handbook	Policy/Procedure Regarding Continuity of Care	Verbal Education	Provider Contract Requirements	Health Coaching	Customer Service/Nurse Line	Other
	S8.3.							
Plan 1			X				X	Members have option to get second opinion.
Plan 2	X			X				
Plan 3		X						Referred to DM department for information; complex cases referred to care coordination department.
Plan 4						X		Targeted outreach
Plan 5								Annual chart audits
Plan 6	X – upon referral by Customer Service						X	
Plan 7					X			

Section 8. Enrollee Rights, Continued

	Language Materials are Available	
Plan Name	**English**	**Spanish**
	S8.4.	
Plan 1	X	X
Plan 2	X	X
Plan 3	X	Select materials; on request
Plan 4	X	X
Plan 5	X	X
Plan 6	X	X
Plan 7	X	X (upon request)

	Steps Taken to Ensure Providers Have Accessible Services for Members with Limited English Proficiency or Who are Hearing Impaired				
Plan Name	**Bilingual Staff**	**Interpreter Services**	**AT&T Language Line**	**TDD/TTY Phone System/Relay Service**	**Other (list)**
	S8.5.				
Plan 1	X	X		X	CLAS (Culturally and Linguistically Appropriate Services)
Plan 2	X		X	X	
Plan 3				X	Members are referred to Member Services for interpretive service needs.
Plan 4				X	-Walk-in customer service is available in one particular service area. -Online provider directories list the language(s) that each physician speaks
Plan 5				X	-Site visits of provider office to audit for access with regard to physical limitations, hearing impaired, and language barriers. If requirements are not met, corrective action is implemented.
Plan 6			X	X	
Plan 7		X (required in provider contract)		X	Assistive devices

	Hearing Impaired Members Have Access to HP Through Relay or TTY Technology	If yes, provide TTY access number for each program
Plan Name	**Yes/No**	**TTY access phone number**
	S8.6.	**S8.6.1.**
Plan 1	Yes	Number provided
Plan 2	Yes	Number provided
Plan 3	Yes	Number provided
Plan 4	Yes	Number provided
Plan 5	Yes	Number provided
Plan 6	Yes	Number provided
Plan 7	Yes	Number provided

Section 9. New Enrollees

Plan Name	Define New Enrollees	Frequency of Notice of Healthy Kids Enrollment	Procedures Used to Monitor for New Enrollees	Length of Time Provided to Enrollee to Select PCP
	S9.1.	S9.2.	S9.3.	S9.4.
Plan 1	"…those individuals meeting FHKC standards of eligibility and who have been enrolled in the program…" -Follows FHKC definition of new and reinstated members where a reinstated member is one who regains eligibility within 60 days as defined by FHKC.	Twice a month	Enrollment load process generates a report that identifies new enrollees; Follow FHK contract requirements from Section 2-1, Participant Identification	Enrollees are automatically assigned a PCP with an option to change PCP at any time by calling the member services toll-free number.
Plan 2	"a first time member in the plan or a member who has had a lapse in coverage" - where a lapse in coverage refers to a lapse of one month or greater	Monthly	Identified in the eligibility file.	N/A – no requirement that enrollee have PCP
Plan 3	"member who did not previously have coverage with FHCP. Previous FHCP members are re-issued their former Medical Record # for continuity of care when their coverage is reinstated"	Twice a month	Enrollment department manually adds members after the supplemental tape is received and faxed authorizations are processed immediately.	60 days
Plan 4	As identified by Florida Healthy Kids. Reinstatements are considered new enrollees if a new effective date is provided by FHKC.	At least twice a month	"HK provides enrollment via electronic full file replacement. All new enrollees are noted by HK"	At anytime
Plan 5	"enrollees that have never (or for more than six months have not) been an active member of the Health Plan."	Twice a month	Match eligibility files with current and past membership; new enrollees are separated.	Enrollees are automatically assigned a PCP with an option to change if they are dissatisfied.
Plan 6	"someone that FHKC has enrolled with our Plan through their replacement or supplemental enrollment files, and that has not been previously enrolled within the past 90 days"	Twice a month	FHKC files are uploaded into plan's member eligibility system; an internal report is generated that can be used to identify and monitor new enrollees.	Members are automatically assigned to PCP within their zip code or nearest zip code. Enrollees can change PCP at anytime to another in-network PCP.
Plan 7	"…distinct new member to the plan or one that is reinstated to the plan with a lapse in coverage" -where a lapse in coverage refers to any lapse in coverage.	Monthly with supplemental reports	Cross-reference current plan membership with most recent file provided by FHKC. Also use coverage effective date.	If enrollee does not select a PCP during enrollment process, PCP is assigned based on enrollee address. Enrollee can change assigned PCP by calling Customer Service.

Section 9. New Enrollees, Continued

Plan Name	Procedures in Place if Enrollee Does Not Choose PCP at Time of Enrollment	Percent of New Enrollees with PCP Assigned by Health Plan	Procedures to Facilitate the First Encounter of the Newly Enrolled Beneficiary with PCP
	S9.5.	S9.6.	S9.7.
Plan 1	PCP is automatically assigned but members are informed that they can change PCP at any time.	N/A – all enrollees are automatically assigned a PCP at time of enrollment.	Letter w/ ID card and notification of PCP and encouraged to contact PCP; membership panel reports note new members for provider outreach
Plan 2	N/A	N/A	New member welcome packet asks member to choose a medical home. Case Management encourages enrollees they work with to choose a medical home.
Plan 3	Member is sent a reminder letter; if PCP is not chosen after 60 days, a PCP is chosen for them	10%	Welcome letter is sent by health plan on behalf of assigned PCP encouraging them to call and make an appointment
Plan 4	PCP is assigned and the plan advises members on how to make changes	N/A – all enrollees are automatically assigned a PCP at time of enrollment.	Correspondence through mail
Plan 5	If previous enrollment, assigned to previous PCP. Automatic assignment of PCP that fits age range and is closest geographically. Manual assignment if automatic assignment fails. Members can change PCP at any time.	N/A – all enrollees are automatically assigned a PCP at time of enrollment.	Welcome letter encouraging member to schedule appointment.
Plan 6	PCP is automatically assigned. If automatic assignment does not occur, health plan staff will manually assign.	N/A – all enrollees are automatically assigned a PCP at time of enrollment.	Welcome call (during which first PCP visit is encouraged), new member letter and handbook (also encourage visit), PCP receives new member list and is encouraged to contact new members during first month of enrollment
Plan 7	A PCP is assigned based on enrollee's address if PCP is not selected during enrollment process.	N/A – all enrollees are automatically assigned a PCP at time of enrollment	ID card includes PCP name and phone number; member handbook encourages new members to make an appointment immediately; customer service is available for assistance

Section 10. Delegation

	Activities Performed by Contractors			
Plan Name	Establish/Maintain Provider Network	Provider Credentialing	Initial Assessment of Enrollees	Care Coordination
	S10.1.			
Plan 1		X	X	X
Plan 2	X	X		
Plan 3				
Plan 4		X	X	
Plan 5	X	X		
Plan 6		X		
Plan 7		X		

	Activities Performed by Contractors, Continued			
Plan Name	Disease Management	Service Authorization	Providing Information to Enrollees	Quality Assessment and Performance Improvement
	S10.1.			
Plan 1		X (ophthalmology)		
Plan 2				
Plan 3				
Plan 4	X	X	X	
Plan 5		**X**		**X**
Plan 6				
Plan 7				

	Activities Performed by Contractors, Continued					
Plan Name	Behavioral Health Care	Other: DME Referrals	Other: Claims Payment	Other: Complaints/ Appeals	Other: Customer Service	Other: Medical Record Documentation Review
	S10.1.					
Plan 1						
Plan 2						
Plan 3		X				
Plan 4	X					
Plan 5	X		X	X	X	
Plan 6						
Plan 7	X					X

Section 10. Delegation, Continued

	Process for Oversight of Delegated Functions		
Plan Name	**Responsible Party**	**Frequency Evaluation**	**Party Taking Action on Evaluation Results**
	S10.2.		
Plan 1	Vendor Selection and Oversight Committee (VSOC)	-Annual oversight audits -Semi-annual operational reviews -Monthly monitoring meetings	VSOC
Plan 2	Experts in the appropriate department – e.g., for credentialing oversight - Credentialing Committee; Ultimately, the Healthy Kids Executive Committee	Annually	Credentialing Committee
Plan 3	Utilization and Compensation Manager oversees the contract and monitors utilization. Meetings are held every other month between delegated entity and plan management.	Meetings held every other month.	Utilization and Compensation Manager
Plan 4	Delegated Oversight Committee, quarterly reporting, on-site chart review, ad hoc analysis.	-Quarterly reporting -Annual oversight review	Review committee with representatives from network management, medical/care management, provider services, sales, quality, and member services.
Plan 5	Experts for each specific delegated function who report to the Delegation Oversight Committee	Annual assessments with monthly audit reports	Experts develop corrective action plan with delegated entity; the oversight committee takes recommendations to the Quality Improvement Committee, which give final approval SME is responsible for monitoring corrective action plan.
Plan 6	Quality Improvement unit and Compliance unit	Annually	Quality Improvement
Plan 7	Delegated Oversight Committee	-Quarterly reports from delegate -Annual reviews of delegate's performance	Oversight Committee

Plan Name	**MCO Monitors Delegate To Make Sure Corrective Action is Implemented**	**Responsible Entity**
	S10.3.	
Plan 1	Yes	Health Plan Director of Quality Management, Director of Regulatory Compliance, and Health Plan Executive Management with monitoring and oversight from Quality Management Committee and VSOC.
Plan 2	Yes	Credentialing Committee and plan's internal Healthy Kids Executive Committee
Plan 3	Yes	Utilization and Compensation Manager
Plan 4	Yes	Medical director, Network Contractors and Provider Performance Improvement Team.
Plan 5	Yes	Experts for specific delegated area with reports to Oversight Committee and Quality Improvement Committee.
Plan 6	Yes	Quality Improvement
Plan 7	Yes	Oversight Committee