

**National Summary of State Medicaid Managed Care
Programs as of June 30, 2002**

Table of Contents

<i>Alabama Maternity Care Program (1932)</i>	Page 1
<i>Alabama Partnership Hospital Program (Voluntary)</i>	Page 3
<i>Alabama Patient First (1915b)</i>	Page 6
<i>Arizona Health Care Cost Containment System (1115)</i>	Page 8
<i>Arkansas Non-Emergency Transportation (1915b)</i>	Page 15
<i>Arkansas Primary Care Physician (1915b)</i>	Page 18
<i>California Altamed Senior Buenacare (1115)</i>	Page 21
<i>California Caloptima (1915b)</i>	Page 24
<i>California Center for Elders Independence (1115)</i>	Page 28
<i>California Central Coast Alliance for Health (1915b)</i>	Page 31
<i>California Health Plan of San Mateo (1915b)</i>	Page 35
<i>California Hudman (1915b)</i>	Page 39
<i>California Managed Care Network (1915b)</i>	Page 40
<i>California *Medi-Cal Mental Health Care Field Test (1915b)</i>	Page 43
<i>California *Medi-Cal Specialty MH Services Consolidation (1915b)</i>	Page 45
<i>California On-Lok Senior Health Services (1115)</i>	Page 47
<i>California Partnership Health Plan of California (1915b)</i>	Page 50
<i>California Prepaid Health Plan Program (Voluntary)</i>	Page 54
<i>California Primary Care Case Management Program (1915b)</i>	Page 58
<i>California Sacramento Geographic Managed Care (1915b)</i>	Page 61
<i>California San Diego Geographic Managed Care (1915b)</i>	Page 66

A GLOSSARY of terms is included at the end of this report.

**National Summary of State Medicaid Managed Care
Programs as of June 30, 2002**

Table of Contents

California Santa Barbara Health Initiative (1915b)..... Page 70

*California *Selective Provider Contracting Program (1915b)* Page 74

California Senior Care Action Network (1115) Page 75

California Sutter Senior Care (1115) Page 78

California Two-Plan Model Program (1915b) Page 81

Colorado Managed Care Program (1915b)..... Page 85

Colorado Mental Health Capitation Program (1915b)..... Page 90

Connecticut Husky A (1915b) Page 93

Delaware Diamond State Health Plan (1115)..... Page 97

District of Columbia DC Medicaid Managed Care Program (1915b) Page 101

District of Columbia Health Services for Children w/Special Needs (Vol) Page 106

Florida Managed Health Care (1915b) Page 110

Florida Prepaid Mental Health Plan (1915b)..... Page 118

Florida Statewide Inpatient Psychiatric Program (1915b) Page 122

Georgia GA Better Health Care (1915b) Page 123

Georgia Non-Emergency Transportation Broker Program (1915b)..... Page 126

Georgia Preadmission Screening and Annual Resident Review (PASAAR) (1915b)... Page 129

Hawaii HI Quest (1115) Page 132

Idaho Healthy Connections (1915b) Page 137

Illinois Voluntary Managed Care Page 139

Indiana Hoosier Healthwise (1915b)..... Page 143

**National Summary of State Medicaid Managed Care
Programs as of June 30, 2002**

Table of Contents

<i>Iowa Medicaid Managed Health Care (1932)</i>	Page 148
<i>Iowa IA Plan for Behavioral Health (1915b)</i>	Page 153
<i>Kansas KMMC: HealthConnect Kansas (1915b)</i>	Page 157
<i>Kansas KMMC: HealthWave 19 (1915b)</i>	Page 160
<i>Kentucky Human Service Transportation (1915b)</i>	Page 164
<i>Kentucky KY Health Care Partnership Program (1115)</i>	Page 167
<i>Kentucky Patient Access and Care (KENPAC) Program (1932)</i>	Page 172
<i>Louisiana Community Care (1915b)</i>	Page 174
<i>Maine MaineCare Primary Care Case Management (1932)</i>	Page 176
<i>Maryland HealthChoice (1115)</i>	Page 179
<i>Massachusetts Mass Health (1115)</i>	Page 184
<i>Michigan Children's Special Health Care Services (Vol)</i>	Page 191
<i>Michigan Comprehensive Health Plan (1915b)</i>	Page 195
<i>Michigan Specialty Community MH Services Program (1915b)</i>	Page 200
<i>Minnesota *Consolidated Chemical Dependency Treatment Fund (1915b)</i>	Page 204
<i>Minnesota MN Disability Health Options – MnDHO (Voluntary)</i>	Page 207
<i>Minnesota MN Senior Health Options Program (Voluntary)</i>	Page 211
<i>Minnesota MNCare Program for Families and Children (1115)</i>	Page 215
<i>Minnesota Prepaid Medical Assistance Program (1115)</i>	Page 219
<i>Mississippi HealthMACS (1932)</i>	Page 217
<i>Missouri MC+ Managed Care (1115)</i>	Page 223

**National Summary of State Medicaid Managed Care
Programs as of June 30, 2002**

Table of Contents

<i>Missouri MC+ Managed Care (1915b)</i>	Page 228
<i>Montana Passport to Health (1915b)</i>	Page 233
<i>Nebraska Health Connection Combined Waiver Program (1915b)</i>	Page 236
<i>Nevada Mandatory Health Maintenance Program (1932)</i>	Page 242
<i>Nevada Voluntary Health Maintenance Program (1932)</i>	Page 246
<i>New Hampshire NH Voluntary Managed Care Program</i>	Page 250
<i>New Jersey NJ Care 2000+ (1915b)</i>	Page 253
<i>New Jersey NJ Care 2000+ (1932)</i>	Page 258
<i>New Mexico SALUD! (1915b)</i>	Page 263
<i>New York Non-Emergency Transportation (1915b)</i>	Page 267
<i>New York Office of MH/Partial Capitation Program (Voluntary)</i>	Page 269
<i>New York Partnership Plan – Family Health Plus (1115)</i>	Page 272
<i>New York Partnership Plan Medicaid Managed Care Program (1115)</i> ...	Page 276
<i>North Carolina Access II/III (1915b)</i>	Page 284
<i>North Carolina Access II/III (1932)</i>	Page 288
<i>North Carolina Carolina ACCESS (1915b)</i>	Page 291
<i>North Carolina Carolina ACCESS (1932)</i>	Page 294
<i>North Carolina Health Care Connection (1915b)</i>	Page 297
<i>North Carolina Health Care Connection (1932)</i>	Page 301
<i>North Dakota ND Access and Care Program (1915b)</i>	Page 305
<i>Ohio PremierCare (1915b)</i>	Page 310

**National Summary of State Medicaid Managed Care
Programs as of June 30, 2002**

Table of Contents

<i>Oklahoma SoonerCare (1115)</i>	Page 315
<i>Oregon OR Health Plan (1115)</i>	Page 320
<i>Oregon* Transportation Program (1915b)</i>	Page 327
<i>Pennsylvania Family Care Network (1915b)</i>	Page 328
<i>Pennsylvania HealthChoices (1915b)</i>	Page 331
<i>Pennsylvania Voluntary HMO Contracts</i>	Page 337
<i>Puerto Rico PR Health Care Reform (Voluntary)</i>	Page 341
<i>Rhode Island Rite Care (1115)</i>	Page 344
<i>South Carolina Health Maintenance Organization (Voluntary)</i>	Page 348
<i>South Carolina Physicians Enhanced Program (Voluntary)</i>	Page 352
<i>South Dakota Dental Program (Voluntary)</i>	Page 355
<i>South Dakota Prime (1915b)</i>	Page 358
<i>Tennessee TennCare (1115)</i>	Page 361
<i>Texas *Lonestar Select I (191b)</i>	Page 367
<i>Texas* Lonestar Select II (1915b)</i>	Page 368
<i>Texas NorthSTAR (1915b)</i>	Page 369
<i>Texas STAR (1915b)</i>	Page 373
<i>Texas STAR+ Plus (1915b)</i>	Page 380
<i>Utah Choice of Health Care Delivery (1915b)</i>	Page 384
<i>Utah Non-Emergency Transportation (1915b)</i>	Page 388
<i>Utah Prepaid Mental Health Program (1915b)</i>	Page 391

**National Summary of State Medicaid Managed Care
Programs as of June 30, 2002**

Table of Contents

<i>Utah Voluntary PCCM/MCO Program (1932)</i>	Page 395
<i>Vermont VT Health Access (1115)</i>	Page 400
<i>Virginia Medallion (1915b)</i>	Page 403
<i>Virginia Medallion II (1915b)</i>	Page 405
<i>Washington Healthy Options (1915b)</i>	Page 409
<i>Washington Integrated Mental Health Services (1915b)</i>	Page 414
<i>West Virginia Mountain Health Trust (1915b)</i>	Page 417
<i>West Virginia Physician Assured Access System (1915b)</i>	Page 422
<i>Wisconsin BadgerCare -SCHIP (1115)</i>	Page 425
<i>Wisconsin Children Come First (Voluntary)</i>	Page 430
<i>Wisconsin Independent Care -I Care (Voluntary)</i>	Page 434
<i>Wisconsin Medicaid HMO Program (1932)</i>	Page 438
<i>Wisconsin WI Partnership Program (1115)</i>	Page 443
<i>Wisconsin WrapAround Milwaukee (Voluntary)</i>	Page 447

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:

County

Initial Waiver Approval Date:

Not Applicable

Operating Authority:

1932 - State Plan Option to Use Managed Care

Implementation Date:

June 01, 1999

Statutes Utilized:

Not Applicable

Waiver Expiration Date:

Not Applicable

Enrollment Broker:

No

Sections of Title XIX Waived:

Not Applicable

For All Areas Phased-In:

Yes

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:

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 or Gynecologists

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

ALABAMA

Maternity Care Program

Subpopulations Excluded from Otherwise

Included Populations:

- American Indian/Alaskan Native
- Other Insurance
- Foster Children
- Special Needs Children (State defined)
- Special Needs Children (BBA defined)
- Medicare Dual Eligible

Lock-In Provision:

No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Maternity Care Program

ADDITIONAL INFORMATION

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

Populations

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

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

Use of Collected Data:

- Beneficiary Provider Selection
- Contract Standard Compliance
- Program Evaluation
- Track Health Service provision

Consumer Self-Report Data

None

Performance Improvement Projects

Clinical Topics

None

Non-Clinical Topics

- Access to early prenatal care

ALABAMA Partnership Hospital Program

CONTACT INFORMATION

State Medicaid Contact: Lynn Sharp
Alabama Medicaid Agency
(334) 242-5588

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

PROGRAM DATA

Program Service Area: Region	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority/Section 1902(a)(4)	Implementation Date: October 01, 1996
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: None
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Medical-only PHP - Full Capitation

Service Delivery

Included Services: Inpatient Hospital	Allowable PCPs: -Not applicable, contractors not required to identify PCPs
---	--

Enrollment

Populations Voluntarily Enrolled: -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	Populations Mandatorily Enrolled: None
Subpopulations Excluded from Otherwise Included Populations: -Medicare Dual Eligible -Poverty Level Pregnant Woman	Lock-In Provision: Does not apply because State only contracts with one managed care entity

ALABAMA Partnership Hospital Program

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

-Blind/Disabled Children and Related Populations

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

Section 1902(a)(4) requires that States provide for methods of administration that the Secretary finds necessary for proper and efficient operations of State Medicaid plan. The application of the requirements of this part to PHPs that do not meet the statutory definition of MCO or to a PCCM is under the authority in Section 1902(a)(4).

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)

-Enrollee Hotlines

-Focused Studies

Use of Collected Data

-Monitor Quality Improvement

Consumer Self-Report Data

None

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

None

Collection: Standardized Forms

None

Validation: Methods

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

-Automated edits of key fields used for calculation (e.g. codes

ALABAMA

Partnership Hospital Program

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

-Procedure Codes

**State conducts general data completeness
assessments**

Yes

within an allowable range)
-Medical record validation

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-Alabama Quality Assurance Foundation

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

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

ALABAMA Patient 1st

CONTACT INFORMATION

State Medicaid Contact:

Kay Hassett
Alabama Medicaid Agency
(334) 242-5019

State Website Address:

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

PROGRAM DATA

Program Service Area:

Statewide

Initial Waiver Approval Date:

January 01, 1997

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

January 01, 1997

Statutes Utilized:

1915(b)(1)
1915(b)(3)
1915(b)(4)

Waiver Expiration Date:

December 26, 2002

Enrollment Broker:

No

Sections of Title XIX Waived:

-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

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:

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

Allowable PCPs:

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

Enrollment

ALABAMA

Patient 1st

Populations Voluntarily Enrolled:
None

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

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-Reviews complaints and grievances to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Patient 1st

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Enrollee Hotlines
-Provider Data

Use of Collected Data:

-Program Evaluation
-Track Health Service provision

Consumer Self-Report Data

None

ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: July 13, 1982
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: October 01, 1982
Statutes Utilized: Not Applicable	Waiver Expiration Date: September 30, 2006
Enrollment Broker: No	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: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(i) -1903(i)(10) Eligibility Expansion, Eligibility Simplification, Family Planning, IMD -1903(m)(2)(A)(i) -1903(m)(2)(A)(ix) -1903(m)(2)(A)(vi) -1903(m)(2)(A)(viii) -1903(m)(4)(A)&(B) HCBS
Guaranteed Eligibility: 6 months guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

Allowable PCPs:

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

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- 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

Subpopulations Excluded from Otherwise

Included Populations:

-No populations are excluded

Lock-In Provision:

12 month lock-in

ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

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

Service Delivery

Included Services:

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

Allowable PCPs:

-PCP is in Medicaid Health Plan

Contractor Types:

-Regional Authority Operated Entity (Public)

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

Subpopulations Excluded from Otherwise**Included Populations:**

-Special Needs Children (State defined)
-Special Needs Children (BBA defined)

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

None

Agencies with which Medicaid Coordinates the Operation of the Program:

None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AZ Physicians IPA (Family Planning Extension)
CIGNA Community Choice (Family Planning Extension)
Cochise Co. Dept. of Health Services (PC)

Department of Economic Security/Childrens Medical and Dental Program (HP)

AZ Physicians IPA (HP)
CIGNA Community Choice (HP)
Department of Economic Security/Childrens Medical and Dental Program (Family Planning Extension)
Department of Economic Security/Division of Developmental Disabilities (PC)

ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

Department of Health Services (Behavioral Health)
Family Health Plan of North Eastern Arizona (Family Planning Extension)
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)

Evercare Select (PC)
Family Health Plan of North Eastern Arizona (HP)
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)

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Dentist Survey
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Physician Survey
- Provider Data
- Quality Improvement Projects (QIPS)
- Quality Management/Quality Improvement Annual Plans and Annual Evaluations

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Child Medicaid AFDC Questionnaire
- Consumer/Beneficiary Focus Groups
- Disenrollment Survey
- State-developed Survey

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

Use of HEDIS

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Provided data submission requirements including documentation describing set of encounter data elements,

ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

Medicaid agency
 -Standards to ensure complete, accurate, timely encounter data submission
 Medicaid Identification Number for
 -ADA - American Dental Association dental claim form help
 -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

definitons, sets of acceptable values, standards for data processing and editing
Collection: Standardized Forms -Required use of
Validation: Methods
 beneficiaries -Automated analysis of encounter data submission to determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
 -Automated edits of key fields used for calculation (e.g. codes within an allowable range)
 -Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
 -Medical record validation
 -Per member per month analysis and comparisons across MCOs/PHPs

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Adolescent Well-Care Visits
- Adults' Access to Preventive/Ambulatory Health Services
- Alzheimers study to evaluate appropriateness of care
- Annual Dental Visits among Children (ages 3 - 20)
- Blood lead screening
- Breast Cancer Screening
- Cervical Cancer Screening
- Children's Access to Primary Care Providers
- Children's Access to Primary Care Providers - KidsCare Population
- Dental Services
- Diabetes Management (ATLCS indicator)
- Health Screenings
- Hearing Services for Individuals less than 21 years of age
- Immunization of 2 year olds
- Influenza Immunizations and Pneumococcal Vaccination Rates in the Elderly and Physically Disabled Population in Nursing Facilities and In Home Community Based Setting (ALTCS indicator)
- Initiation of Prenatal Care
- Lead Screening Rate
- Low Birth Weight Deliveries
- Number of new Perinatal cases of HIV/AIDS
- Patient Satisfaction With Care
- Percentage of beneficiaries who are satisfied with their

Health Status/Outcomes Quality

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

ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

ability to obtain care

- Prenatal Care in the First Trimester
- Timeliness of Initiation of Services (ALTCS Indicator)
- Utilization of Family Planning Services (Internal Report Only)
- Vision services for individuals less than 21 years of age
- Well-child visits at 3,4,5 and 6 years of age
- Well-child visits up to 15 month of age

Access/Availability of Care

- Alzheimer study to evaluate appropriateness of HCBS care
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of days in ICF or SNF per beneficiary over 64 years
- Number of home health visits per beneficiary
- Number of PCP visits per beneficiary
- Percentage of beneficiaries with at least one dental visit
- Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of

- Actual reserves held by plan
- Days in unpaid claims/claims outstanding
- Expenditures by medical category of service (i.e., inpatient, ER, Pharmacy, lab, x-ray, dental, vision, etc.)
- Financial Viability Ratios (i.e., Current Ratio, Medical Expense, Administrative, Equity/Member)
- Net income
- State minimum reserve requirements
- Total revenue

Health Plan/ Provider Characteristics

- Languages Spoken (other than English)

Beneficiary Characteristics

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

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Well-Care visits
- 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
- Influenza immunizations and Pneumococcal vaccination rates in the Elderly and Physically Disabled population in nursing facilities and home and community based settings
- 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/EPSTD

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/PHP Standards

- CMS's Quality Improvement System for Managed Care (QISM) 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

None

Accreditation for Deeming

None

EQRO Name

- Health Services Advisory Group
- William Mercer

EQRO Organization

- Quality Improvement Organization

EQRO Activities

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

ARKANSAS

Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Roy Jeffus
Medicaid Agency
(501) 682-1671

State Website Address:

<http://www.medicaid.state.ar.us>

PROGRAM DATA

Program Service Area:

County

Initial Waiver Approval Date:

February 19, 1998

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

March 01, 1998

Statutes Utilized:

1915(b)(1)
1915(b)(4)

Waiver Expiration Date:

August 22, 2003

Enrollment Broker:

No

Sections of Title XIX Waived:

-1902(a)(23) Freedom of Choice

For All Areas Phased-In:

No

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

Guaranteed Eligibility:

None

SERVICE DELIVERY

Transportation PHP - Full Capitation

Service Delivery

Included Services:

Non-Emergency Transportation

Allowable PCPs:

-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

15

ARKANSAS

Non-Emergency Transportation

Subpopulations Excluded from Otherwise Included Populations:

- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- QMB
- Special low income beneficiaries
- Qualified individuals 1 and 2
- 1115 demonstration waivers

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Not Applicable

Agencies with which Medicaid Coordinates the Operation of the Program:

- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

The state contracts with transportation brokers on a capitation basis.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Field Audits
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Provider Data

Use of Collected Data

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

Consumer Self-Report Data

- State-developed Survey

Use of HEDIS

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

None

Collection: Standardized Forms

None

Validation: Methods

- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP

ARKANSAS

Non-Emergency Transportation

commercial utilization rates, comparisons to national norms,
comparisons to submitted bills
-Medical record validation

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

-Provider ID
-Type of Service
-Medicaid Eligibility

State conducts general data completeness assessments

Yes

Standards/Accreditation

MCO/PHP Standards

-State-Developed/Specified Standards

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-Arkansas Foundation for Medical Care

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

-Administration or validation of consumer or provider surveys

ARKANSAS

Primary Care Physician

CONTACT INFORMATION

State Medicaid Contact:

Roy Jeffus
State Medicaid Agency
(501) 682-1671

State Website Address:

<http://www.medicaid.state.ar.us>

PROGRAM DATA

Program Service Area:

Statewide

Initial Waiver Approval Date:

October 30, 1996

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

November 01, 1996

Statutes Utilized:

1915(b)(1)

Waiver Expiration Date:

December 17, 2004

Enrollment Broker:

No

Sections of Title XIX Waived:

-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

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:

Case Management, Durable Medical Equipment, EPSDT(25 counties), Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Physician, Podiatry, X-Ray

Allowable PCPs:

-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Area Health Education Centers (AHECs)
-Pediatricians
-General Practitioners
-Family Practitioners

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

ARKANSAS

Primary Care Physician

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

Subpopulations Excluded from Otherwise Included Populations:

- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Eligibility Period that is Retroactive
- Medically Needy "Spendedown" Categories

Lock-In Provision:

6 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Connect Care

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Enrollee Hotlines
- 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

None

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

- Number of children with diagnosis of rubella(measles)/1,000 children
- Percentage of low birth weight infants

ARKANSAS

Primary Care Physician

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
Altamed Senior Buenacare
CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
September 28, 1998

Operating Authority:
1115 - Demonstration Waiver Program

Implementation Date:
November 01, 1998

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
November 24, 2002

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewide
-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:
-1903(f)(4)(C)
-1903(m)(A)(I)(II)

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

Long Term Care MCO - Full Capitation

Service Delivery

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

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

Enrollment

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

Populations Mandatorily Enrolled:
None

CALIFORNIA

Altamed Senior Buenacare

Subpopulations Excluded from Otherwise Included Populations:

- Poverty Level Pregnant Woman
- Enrolled in Another Managed Care Program
- Special Needs Children

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Health fairs, presentations to Senior Groups
- Mass Mailings to Potential Enrollees
- Uses eligibility data to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Altamed Senior BuenaCare

ADDITIONAL INFORMATION

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

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Does not Collect Quality Data

Use of Collected Data

- Not Applicable

Consumer Self-Report Data

None

Use of HEDIS

- Not Applicable

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

- Not Applicable

CALIFORNIA
Altamed Senior Buenacare

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA

Caloptima

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: October 01, 1995
Operating Authority: 1915(b) - Waiver Program	Implementation Date: October 01, 1995
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: July 29, 2003
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
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

Included Services: Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Long Term Care, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Nurse Practitioners -Federally Qualified Health Centers (FQHCs) -Nurse Midwives -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists
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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

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility data to identify members of these groups
- Uses other means to identify members of these groups - program linkage and/or family contact
- Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Caloptima

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

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

Consumer Self-Report Data

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

Use of HEDIS

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

CALIFORNIA

Caloptima

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

Encounter Data

Collection: Requirements

-Specifications for the submission of encounter data to the
Medicaid agency

Collections: Submission Specifications

-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms

None

Validation: Methods

None

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

None

State conducts general data completeness assessments

No

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

None

Access/Availability of Care

None

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

-Childhood Immunization
-Well Child Care/EPSTD

Non-Clinical Topics

-Availability of language interpretation services

CALIFORNIA

Caloptima

Standards/Accreditation

MCO/PHP Standards

None

Accreditation for Deeming

None

EQRO Organization

-Private Accreditation Organization

Accreditation Required for Participation

None

EQRO Name

-Health Services Advisory Group

EQRO Activities

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

**CALIFORNIA
Center For Elders Independence**

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
April 04, 1995

Operating Authority:
1115 - Demonstration Waiver Program

Implementation Date:
April 01, 1995

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
November 24, 2002

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewide
-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:
-1903(a)(23)
-1903(m)(2)(A)(I)(II)

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

Long Term Care MCO - Full Capitation

Service Delivery

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

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

Enrollment

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

Populations Mandatorily Enrolled:
None

CALIFORNIA

Center For Elders Independence

Subpopulations Excluded from Otherwise

Included Populations:

- Poverty Level Pregnant Woman
- Enrolled in Another Managed Care Program
- Special Needs Children

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Health Fairs, presentations, Senior Groups
- Mass Mailings to Potential Enrollees
- Uses eligibility data to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Centers for Elders Independence

ADDITIONAL INFORMATION

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

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Does not Collect Quality Data

Use of Collected Data

-Not Applicable

Consumer Self-Report Data

None

Use of HEDIS

-Not Applicable

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Not Applicable

CALIFORNIA

Center For Elders Independence

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA

Central Coast Alliance for Health

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: January 01, 1996
Operating Authority: 1915(b) - Waiver Program	Implementation Date: January 01, 1996
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: June 02, 2003
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 -OBRA 1985 & 1990
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(2)(A)(ii)and(vi)
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

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

CALIFORNIA

Central Coast Alliance for Health

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

Subpopulations Excluded from Otherwise

Included Populations:

- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility data to identify members of these groups
- Uses other means to identify members of these groups - program linkage and/or family contact
- Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Central Coast Alliance for Health

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

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

Consumer Self-Report Data

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

Use of HEDIS

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

CALIFORNIA

Central Coast Alliance for Health

- State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous enrollment requirement for some or all of the measures
- State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous enrollment

Encounter Data

Collection: Requirements

-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of "home grown" forms

Collection: Standardized Forms

None

Validation: Methods

None

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

None

State conducts general data completeness assessments

No

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

None

Access/Availability of Care

None

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Childhood Immunization
- Well Child Care/EPSTD

CALIFORNIA

Central Coast Alliance for Health

Non-Clinical Topics

-Availability of language interpretation services

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-Health Services Advisory Group

EQRO Organization

-Private Accreditation Organization

EQRO Activities

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

CALIFORNIA
Health Plan of San Mateo
CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: November 30, 1987
Operating Authority: 1915(b) - Waiver Program	Implementation Date: November 30, 1987
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: August 26, 2004
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)(30) -1902(a)(5)
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: -OBRA 1985 & 1990-1903(m)(2)(A)(ii)and(vi)
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

Included Services: Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Obstetricians/Gynecologists or Gynecologists -Nurse Midwives -Indian Health Service (IHS) Providers
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Enrollment

CALIFORNIA

Health Plan of San Mateo

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

Subpopulations Excluded from Otherwise

Included Populations:

- Reside in ICF/MR

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility 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 CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

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

Consumer Self-Report Data

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

Use of HEDIS

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

CALIFORNIA

Health Plan of San Mateo

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

Encounter Data

Collection: Requirements

-Specifications for the submission of encounter data to the
Medicaid agency

Collections: Submission Specifications

-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms

None

Validation: Methods

None

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

None

State conducts general data completeness assessments

No

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care
-Check-ups after delivery
-Diabetes management
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

Health Status/Outcomes Quality

None

Access/Availability of Care

None

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)

Non-Clinical Topics

-Improving the Quality of Pediatric Data
-Initial Health Assessments

CALIFORNIA

Health Plan of San Mateo

Standards/Accreditation

MCO/PHP Standards

None

Accreditation for Deeming

None

EQRO Organization

-Private Accreditation Organization

Accreditation Required for Participation

None

EQRO Name

-Health Services Advisory Group

EQRO Activities

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

CALIFORNIA Hudman

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: April 24, 1992
Operating Authority: 1915(b) - Waiver Program	Implementation Date: April 24, 1992
Statutes Utilized: 1915(b)(4)	Waiver Expiration Date: July 15, 2003
Solely Reimbursement Arrangement: Yes	Sections of Title XIX Waived: -1902(a)(23) Freedom of Choice
	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

ADDITIONAL INFORMATION

This waiver is a mechanism for placement in freestanding nursing facilities rather than hospital based distinct part nursing facilities unless waiver exemptions allow residents to remain in distinct part nursing facilities.

CALIFORNIA Managed Care Network

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: February 28, 1997
Operating Authority: 1915(b) - Waiver Program	Implementation Date: March 01, 1997
Statutes Utilized: 1915(b)(1) 1915(b)(2) 1915(b)(4)	Waiver Expiration Date: May 18, 2003
Enrollment Broker: No	Sections of Title XIX Waived: -1902(a)(1) Statewide -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

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, EPSDT, Family Planning, Health Education and Preventive, Home Health, Immunization, Laboratory, Outpatient Hospital, Physician, Transportation, X-Ray

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

CALIFORNIA Managed Care Network

Enrollment

Populations Voluntarily Enrolled:

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

Subpopulations Excluded from Otherwise

Included Populations:

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

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- County Medical Services Program Eligibles

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility data to identify members of these groups
- Uses other means to identify members of these groups - program linkage and/or family contact
- Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Placer County Managed Care Network

Sonoma County Managed Care Network

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Complaint log review
- Consumer Self-Report Data
- On-Site Reviews
- Provider Data
- Quality Improvement Committee monthly meetings

Use of Collected Data:

-None

CALIFORNIA Managed Care Network

Consumer Self-Report Data
-Not Applicable

CALIFORNIA

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

CONTACT INFORMATION

State Medicaid Contact: Rita McCabe-Hax
Managed Care Implementation
(916) 654-5691

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: February 13, 1995
Operating Authority: 1915(b) - Waiver Program	Implementation Date: April 01, 1995
Statutes Utilized: 1915(b)(4)	Waiver Expiration Date: July 29, 2003
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
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

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

Service Delivery

Included Services: Inpatient Mental Health, Outpatient Mental Health, Pharmacy, Pharmacy-related laboratory	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 -Other(State-Only Medi-Cal and Emergency Services Only populations) -Section 1931 (AFDC/TANF) Children and Related
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CALIFORNIA

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

Subpopulations Excluded from Otherwise

Included Populations:

-Not Applicable

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-Children with Special Health Care Needs as required by CMS

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency Populations

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

One Prepaid Health Plan

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Not Applicable

Use of Collected Data:

-Not Applicable

Consumer Self-Report Data

None

CALIFORNIA

Medi-Cal Specialty Mental Health Services Consolidation

CONTACT INFORMATION

State Medicaid Contact:

Rita McCabe-Hax
Managed Care Implementation
(916) 654-5691

State Website Address:

<http://www.dmh.cahwnet.gov>

PROGRAM DATA

Program Service Area:

Statewide (Except Solano and S

Initial Waiver Approval Date:

March 15, 1995

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

March 15, 1995

Statutes Utilized:

1915(b)(4)

Waiver Expiration Date:

November 19, 2002

Enrollment Broker:

No

Sections of Title XIX Waived:

-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

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

Service Delivery

Included Services:

Inpatient Mental Health, Outpatient Mental Health, Targeted
Case Management

Allowable PCPs:

-Not Applicable

Contractor Types:

None

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

CALIFORNIA

Medi-Cal Specialty Mental Health Services Consolidation

Subpopulations Excluded from Otherwise Included Populations:
-Not Applicable

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

-Children with special health care needs as required by CMS

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

54 Prepaid Health Plans

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Not Applicable

Use of Collected Data:
-Not Applicable

Consumer Self-Report Data
None

CALIFORNIA

On Lok Senior Health Services

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: November 01, 1983
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: November 01, 1983
Statutes Utilized: Not Applicable	Waiver Expiration Date: November 24, 2002
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
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(f)(4)(C) -1903(m)(A)(I)(II)
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

Long Term Care MCO - Full Capitation

Service Delivery

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

Populations Voluntarily Enrolled: -Blind/Disabled Adults and Related Populations -Aged and Related Populations	Populations Mandatorily Enrolled: None
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CALIFORNIA

On Lok Senior Health Services

Subpopulations Excluded from Otherwise

Included Populations:

- Poverty Level Pregnant Woman
- Enrolled in Another Managed Care Program
- Special Needs Children

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Health Fairs, presentations Senior Groups
- Mass Mailings to Potential Enrollees
- Uses eligibility data to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

On Lok

ADDITIONAL INFORMATION

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

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Does Not Collect Quality Data

Use of Collected Data

-Not Applicable

Consumer Self-Report Data

None

Use of HEDIS

-Not Applicable

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Not Applicable

CALIFORNIA

On Lok Senior Health Services

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA

Partnership Health Plan of California

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: May 01, 1994
Operating Authority: 1915(b) - Waiver Program	Implementation Date: May 01, 1994
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: February 10, 2003
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 -OBRA 1985 & 1990
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(2)(A)(ii) and (vi)
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

Included Services: Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health (Solano Co. only), Laboratory, Long Term Care - Counseling and Social Support, Outpatient Hospital, Outpatient Mental Health (Solano County only), Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Pediatricians -General Practitioners
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Enrollment

CALIFORNIA

Partnership Health Plan of California

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

Subpopulations Excluded from Otherwise

Included Populations:

- Participate in HCBS Waiver

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility data to identify members of these groups
- Uses other means to identify members of these groups - program linkage and/or family contact
- Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Partnership Health Plan

ADDITIONAL INFORMATION

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

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

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

Consumer Self-Report Data

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

Use of HEDIS

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

CALIFORNIA

Partnership Health Plan of California

collects, BUT modifies the continuous enrollment requirement for some or all of the measures
-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous enrollment

Encounter Data

Collection: Requirements

-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms

None

Validation: Methods

None

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

None

State conducts general data completeness assessments

No

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

None

Access/Availability of Care

None

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

-Childhood Immunization
-Well Child Care/EPSTD

Non-Clinical Topics

-Availability of language interpretation services

CALIFORNIA

Partnership Health Plan of California

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-Health Services Advisory Group

EQRO Organization

-Private Accreditation Organization

EQRO Activities

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

-Validation of performance improvement projects

-Validation of performance measures

CALIFORNIA Prepaid Health Plan Program

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: January 01, 1972
Statutes Utilized: 1915(b)(4)	Waiver Expiration Date: Not Applicable
Enrollment Broker: 1) Health Care Options for Marin County 2) Partners for Health Managed Care Network for Sonoma County	Sections of Title XIX Waived: None
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision,	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Nurse Practitioners -Nurse Midwives
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Enrollment

Populations Voluntarily Enrolled: -Blind/Disabled Adults and Related Populations -Blind/Disabled Children and Related Populations -Aged and Related Populations	Populations Mandatorily Enrolled: None
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CALIFORNIA

Prepaid Health Plan Program

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

Subpopulations Excluded from Otherwise

Included Populations:

- Other Insurance
- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver

Lock-In Provision:

No lock-in

Dental PHP - Full Capitation

Service Delivery

Included Services:

Dental

Allowable PCPs:

-Dentists

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

Enrollment

Populations Voluntarily Enrolled:

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

Populations Mandatorily Enrolled:

None

Subpopulations Excluded from Otherwise

Included Populations:

- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver
- Populations residing outside plans service area defined by contract

Lock-In Provision:

No lock-in

CALIFORNIA Prepaid Health Plan Program

PHP (Only for Emotional Support) - Full Capitation

Service Delivery

Included Services:
Emotional Support

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Mental Health

Populations Mandatorily Enrolled:
None

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

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan
Care 1st Health Plan-Dental PHP
Kaiser Foundation
San Francisco City
UHP Healthcare-Dental
Western Dental Services

American Health Guard-Dental Plan
Foundation Dental
Maxicare Dental PHP
Tower Health Care-Dental PHP
Universal Care-Dental

ADDITIONAL INFORMATION

San Francisco City under this program only provides emotional support to severely emotionally disturbed children.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Does Not Collect Quality Data

Use of Collected Data

-Not Applicable

CALIFORNIA

Prepaid Health Plan Program

Consumer Self-Report Data
-Not Applicable

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA

Primary Care Case Management Program

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: December 20, 1982
Operating Authority: 1915(b) - Waiver Program	Implementation Date: August 01, 1984
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: February 04, 2004
Enrollment Broker: No	Sections of Title XIX Waived: -1902(a)(30) Upper Payment Limit
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Medical-only PHP - Full Capitation

Service Delivery

Included Services: Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Laboratory, Outpatient Hospital, Pharmacy, Physician, Specialty Mental Health, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Nurse Practitioners -Nurse Midwives -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists
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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	Populations Mandatorily Enrolled: None
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CALIFORNIA

Primary Care Case Management Program

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

Subpopulations Excluded from Otherwise Included Populations:

- Eligibility Period Less Than 3 Months
- Poverty Level Pregnant Woman
- Member approved for a Major Organ Transplant

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Plan is responsible to identify this group

Agencies with which Medicaid Coordinates the Operation of the Program:

- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Positive Healthcare/AIDS Health Care

ADDITIONAL INFORMATION

PCPs contract to provide and assume risk for primary care, specialty physician services, and selected outpatient preventive and treatment services. The Program is designed for people living with AIDS.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Does Not Collect Quality Data

Use of Collected Data

- Not Applicable

Consumer Self-Report Data

None

Use of HEDIS

- Not Applicable

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

- Not Applicable

CALIFORNIA

Primary Care Case Management Program

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA

Sacramento Geographic Managed Care

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: January 01, 1994
Operating Authority: 1915(b) - Waiver Program	Implementation Date: April 01, 1994
Statutes Utilized: 1915(b)(1) 1915(b)(2) 1915(b)(4)	Waiver Expiration Date: November 10, 2002
Enrollment Broker: Health Care Options/Maximus	Sections of Title XIX Waived: -1902(a)(1) Statewideness -1902(a)(10)(B) Comparability of Services -1902(a)(23) Freedom of Choice -1902(a)(5)
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) - Full 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 Abuse, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray	Allowable PCPs: -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Nurse Practitioners -Nurse Midwives -Indian Health Service (IHS) Providers -Psychiatrists -Pediatricians -Family Practitioners -Internists -General Practitioners
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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

Subpopulations Excluded from Otherwise Included Populations:

- Reside in Nursing Facility or ICF/MR
- Eligibility Period Less Than 3 Months
- Participate in HCBS Waiver

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

Lock-In Provision:

No lock-in

Dental PHP - Full Capitation

Included Services:

Dental

Service Delivery

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

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

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

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility data to identify members of these groups
- Uses other means to identify members of these groups - program linkage and/or family contact
- Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

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

CALIFORNIA

Sacramento Geographic Managed Care

- Public Health Agency
- Social Services Agency
- Substance Abuse Agency
- Title V

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan-Sacramento GMC
Delta Dental Plan
Health Net-Sacramento GMC
Maxicare-Sacramento GMC
Western Dental Services-Sacramento GMC

Blue Cross of California-Sacramento GMC
Dentcare of California-Sacramento GMC
Kaiser Foundation-Sacramento GMC
Molina Medical Centers-Sacramento GMC
Western Health Advantage-Sacramento GMC

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid Questionnaire
 - Child Medicaid Questionnaire

Use of Collected Data

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

Use of HEDIS

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

Encounter Data

Collection: Requirements

- Specifications for the submission of encounter data to the Medicaid agency

Collection: Standardized Forms

- ANSI ASC X12 837 - transaction set format for transmitting health care claims data
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- National Drug Code assigned by the Federal Drug Administration
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing

Collections: Submission Specifications

- Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission

Validation: Methods

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

CALIFORNIA

Sacramento Geographic Managed Care

data between trading partners, such as hospitals, long term care facilities

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

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

State conducts general data completeness assessments

No

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

None

Access/Availability of Care

None

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Asthma management
- Breathe with ease (a comprehensive multi-disciplinary health management system for children with asthma)
- CHDP documentation
- Childhood Immunization
- Improving the quality of asthma care and reduction of inappropriate use of services through patient self-management
- Pediatric preventive services

Non-Clinical Topics

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

CALIFORNIA

Sacramento Geographic Managed Care

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-Health Services Advisory Group

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

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

CALIFORNIA

San Diego Geographic Managed Care

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: October 17, 1998
Operating Authority: 1915(b) - Waiver Program	Implementation Date: October 17, 1998
Statutes Utilized: 1915(b)(1) 1915(b)(2) 1915(b)(4)	Waiver Expiration Date: October 10, 2003
Enrollment Broker: Health Care Options/Maximus	Sections of Title XIX Waived: -1902(a)(1) Statewideness -1902(a)(10)(B) Comparability of Services -1902(a)(23) Freedom of Choice -1902(a)(5), 1902(a)(30)
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) - Full 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:

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

CALIFORNIA

San Diego Geographic Managed Care

Enrollment

Populations Voluntarily Enrolled:

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

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

Populations Mandatorily Enrolled:

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

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility data to identify members of these groups
- 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:

- 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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross of California-San Diego GMC
Health Net-San Diego GMC
Sharp Health Plan
Universal Care

Community Health Group
Kaiser Foundation-San Diego GMC
UCSD Health Plan

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

CALIFORNIA

San Diego Geographic Managed Care

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)

Consumer Self-Report Data

- Adult and child English and Spanish
- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Child Medicaid AFDC Questionnaire

Use of Collected Data

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

Use of HEDIS

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

Encounter Data

Collection: Requirements

- Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

- Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission

Collection: Standardized Forms

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

Validation: Methods

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

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

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

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

State conducts general data completeness assessments

No

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

None

CALIFORNIA

San Diego Geographic Managed Care

Access/Availability of Care

None

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Childhood Immunization
- Well Child Care/EPSTD

Non-Clinical Topics

- Availability of language interpretation services

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

- Health Services Advisory Group

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

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

CALIFORNIA

Santa Barbara Health Initiative

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: September 01, 1983
Operating Authority: 1915(b) - Waiver Program	Implementation Date: September 01, 1983
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: January 11, 2003
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
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

Included Services: Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education and Counseling, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Practitioners -Nurse Midwives -Indian Health Service (IHS) Providers
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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
- All Categories of Federally Eligible Medi-Cal Beneficiaries

Subpopulations Excluded from Otherwise Included Populations:

- Eligibility Period Less Than 3 Months

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility data to identify members of these groups
- Uses other means to identify members of these groups - program linkage and/or family contact
- Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Families
Santa Barbara Health Initiative

Pre-Natal Plus 2

ADDITIONAL INFORMATION

Established under State Statute of 1982.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

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

Consumer Self-Report Data

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

Use of HEDIS

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

CALIFORNIA

Santa Barbara Health Initiative

for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous enrollment requirement for some or all of the measures
-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous enrollment

Encounter Data

Collection: Requirements

-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

-Deadlines for regular/ongoing encounter data submission(s)

Collection: Standardized Forms

None

Validation: Methods

None

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

None

State conducts general data completeness assessments

No

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

None

Access/Availability of Care

None

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

-Childhood Immunization
-Well Child Care/EPSTD

Non-Clinical Topics

-Availability of language interpretation services

CALIFORNIA

Santa Barbara Health Initiative

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Health Services Advisory Group

EQRO Organization

-Private Accreditation Organization

EQRO Activities

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

-Validation of performance improvement projects

-Validation of performance measures

CALIFORNIA

Selective Provider Contracting Program

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: September 21, 1982
Operating Authority: 1915(b) - Waiver Program	Implementation Date: September 21, 1982
Statutes Utilized: 1915(b)(4)	Waiver Expiration Date: October 31, 2002
Solely Reimbursement Arrangement: Yes	Sections of Title XIX Waived: -1902(a)(13) -1902(a)(23) Freedom of Choice -1902(a)(30) -1902(a)(5)
Guaranteed Eligibility: None	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 Senior Care Action Network

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
June 07, 1985

Operating Authority:
1115 - Demonstration Waiver Program

Implementation Date:
January 01, 1985

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
July 31, 2003

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)(30)
-1902(e)(2)(A)

For All Areas Phased-In:
No

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

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

Social HMO - Full 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, Speech Therapy, Transportation, Vision, X-Ray

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

Enrollment

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

Populations Mandatorily Enrolled:
None

CALIFORNIA

Senior Care Action Network

Subpopulations Excluded from Otherwise

Included Populations:

- Poverty Level Pregnant Woman
- Enrolled in Another Managed Care Program
- Eligibility Period Less Than 3 Months
- Special Needs Children

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-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

ADDITIONAL INFORMATION

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

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Does Not Collect Quality Data

Use of Collected Data

-Not Applicable

Consumer Self-Report Data

None

Use of HEDIS

-Not Applicable

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Not Applicable

CALIFORNIA

Senior Care Action Network

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA

Sutter Senior Care

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
July 14, 1994

Operating Authority:
1115 - Demonstration Waiver Program

Implementation Date:
May 01, 1994

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
November 24, 2002

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewide
-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:
-1903(f)(4)(c)
-1903(m)(2)(A)(I)(II)

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

Long Term Care MCO - Full Capitation

Service Delivery

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

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

Enrollment

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

Populations Mandatorily Enrolled:
None

CALIFORNIA

Sutter Senior Care

Subpopulations Excluded from Otherwise

Included Populations:

- Poverty Level Pregnant Woman
- Enrolled in Another Managed Care Program
- Special Needs Children

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Health Fairs, presentations, Senior Groups
- Uses eligibility data to identify members of these groups
- Uses mass mailings to potential enrollees

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Sutter Senior Care

ADDITIONAL INFORMATION

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

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Does Not Collect Quality Data

Use of Collected Data

-Not Applicable

Consumer Self-Report Data

None

Use of HEDIS

-Not Applicable

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Not Applicable

CALIFORNIA

Sutter Senior Care

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA

Two-Plan Model Program

CONTACT INFORMATION

State Medicaid Contact:

Cheri Rice
Medi-Cal Managed Care Division
(916) 654-8076

State Website Address:

<http://www.dhs.ca.gov>

PROGRAM DATA

Program Service Area:

County

Initial Waiver Approval Date:

January 22, 1996

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

January 23, 1996

Statutes Utilized:

1915(b)(1)
1915(b)(2)
1915(b)(4)

Waiver Expiration Date:

November 08, 2003

Enrollment Broker:

Health Care Options/Maximus

Sections of Title XIX Waived:

-1902(a)(1) Statewide
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

For All Areas Phased-In:

Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

Guaranteed Eligibility:

No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, 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, Vision, X-Ray

Allowable PCPs:

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

Enrollment

CALIFORNIA

Two-Plan Model Program

Populations Voluntarily Enrolled:

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

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related

Subpopulations Excluded from Otherwise

Included Populations:

- Poverty Level Pregnant Woman
- Reside in Nursing Facility or ICF/MR
- Eligibility Period Less Than 3 Months
- Participate in HCBS Waiver

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility data to identify members of these groups
- Uses other means to identify members of these groups - program linkage and/or family contact
- Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Alameda Alliance for Health
Contra Costa Health Plan
Health Plan of San Joaquin
Kern Family Health Care
Molina Medical Centers-TPMP
Santa Clara Family Health Plan

Blue Cross of California-TPMP
Health Net-TPMP
Inland Empire Health Plan
LA Care Health Plan
San Francisco Health Plan

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

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

CALIFORNIA

Two-Plan Model Program

Consumer Self-Report Data

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

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
- State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous enrollment requirement for some or all of the measures
- State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous enrollment

Encounter Data

Collection: Requirements

- Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

- Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission

Collection: Standardized Forms

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

Validation: Methods

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

- National Drug Codes assigned by the Federal Drug Administration

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

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

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

State conducts general data completeness assessments

No

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

None

Access/Availability of Care

None

Use of Services/Utilization

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

CALIFORNIA

Two-Plan Model Program

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

-Childhood Immunization
-Well Child Care/EPSTD

Non-Clinical Topics

-Availability of language interpretation services

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

COLORADO

Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

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

State Website Address:

<http://www.CHCPF.state.co.us>

PROGRAM DATA

Program Service Area:

Statewide

Initial Waiver Approval Date:

August 01, 1982

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

May 01, 1983

Statutes Utilized:

1915(b)(1)
1915(b)(2)

Waiver Expiration Date:

April 14, 2003

Enrollment Broker:

MAXIMUS, INC.

Sections of Title XIX Waived:

-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

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:

Case Management, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Outpatient Hospital, Physician, Skilled Nursing Facility

Allowable PCPs:

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

Enrollment

Populations Voluntarily Enrolled:

-Aged and Related Populations

Populations Mandatorily Enrolled:

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

COLORADO

Managed Care Program

-Foster Care Children
-Medicare Dual Eligible

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

Subpopulations Excluded from Otherwise

Included Populations:

-Enrolled in Another Managed Care Program
-Presumptive Eligible

Lock-In Provision:

12 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

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

Allowable PCPs:

-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:

-Aged and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:

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

Subpopulations Excluded from Otherwise

Included Populations:

-Enrolled in Another Managed Care Program
-Presumptive Eligible

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Colorado Access
Kaiser

Community Health Plan of the Rockies
Primary Care Physician Program

COLORADO Managed Care Program

Rocky Mountain HMO
United Healthcare of Colorado

Total Long Term Care

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Deeming (see below for details)
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data

- Beneficiary Plan Selection
- Contract Standard Compliance
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation

Consumer Self-Report Data

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

Use of HEDIS

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

Encounter Data

Collection: Requirements

- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

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

Collection: Standardized Forms

None

Validation: Methods

-Not Applicable

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

None

State conducts general data completeness assessments

No

Performance Measures

COLORADO

Managed Care Program

Process Quality

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

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

- Average wait time for an appointment with PCP

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of None

Health Plan/ Provider Characteristics None

Beneficiary Characteristics

- MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements

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

Clinical Topics

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

Non-Clinical Topics

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

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for Participation

- None

Accreditation for Deeming

- NCQA (National Committee for Quality Assurance)

EQRO Name

- First Peer Review of Colorado

EQRO Organization

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

EQRO Activities

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

COLORADO

Managed Care Program

Quality Oversight Activities:

- Consumer Self-Report Data
- Focused Studies
- Ombudsman
- Performance Improvements Projects (see below for details)
- Provider Data
- Performance Measures (see below for details)

Use of Collected Data:

- Monitor Quality Improvement
- Provider Profiling
- Track Health Service provision

Consumer Self-Report Data

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

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

- Average wait time for an appointment with primary care case manager

Use of Services/Utilization

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

Provider Characteristics

None

Beneficiary Characteristics

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

Performance Improvement Projects

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSTD
- Childhood Immunization
- Pre-natal care
- Well Child Care/EPSTD

Non-Clinical Topics

- Availability of language interpretation services

COLORADO

Mental Health Capitation Program

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: October 04, 1993
Operating Authority: 1915(b) - Waiver Program	Implementation Date: July 01, 1995
Statutes Utilized: 1915(b)(1) 1915(b)(3) 1915(b)(4)	Waiver Expiration Date: April 09, 2003
Enrollment Broker: No	Sections of Title XIX Waived: -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: None	

SERVICE DELIVERY

Mental Health (MH) PHP - Full Capitation

Service Delivery

Included Services: Crisis, IMD, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support	Allowable PCPs: -Not applicable, contractors not required to identify PCPs
Contractor Types: -Behavioral Health MCO (Private) -CMHC Operated Entity (Public)	

Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Section 1931 (AFDC/TANF) Adults and Related Populations -Blind/Disabled Adults and Related Populations -Aged and Related Populations
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COLORADO

Mental Health Capitation Program

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

Subpopulations Excluded from Otherwise

Included Populations:

-No populations are excluded

Lock-In Provision:

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Behavioral Care
Mental Health Center of Boulder
Northeast Behavioral Health
West Slope-Options Colorado Health Networks

Behavioral Healthcare, Inc.
North Range Behavioral
SyCare-Options Colorado Health Networks

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-Mental Health Statistics Improvement Program (MHSIP)

Use of HEDIS

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

None

COLORADO

Mental Health Capitation Program

- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for MCOs to collect and maintain encounter data

Collection: Standardized Forms

None

Validation: Methods

- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Medical record validation
- Per member per month analysis and comparisons across MCOs/PHPs

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

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

- Average wait time for an appointment with PCP

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

- Languages Spoken (other than English)
- Provider turnover

Beneficiary Characteristics

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

Standards/Accreditation

MCO/PHP Standards

- State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

- Not Applicable

EQRO Organization

- Not Applicable

EQRO Activities

- Validation of performance improvement projects

**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

Initial Waiver Approval Date:
July 20, 1995

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
October 01, 1995

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

Waiver Expiration Date:
May 30, 2004

Enrollment Broker:
Benova

Sections of Title XIX Waived:
-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:
6 months guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

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

Allowable PCPs:

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

Enrollment

CONNECTICUT HUSKY A

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Foster Care Children
- Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

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

Lock-In Provision:

12 months lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of the Balanced Budget Act group.

Agencies with which Medicaid Coordinates the Operation of the Program:

- Child Welfare Agency
- Education Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem Blue Care Family Plan
FirstChoice Health Plan- Preferred One

Community Health Network of Connecticut
HealthNet - Healthy Options

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

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

CONNECTICUT HUSKY A

-Provider Data

-Track Health Service provision

Consumer Self-Report Data

-CAHPS

Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

Use of HEDIS

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

Collection: Standardized Forms

None

Validation: Methods

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

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

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

None

CONNECTICUT HUSKY A

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

Access/Availability of Care

- Ratio of Dental Providers to beneficiaries
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCP's to beneficiaries

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

- Days cash on hand
- Days in unpaid claims/claims outstanding
- Medical loss ratio
- Net income
- Net worth
- Total revenue

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Asthma management
- Child/Adolescent Dental Screening and Services

Non-Clinical Topics

None

Standards/Accreditation

MCO/PHP Standards

- NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

- Qualidigm

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

- Conduct performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- On-site operations reviews
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters

DELAWARE

Diamond State Health Plan

CONTACT INFORMATION

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

State Website Address: DSS.State.De.Us

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: July 27, 1995
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: January 01, 1996
Statutes Utilized: Not Applicable	Waiver Expiration Date: March 15, 2004
Enrollment Broker: EDS, Inc.	Sections of Title XIX Waived: -1902(a)(10) -1902(a)(10)(B) -1902(a)(13)(E) -1902(a)(23) Freedom of Choice -1902(a)(30)(A) -1902(a)(34)
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(2)(A)(ii)(vi) -1903(m)(2)(A)(vi) Eligibility Expansion, Family Planning, IMD
Guaranteed Eligibility: 6 months guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: All Other Delaware Medicaid Services, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Skilled Nursing Facility, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Nurse Practitioners -Nurse Midwives -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Other Specialists Approved on a Case-by-Case Basis
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DELAWARE

Diamond State Health Plan

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
- Aged and Related Populations
- Pregnant Women
- Expanded Population Adults Under 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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Asks advocacy groups to identify members of these groups
- Enrollment Broker Contacts
- State developed advocacy group (Delawearns with Special Needs
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Easter Seals
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coventry/DelawareCare

First State Health Plan

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- CAHPS- Partially
- Consumer Self-Report Data (see below for details)

Use of Collected Data

- Contract Standard Compliance
- Fraud and Abuse

DELAWARE

Diamond State Health Plan

- Encounter Data (see below for details)
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman
- On-Site Reviews
- Performance Improvements Projects (see below for details)

- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation

Consumer Self-Report Data

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

Use of HEDIS

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

- Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Validation: Methods

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

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

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

State conducts general data completeness assessments

Yes

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Immunization
- Asthma management
- Beta Blocker treatment after a heart attack
- Breast cancer screening (Mammography)
- Cervical cancer screening (Pap Test)
- Childhood Immunization
- Diabetes management
- Otitis Media management
- Sickle cell anemia management

DELAWARE

Diamond State Health Plan

Non-Clinical Topics

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

Standards/Accreditation

MCO/PHP Standards

- CMS's Quality Improvement System for Managed Care (QISM) Standards for Medicaid and Medicare

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Delmarva Foundation/Mercer

EQRO Organization

- PRO-like Entity

EQRO Activities

- Conduct performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters
- Validation of performance improvement projects

DISTRICT OF COLUMBIA

District of Columbia Medicaid Managed Care Program

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: April 01, 1993
Operating Authority: 1915(b) - Waiver Program	Implementation Date: April 01, 1994
Statutes Utilized: 1915(b)(1) 1915(b)(2) 1915(b)(4)	Waiver Expiration Date: September 23, 2003
Enrollment Broker: ACS, Inc.	Sections of Title XIX Waived: -1902(a)(10)(B) Comparability of Services -1902(a)(23) Freedom of Choice
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: 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 Abuse, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Nurse Practitioners -Nurse Midwives -Addictionologists -Clinical Social Workers -Psychologists -Psychiatrists -Other Specialists Approved on a Case-by-Case Basis
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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
- Foster Care Children

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Advantage Health, Incorporated
DC Chartered Health Plan, Incorporated

Americaid Community Care
Health Right, Incorporated

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Participation (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- 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/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous 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

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

DISTRICT OF COLUMBIA

District of Columbia Medicaid Managed Care Program

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

Collection: Standardized Forms

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

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

- Date of Service
- Date of Processing

- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
- Medical record validation
- Per member per month analysis and comparisons across MCOs/PHPs
- Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments

No

Performance Measures

Process Quality

- Adolescent immunization rate
- Check-ups after delivery
- Dental services
- Depression management
- Diabetes management
- Hearing services for individuals less than 21 years of age
- HIV/AIDS care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries with at least one dental visit
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Access/Availability of Care

- Ratio of dental providers to beneficiaries
- Ratio of mental health providers to number of beneficiaries

Health Status/Outcomes Quality

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

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
- Percentage of beneficiaries with at least one dental visit
- Re-admission rates of MH/SA

DISTRICT OF COLUMBIA

District of Columbia Medicaid Managed Care Program

Health Plan Stability/ Financial/Cost of

- Net income
- Net worth
- Total revenue

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSTD
- 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
- Diabetes management
- Well Child Care/EPSTD

Non-Clinical Topics

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

DISTRICT OF COLUMBIA

District of Columbia Medicaid Managed Care Program

Standards/Accreditation

MCO/PHP Standards

- JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
- NCQA (National Committee for Quality Assurance) Standards
- State-Developed/Specified Standards

Accreditation for Deeming

None

EQRO Organization

- Peer Review Organization (PRO)

Accreditation Required for Participation

- JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

EQRO Name

- Delmarva Foundation for Medical Care

EQRO Activities

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

DISTRICT OF COLUMBIA

Health Services for Children with Special Needs

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: February 01, 1996
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: ACS,Inc	Sections of Title XIX Waived: None
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Medical-only PHP (non-risk, comprehensive) - Partial Capitation

Service Delivery

Included Services: Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Most Medicaid Services, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Nurse Practitioners -Nurse Midwives -Other Specialists Approved on a Case-by-Case Basis
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Enrollment

Populations Voluntarily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -TITLE XXI SCHIP -Special Needs Children (State defined)	Populations Mandatorily Enrolled: None
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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

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. Skilled Nursing Facility for first 30 days. Program provides Emergency Transportation only. Under the new contract, children with special needs are defined as "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 CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

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

DISTRICT OF COLUMBIA

Health Services for Children with Special Needs

-Provider Data

-Track Health Service provision

Consumer Self-Report Data

None

Use of HEDIS

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

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,

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

State conducts general data completeness assessments

Yes

Performance Measures

DISTRICT OF COLUMBIA

Health Services for Children with Special Needs

Process Quality

- Adolescent immunization rate
- Check-ups after delivery
- Dental services
- Depression management
- Diabetes management
- Hearing services for individuals less than 21 years of age
- HIV/AIDS care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries with at least one dental visit
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Access/Availability of Care

- Ratio of dental providers to beneficiaries
- Ratio of mental health providers to number of beneficiaries

Health Plan Stability/ Financial/Cost of

- Net income
- Net worth
- Total revenue

None

Health Status/Outcomes Quality

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

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
- Percentage of beneficiaries with at least one dental visit
- Re-admission rates of MH/SA

Health Plan/ Provider Characteristics

- Board Certification
- Languages Spoken (other than English)
- Provider turnover

Standards/Accreditation

MCO/PHP Standards

- JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
- NCQA (National Committee for Quality Assurance) Standards
- State-Developed/Specified Standards

Accreditation for Deeming

None

EQRO Organization

- Peer Review Organization (PRO)

Accreditation Required for

None

EQRO Name

- Delmarva Foundation for Medical Care

EQRO Activities

- Administration or validation of consumer or provider surveys
- Calculation of performance measures
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters
- Validation of performance measures

FLORIDA

Managed Health Care

CONTACT INFORMATION

State Medicaid Contact: David Rogers
Agency for Health Care Administration (AHCA)
(850) 487-2355

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: October 01, 1992
Operating Authority: 1915(b) - Waiver Program	Implementation Date: October 01, 1992
Statutes Utilized: 1915(b)(1) 1915(b)(2) 1915(b)(4)	Waiver Expiration Date: September 26, 2004
Enrollment Broker: Concera Corp.	Sections of Title XIX Waived: -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: 12 months guaranteed eligibility for children	

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Advanced Registered Nurse Practitioner, Ambulatory Surgical Center, Case Management, Chiropractic (limited direct access), County Health Department, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Pharmacy, Physician, Podiatric (limited direct access), Therapy, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Practitioners -Physician Assistants -Other Specialists Approved on a Case-by-Case Basis -Nurse Midwives -Psychiatrists
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FLORIDA Managed Health Care

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

Subpopulations Excluded from Otherwise

Included Populations:

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

Lock-In Provision:

12 month lock-in

FLORIDA Managed Health Care

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

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 Abuse, Laboratory, Mental Health Targeted Case Management in specific area only, Outpatient Hospital, Pharmacy, Physician, Therapy, Transportation, Vision, X-Ray

Allowable PCPs:

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

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

Subpopulations Excluded from Otherwise

Included Populations:

- Other Insurance
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- State Hospital Services
- Hospice
- Medically Needy
- Medicaid Eligibles in Residential Commitment Facilities
- Eligibles in Residential Group Care
- Children in Residential Treatment Facilities
- Residents in ADM Residential Treatment Facilities
- AIDs HCBS Waiver Enrollees
- Assisted Living HCBS Waiver Enrollees
- Prescribed Pediatric Extended Care Center Residents
- Qualified Medicare Beneficiaries - QMBs
- Medically Complex Children in CMS Program

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility criteria for special codes
- Uses enrollment forms to identify members of these groups
- 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
- Public Health Agency
- Social Services Agency

FLORIDA Managed Health Care

groups

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AvMed - St. Augustine Health Care
Discovery Health Plan
Foundation Health
Healthy Palm Beaches
JMH Health Plan
Neighborhood Health Partnership, Inc.
Preferred Medical Plan
Staywell Health Plan

Beacon Health Plan
Florida 1st Health Plan
Healthease
Humana Family Health Plan
Medipass
Physicians Healthcare Plans
Provider Service Network
United Healthcare Plans of Florida

ADDITIONAL INFORMATION

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

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

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

The 12 month guaranteed eligibility applies only to children under age 6.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Consumer Self-Report Data

- CAHPS
Adult Medicaid AFDC Questionnaire
- Disenrollment Survey
- MCO Member Satisfaction Surveys

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

Use of HEDIS

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

Encounter Data

FLORIDA

Managed Health Care

Collection: Requirements

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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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

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

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of "home grown" forms
- Use of Medicaid Identification Number for beneficiaries

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

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

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

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

Health Status/Outcomes Quality

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

Use of Services/Utilization

- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary
- Number of PCP visits per beneficiary

FLORIDA

Managed Health Care

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/PHPs
- Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSTD
- 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
- Domestic violence
- Emergency Room service utilization
- ETOH and other substance abuse screening and treatment
- Hypertension management
- Lead toxicity
- Pharmacy management
- Pregnancy Prevention
- Pre-natal care
- Sexually transmitted disease screening
- Sexually transmitted disease treatment
- Sickle cell anemia management
- Treatment of myocardial infraction
- Tuberculosis screening and treatment
- Well Child Care/EPSTD

Non-Clinical Topics

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

FLORIDA Managed Health Care

Standards/Accreditation

MCO/PHP Standards

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

Accreditation for Deeming

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

EQRO Organization

- None

Accreditation Required for Participation

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

EQRO Name

- None

EQRO Activities

- None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

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

Use of Collected Data:

- Beneficiary Plan Selection
- Contract Standard Compliance
- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Adult Medicaid SSI Questionnaire
 - Adult with Special Needs Questionnaire
- Disenrollment Survey
- State-developed Survey

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

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

FLORIDA

Managed Health Care

-Well-child care visit rates

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

Provider Characteristics

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

Use of Services/Utilization

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

Beneficiary Characteristics

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

Performance Improvement Projects

Clinical Topics

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

Non-Clinical Topics

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

FLORIDA Prepaid Mental Health Plan

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: January 31, 1996
Operating Authority: 1915(b) - Waiver Program	Implementation Date: March 01, 1996
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: June 30, 2003
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
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Mental Health (MH) PHP - Full 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. -PHP subcontracting with local community mental health providers and an Administrative Service Organization	

Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -SOBRA CHILDREN -Section 1931 (AFDC/TANF) Children and Related Populations
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FLORIDA

Prepaid Mental Health Plan

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

Subpopulations Excluded from Otherwise Included Populations:

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

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

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 Psychiatric 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 CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

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

FLORIDA

Prepaid Mental Health Plan

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

Consumer Self-Report Data

- Consumer/Beneficiary Focus Groups
- State-approved Survey

Use of HEDIS

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

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

Collection: Standardized Forms

None

Validation: Methods

- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills)
- Medical record validation

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

- Change in level of functioning
- Patient satisfaction with care

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

- Board Certification
 - Credentials and numbers of professional staff
- 120

FLORIDA

Prepaid Mental Health Plan

-Languages Spoken (other than English)

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Coordination of 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

MCO/PHP Standards

- CMS's Quality Improvement System for managed Care (QISM) 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)

Accreditation for Deeming

None

EQRO Name

-University of South Florida

EQRO Organization

- State
- University

EQRO Activities

- Administration or validation of consumer or provider surveys
- Calculation of performance measures
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters
- Validation of performance measures

FLORIDA

Statewide Inpatient Psychiatric Program

CONTACT INFORMATION

State Medicaid Contact:

Catharine Nelson
Agency for Health Care Administration
(850) 922-7343

State Website Address:

<http://www.fdhc.state.fl.us>

PROGRAM DATA

Program Service Area:

Statewide

Initial Waiver Approval Date:

March 23, 1998

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

April 01, 1999

Statutes Utilized:

1915(b)(4)

Waiver Expiration Date:

December 31, 2003

Solely Reimbursement Arrangement:

Yes

Sections of Title XIX Waived:

-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

Guaranteed Eligibility:

None

ADDITIONAL INFORMATION

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

GEORGIA

Georgia Better Health Care

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: July 14, 1993
Operating Authority: 1915(b) - Waiver Program	Implementation Date: October 01, 1993
Statutes Utilized: 1915(b)(1)	Waiver Expiration Date: March 14, 2003
Enrollment Broker: No	Sections of Title XIX Waived: -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

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Durable Medical Equipment, EPSDT, Home Health, Immunization, In-home Nursing, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Clinics (RHCs) -Nurse Practitioners -Other Specialists Approved on a Case-by-Case Basis
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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
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GEORGIA

Georgia Better Health Care

- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise

Included Populations:

- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Poverty Level Pregnant Woman
- Eligibility Less Than 3 Months
- Participate in HCBS Waiver
- American Indian/Alaskan Native
- SOBRA Eligible Pregnant Women
- Medicare Dual Eligible
- Special Needs Children (State defined)

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Reviews complaints and grievances 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

Georgia Better Health Care

ADDITIONAL INFORMATION

Special needs children include children with severe illnesses.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

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

Use of Collected Data:

- Program Evaluation

Consumer Self-Report Data

- State-developed Survey

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

- Average distance to primary care case manager
- Average wait time for an appointment with primary care case manager

Use of Services/Utilization

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

GEORGIA

Georgia Better Health Care

-Ratio of primary care case managers to 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

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	Initial Waiver Approval Date: September 08, 1999
Operating Authority: 1915(b) - Waiver Program	Implementation Date: October 01, 1997
Statutes Utilized: 1915(b)(4)	Waiver Expiration Date: September 07, 2003
Enrollment Broker: No	Sections of Title XIX Waived: -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: None	

SERVICE DELIVERY

Transportation PHP - Full Capitation

Service Delivery

Included Services: Non-Emergency Transportation	Allowable PCPs: -Not Applicable
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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
Subpopulations Excluded from Otherwise Included Populations: -No populations are excluded	Lock-In Provision: Does not apply because State only contracts with one managed care entity

GEORGIA

Non-Emergency Transportation Broker Program

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Surveys medical needs of enrollee to identify members of these groups
- Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Social Services Agency
- Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

- Contract Standard Compliance

Consumer Self-Report Data

None

Use of HEDIS

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

Encounter Data

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

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

Collection: Standardized Forms

None

Validation: Methods

- Accuracy Audits

GEORGIA

Non-Emergency Transportation Broker Program

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

-Date of Service
-Type of Service

State conducts general data completeness assessments

No

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

None

Access/Availability of Care

-Record Audits

Use of Services/Utilization

-Utilization by Type

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

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

Non-Clinical Topics

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

Standards/Accreditation

MCO/PHP Standards

-State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Not Applicable

EQRO Organization

-Not Applicable

EQRO Activities

-Not Applicable

GEORGIA

Preadmission Screening and Annual Resident Review (PASARR)

CONTACT INFORMATION

State Medicaid Contact: Pamela Madden
Department of Community Health/Division of Medical
(404) 657-9946

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: April 01, 1994
Operating Authority: 1915(b) - Waiver Program	Implementation Date: November 01, 1994
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: April 08, 2003
Enrollment Broker: No	Sections of Title XIX Waived: -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: None	

SERVICE DELIVERY

Mental Health (MH) PHP - Full Capitation

Service Delivery

Included Services: Mental Health/Mental Retardation Rehabilitation	Allowable PCPs: -Psychiatrists -Other Specialists Approved on a Case-by-Case Basis -Psychologists -Clinical Social Workers
Contractor Types: -Private	

Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -Blind/Disabled Adults and Related Populations -Aged and Related Populations
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GEORGIA

Preadmission Screening and Annual Resident Review (PASARR)

Subpopulations Excluded from Otherwise Included Populations:

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

Lock-In Provision:

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Preadmission Screening and Annual Resident Review (PASARR)

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Encounter Data (see below for details)
- Focused Studies
- Ombudsman
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data

- Program Evaluation
- Program Modification, Expansion, or Renewal

Consumer Self-Report Data

None

Use of HEDIS

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

None

GEORGIA

Preadmission Screening and Annual Resident Review (PASARR)

Collection: Standardized Forms

None

Validation: Methods

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

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

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

None

Access/Availability of Care

-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization

None

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-OASYS

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

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

HAWAII

Hawaii QUEST

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: July 16, 1993
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: August 01, 1994
Statutes Utilized: Not Applicable	Waiver Expiration Date: March 31, 2003
Enrollment Broker: No	Sections of Title XIX Waived: -1902(a)(10) -1902(a)(10)(A)(i)(I),(III)-(VII) -1902(a)(10)(B) Comparability of Services -1902(a)(10)(C)(ii) -1902(a)(13) -1902(a)(13)(E) -1902(a)(14) -1902(a)(17)(D) -1902(a)(23) Freedom of Choice -1902(a)(25)(G) -1902(a)(30) -1902(a)(34) -1902(a)(4) -1902(a)(51)(B) -1902(a)(52) -1902(a)(58) -1902(e)(1)(A) -1902(e)(4)-(7)
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(2)(A)(vi) Eligibility Expansion -1903(m)(a)(A)(i) -1903(m)(l)(A)
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

HAWAII

Hawaii QUEST

Included Services:

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

Allowable PCPs:

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

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Foster Care Children
- General Assistance (GA) Program
- Others who meet QUEST eligibility requirements

Subpopulations Excluded from Otherwise

Included Populations:

- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver
- Special Needs Children

12 month lock-in

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

Service Delivery

Included Services:

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

Allowable PCPs:

- Psychiatrists
- Psychologists

Contractor Types:

- Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

Subpopulations Excluded from Otherwise

Included Populations:

- Special Needs Children
- Participate in HCBS Waiver
- All children are excluded

Lock-In Provision:

No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HAWAII

Hawaii QUEST

Aloha Care

Early Intervention Programs, Department of Health
HMSA-Medical
Kapiolani Health Hawaii

Child & Adolescent Mental Health Division, Department of Health

HMSA-Behavior Health for SMI
Kaiser Permanente
Queens Hawaii Care

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. Special needs children include children who satisfy the disability criteria under State law.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Consumer Self-Report Data

- CAHPS
Adult Medicaid AFDC Questionnaire

Use of Collected Data

- Beneficiary Plan Selection
- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting

Use of HEDIS

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

Encounter Data

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for 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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of "home grown" forms
- Use of Medicaid Identification Number for beneficiaries

HAWAII

Hawaii QUEST

Collection: Standardized Forms

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

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

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

-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality

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

Access/Availability of Care

-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

-Actual reserves held by plan
-Expenditures by medical category of service
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics

-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics

-Beneficiary need for interpreter
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

HAWAII

Hawaii QUEST

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSDT
- Childhood Immunization
- Pharmacy management
- Prescription drug abuse
- Well Child Care/EPSDT

Non-Clinical Topics

- Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Mountain-Pacific Quality Health Foundation

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

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

IDAHO
Healthy Connections
CONTACT INFORMATION

State Medicaid Contact: Robin Pewtress
Bureau of Benefits & Reimbursement Policy
(208) 364-1892

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: October 01, 1993
Operating Authority: 1915(b) - Waiver Program	Implementation Date: October 01, 1993
Statutes Utilized: 1915(b)(1) 1915(b)(2)	Waiver Expiration Date: September 21, 2004
Enrollment Broker: No	Sections of Title XIX Waived: -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: 12 months guaranteed eligibility for children	

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 Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Podiatry, Standard/HIV Testing and Treatment, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Practitioners -Nurse Midwives -Indian Health Service (IHS) Providers -Physician Assistants -Other Specialists Approved on a Case-by-Case Basis
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Enrollment

IDAHO

Healthy Connections

Populations Voluntarily 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
- Aged and Related Populations
- Foster Care Children

Populations Mandatorily Enrolled:

None

Subpopulations Excluded from Otherwise

Included Populations:

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

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Education Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Connections

ADDITIONAL INFORMATION

Case management fee per member per month; two mandatory counties. The program will be shifting from mainly voluntary enrollment to mainly mandatory enrollment for the next waiver period.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Consumer Self-Report Data
- Disenrollment Surveys
- Enrollee Hotlines
- Enrollee Satisfaction Surveys
- Focused Studies
- Focuses Clinical Studies
- Grievance and Complaints
- Ombudsman
- Required Board Certification of Providers

Use of Collected Data:

- Program Evaluation

Consumer Self-Report Data

- State-developed Survey

ILLINOIS

Voluntary Managed Care

CONTACT INFORMATION

State Medicaid Contact:

A. George Hovanec
Illinois Department of Public Aid
(217) 782-2570

State Website Address:

<http://www.state.il.us/dpa>

PROGRAM DATA

Program Service Area:

County

Initial Waiver Approval Date:

Not Applicable

Operating Authority:

Voluntary - No Authority

Implementation Date:

November 01, 1974

Statutes Utilized:

Not Applicable

Waiver Expiration Date:

Not Applicable

Enrollment Broker:

No

Sections of Title XIX Waived:

None

For All Areas Phased-In:

Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

Guaranteed Eligibility:

No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

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

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists

Enrollment

Populations Voluntarily Enrolled:

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

Populations Mandatorily Enrolled:

None

ILLINOIS

Voluntary Managed Care

Subpopulations Excluded from Otherwise

Included Populations:

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

Lock-In Provision:

No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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 CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Child Medicaid AFDC Questionnaire
- Modified CAHPS Survey

Use of Collected Data

- Contract Standard Compliance
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Use of HEDIS

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

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

ILLINOIS

Voluntary Managed Care

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

-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-IDPA - approved electronic flat file for transmitting pharmacy encounters
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods

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

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

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

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

Access/Availability of Care

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

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

-Actual reserves held by plan
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics

-Admitting and delivery privileges
-Provider license number
-Specialty of providers

ILLINOIS

Voluntary Managed Care

Beneficiary Characteristics

-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements

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

Clinical Topics

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

Non-Clinical Topics

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

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-CIMRO

EQRO Organization

-PRO-like Entity

EQRO Activities

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

INDIANA

Hoosier Healthwise

CONTACT INFORMATION

State Medicaid Contact: 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	Initial Waiver Approval Date: September 13, 1993
Operating Authority: 1915(b) - Waiver Program	Implementation Date: July 01, 1994
Statutes Utilized: 1915(b)(1)	Waiver Expiration Date: April 23, 2003
Enrollment Broker: Lifemark Corporation	Sections of Title XIX Waived: -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

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Case Management, Chiropractic, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Podiatry, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -Internists -Obstetricians/Gynecologists or Gynecologists -General Practitioners -Family Practitioners
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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 -Pregnant Women 143
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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

Lock-In Provision:

No lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

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

Allowable PCPs:

- Pediatricians
- General Practitioners
- Family Practitioners
- Internists
- Obstetricians/Gynecologists or Gynecologists

Enrollment

Populations Voluntarily Enrolled:

- Foster Care Children
- American Indian/Alaskan Native

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- TITLE XXI SCHIP
- Pregnant Women

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Surveys medical needs of enrollee to identify members of these groups
- Uses combined enrollment form at certain locations to identify members of the group.

Agencies with which Medicaid Coordinates the Operation of the Program:

- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Harmony Health Plans of Indiana

INDIANA

Hoosier Healthwise

MDwise

Managed Health Services (MHS)
PCCM (PrimeStep)

ADDITIONAL INFORMATION

Inpatient psychiatric hospital and outpatient psychiatric 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.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Consumer Self-Report Data

- State-developed Survey

Use of Collected Data

- Monitor Quality Improvement
- Program Evaluation
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
- State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous enrollment

Encounter Data

Collection: Requirements

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

Collection: Standardized Forms

- ANSI ASC X12 837 - transaction set format for transmitting health care claims data
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

INDIANA

Hoosier Healthwise

care facilities

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

- Date of Service
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

- Average wait time for an appointment with PCP
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

None

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSTD
- Childhood Immunization
- Low birth-weight baby
- Pre-natal care
- Smoking prevention and cessation
- Well Child Care/EPSTD

Non-Clinical Topics

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

INDIANA

Hoosier Healthwise

Standards/Accreditation

MCO/PHP Standards

-NCQA recommended, not required.

Accreditation for Deeming

None

EQRO Organization

-PRO-like Entity

Accreditation Required for Participation

None

EQRO Name

-Tucker Alan, Incorporated

EQRO Activities

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

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

Use of Collected Data:

- Monitor Quality Improvement
- Program Evaluation
- Provider Profiling
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

- State-developed Survey

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

- Average wait time for an appointment with primary care case manager
- Ratio of primary care case managers to beneficiaries
- Statistical Data on Access to Pediatric care

Use of Services/Utilization

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

Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Clinical Topics

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

Non-Clinical Topics

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

IOWA

Iowa Medicaid Managed Health Care

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932 - State Plan Option to Use Managed Care	Implementation Date: December 01, 1986
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: ACS/Consultec	Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Case Management, Durable Medical Equipment (MCO Option), EPSDT, Family Planning, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, X-Ray	Allowable PCPs: -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Pediatricians
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Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Section 1931 (AFDC/TANF) Adults and Related Populations
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IOWA

Iowa Medicaid Managed Health Care

Subpopulations Excluded from Otherwise Included Populations:

- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver
- American Indian/Alaskan Native
- Special Needs Children (BBA defined)

Lock-In Provision:

6 month lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:

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

Allowable PCPs:

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

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
- Participate in HCBS Waiver
- American Indian/Alaskan Native
- Special Needs Children (BBA defined)

Lock-In Provision:

6 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coventry Health Care
John Deere Health Plan, Inc.

Iowa Health Solutions
Medipass

ADDITIONAL INFORMATION

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

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.

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

IOWA

Iowa Medicaid Managed Health Care

State Quality Assessment and Improvement Activities:

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

Consumer Self-Report Data

None

Use of Collected Data

- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Track Health Service provision

Use of HEDIS

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

Collection: Standardized Forms

None

Collections: Submission Specifications

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

Validation: Methods

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

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

IOWA

Iowa Medicaid Managed Health Care

Process Quality

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

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of PCPs to beneficiaries

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

Beneficiary Characteristics

None

Health Status/Outcomes Quality

- Patient satisfaction with care

Use of Services/Utilization

- Drug Utilization
- Inpatient admissions/1,000 beneficiary

Health Plan/ Provider Characteristics

- Board Certification
- Provider turnover

Performance Improvement Projects

Project Requirements

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

Clinical Topics

None

Non-Clinical Topics

- Availability of language interpretation services

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for Participation

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

Accreditation for Deeming

None

EQRO Name

- Iowa Foundation for Medical Care

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

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

IOWA

Iowa Medicaid Managed Health Care

-Validation of performance measures

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Focused Studies
- 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
- Program Evaluation

Consumer Self-Report Data

None

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

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

Use of Services/Utilization

- Drug Utilization
- Inpatient admissions/1,000 beneficiary
- Number of primary care case manager visits per beneficiary
- Number of specialist visits per beneficiary

Provider Characteristics

- Board Certification
- Provider turnover

Beneficiary Characteristics

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

Performance Improvement Projects

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSTD
- Asthma management
- Childhood Immunization
- Well Child Care/EPSTD

Non-Clinical Topics

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

IOWA

Iowa Plan For Behavioral Health

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: January 01, 1999
Operating Authority: 1915(b) - Waiver Program	Implementation Date: January 01, 1999
Statutes Utilized: 1915(b)(1) 1915(b)(3) 1915(b)(4)	Waiver Expiration Date: February 28, 2003
Enrollment Broker: No	Sections of Title XIX Waived: -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: None	

SERVICE DELIVERY

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

Service Delivery

Included Services: Ambulance, Clinic, Detoxification, Enhanced Services, Home Health, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory and X-Ray, Mental Health Outpatient, Outpatient Substance Abuse	Allowable PCPs: -Not applicable, contractors not required to identify PCPs
Contractor Types: -Behavioral Health MCO (Private)	

Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Section 1931 (AFDC/TANF) Adults and Related Populations -Blind/Disabled Adults and Related Populations -Blind/Disabled Children and Related Populations
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IOWA

Iowa Plan For Behavioral Health

- Medicare Dual Eligibles
- Foster Care Children

Subpopulations Excluded from Otherwise

Included Populations:

- Medically Needy with cash spenddown
- Reside in State Hospital-School
- Eligible for Limited Benefit Package
- Age 65 or older

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility data to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Iowa Plan For Behavioral Health

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Participation (see below for details)
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Focused Studies
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data

- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation

Consumer Self-Report Data

- Consumer/Beneficiary Focus Groups
- State-developed Survey

Use of HEDIS

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

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)

IOWA

Iowa Plan For Behavioral Health

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

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

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

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

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

-Patient satisfaction with care

Access/Availability of Care

-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

-Dual diagnosis MH/SA

IOWA

Iowa Plan For Behavioral Health

Non-Clinical Topics

None

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

-NCQA (National Committee for Quality Assurance)

Accreditation for Deeming

None

EQRO Name

-Iowa Foundation for Medical Care

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

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

KANSAS

KMMC: HealthConnect Kansas

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: January 01, 1984
Operating Authority: 1915(b) - Waiver Program	Implementation Date: January 01, 1984
Statutes Utilized: 1915(b)(1) 1915(b)(2) 1915(b)(4)	Waiver Expiration Date: October 04, 2002
Enrollment Broker: MAXIMUS, Inc	Sections of Title XIX Waived: -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: 12 months continuous eligibility for children	

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Nursing Facility, Obstetrical, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Personal Care, Pharmacy, Physician, Therapies, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Nurse Practitioners -Indian Health Service (IHS) Providers -Nurse Midwives -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Osteopaths -Local Health Departments (LHDs)
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KANSAS

KMMC: HealthConnect Kansas

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
- Pregnant Women
- Special Needs Children (BBA)

Subpopulations Excluded from Otherwise Included Populations:

- Spendedown Eligible
- Participate in HCBS Waiver
- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Reside in Juvenile Justice Facility or other State Institution
- Medically Needy-eligible
- Foster Care Children
- Receive Adoption Support

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility data to identify members of these groups
- Uses information from Title V agency to identify members

Agencies with which Medicaid Coordinates the Operation of the Program:

- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HealthConnect Kansas

ADDITIONAL INFORMATION

MAXIMUS, Inc. contract is from October 1, 2001 to June 30, 2003.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

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

Use of Collected Data:

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

KANSAS

KMMC: HealthConnect Kansas

Consumer Self-Report Data

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

Performance Measures

Process Quality

- Adolescent immunization rate
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds
- Lead screening rate
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

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

Provider Characteristics

- Board Certification
- Languages spoken (other than English)

Health Status/Outcomes Quality

- Patient satisfaction with care

Use of Services/Utilization

- Drug Utilization

Beneficiary Characteristics

None

KANSAS
KMMC: HealthWave 19
CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: December 28, 1994
Operating Authority: 1915(b) - Waiver Program	Implementation Date: December 01, 1995
Statutes Utilized: 1915(b)(1) 1915(b)(2) 1915(b)(4)	Waiver Expiration Date: October 04, 2002
Enrollment Broker: MAXIMUS, Inc	Sections of Title XIX Waived: -1902(a)(1) Statewide -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: 12 months continuous eligibility for children	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Durable Medical Equipment, Emergency, EPSDT, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Newborn, Nutrition, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Prenatal Health Promotion, Speech Therapy, Transfusions, Transplants, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Internists -Obstetricians/Gynecologists or Gynecologists -Indian Health Service (IHS) Providers -Nurse Practitioners -Nurse Midwives
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Enrollment

KANSAS

KMMC: HealthWave 19

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Pregnant Women
- Special Needs Children (BBA defined)

Subpopulations Excluded from Otherwise Included Populations:

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

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility data to identify members of these groups
- Uses information from the Title V agency to identify

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

FirstGuard Health Plan Kansas, Inc.

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data

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

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

KANSAS

KMMC: HealthWave 19

-State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements

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

Collection: Standardized Forms

- ADA - American Dental Association dental claim form
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

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

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

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

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of PCPs to beneficiaries

Health Status/Outcomes Quality

- Patient satisfaction with care

Use of Services/Utilization

- Drug Utilization

KANSAS

KMMC: HealthWave 19

Health Plan Stability/ Financial/Cost of Care

- Days cash on hand
- Days in unpaid claims/claims outstanding
- Medical loss ratio
- Net income
- Net worth
- Total revenue

Health Plan/ Provider Characteristics

- Board Certification
- Languages Spoken (other than English)

Beneficiary Characteristics

- Information on primary languages spoken by beneficiaries
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Standards/Accreditation

MCO/PHP Standards

- State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Kansas Foundation for Medical Care

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

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

KENTUCKY

Human Service Transportation

CONTACT INFORMATION

State Medicaid Contact: Cindy Stoops
KY Department for Medicaid Services
(502) 564-4923

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

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: February 01, 1996
Operating Authority: 1915(b) - Waiver Program	Implementation Date: June 01, 1998
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: March 07, 2003
Enrollment Broker: No	Sections of Title XIX Waived: -1902(a)(23) Freedom of Choice
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Transportation PHP - Full Capitation

Service Delivery

Included Services: Non-Emergency Transportation	Allowable PCPs: -Not Applicable
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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
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KENTUCKY

Human Service Transportation

Subpopulations Excluded from Otherwise

Included Populations:

-No populations are excluded

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Human Service Transportation

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of MCO/PHP Standards
-Ombudsman

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

None

KENTUCKY

Human Service Transportation

Collection: Standardized Forms

None

Validation: Methods

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

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-Not Applicable

EQRO Organization

-None

EQRO Activities

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

KENTUCKY

Kentucky Health Care Partnership Program

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: Region	Initial Waiver Approval Date: October 06, 1995
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: November 01, 1997
Statutes Utilized: Not Applicable	Waiver Expiration Date: November 01, 2002
Enrollment Broker: No	Sections of Title XIX Waived: -1902(a)(1) Statewide -1902(a)(10) Payment of FQHC -1902(a)(10)(B) Comparability of Services -1902(a)(13)(E) -1902(a)(23) Freedom of Choice -1902(c)(34) Retroactive eligibility
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(2)(A)(ii)(vi) -1903(m)(2)(A)(vi) Guaranteed Eligibility
Guaranteed Eligibility: 6 months guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Practitioners -Physician Assistants -Other Specialists Approved on a Case-by-Case Basis
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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
- Most Medicaid Eligibles
- Dual Eligibles for Medicaid Services only

Subpopulations Excluded from Otherwise**Included Populations:**

- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver
- Psychiatric Residential Treatment Facility PRTF
- Eligibility for Spend down
- Residents of Institutions for Mental Disease

Lock-In Provision:

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Asks advocacy groups to identify members of these groups
- Reviews complaints and grievances to identify members of these groups
- Uses claims data to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- KY Commission for Children with Special Health Care Needs
- Transportation Agency
- 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 CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Participation (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman
- On-Site Reviews

Use of Collected Data

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

KENTUCKY

Kentucky Health Care Partnership Program

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

Consumer Self-Report Data

None

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous 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/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills)
- Comparison to plan claims payment data
- Per member per month analysis and comparisons across MCOs/PHPs

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

KENTUCKY

Kentucky Health Care Partnership Program

Process Quality

- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Dental services
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit

Health Status/Outcomes Quality

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

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary
- Number of home health visits per 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/PHPs are required to conduct a project(s) of their own choosing
- Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics

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

Non-Clinical Topics

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

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for Participation

-Plan required to obtain MCO accreditation by NCQA or other accrediting body

Accreditation for Deeming

None

EQRO Name

-Health Care Review Corporation

EQRO Organization

- Federally Designated PRO-like Entity

EQRO Activities

- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
 - Review of high cost services and procedures
 - Review of MCO compliance with structural and operational
- 170

KENTUCKY

Kentucky Health Care Partnership Program

standards established by the state

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

KENTUCKY

Kentucky Patient Access and Care (KENPAC) Program

CONTACT INFORMATION

State Medicaid Contact: Marilyn Duke
KY Department for Medicaid Services
(502) 564-4321

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

PROGRAM DATA

Program Service Area: Region	Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932 - State Plan Option to Use Managed Care	Implementation Date: April 01, 2000
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: Yes	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: 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 or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Practitioners -Other Specialists Approved on a Case-by-Case Basis
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Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Section 1931 (AFDC/TANF) Adults and Related Populations
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KENTUCKY

Kentucky Patient Access and Care (KENPAC) Program

Subpopulations Excluded from Otherwise Included Populations:

- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- Special Needs Children
- X-Ray -Spendedown
- American Indian/Alaskan Native
- Special Needs Children (BBA defined)

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- 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

The KenPAC Program was implemented under a state plan amendment in all counties in Kentucky except region 3 in April of 2000. For the following Included services- EPDST, Mental Health, and Maternity Care including prenatal care delivery and post partum beneficiary may go to any participating provider for these services without a referral. Title V, Commission for Children with Special Health Care Needs are receiving comprehensive case management services.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Consumer Surveys
- Enrollee Hotlines
- Ombudsman
- Provider Data

Use of Collected Data:

- Beneficiary Provider Selection
- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

None

LOUISIANA Community Care

CONTACT INFORMATION

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

State Website Address: <http://www.dhh.state.la.us>

PROGRAM DATA

Program Service Area: Parish	Initial Waiver Approval Date: June 01, 1992
Operating Authority: 1915(b) - Waiver Program	Implementation Date: June 01, 1992
Statutes Utilized: 1915(b)(1)	Waiver Expiration Date: March 25, 2003
Enrollment Broker: No	Sections of Title XIX Waived: -1902(a)(23) Freedom of Choice
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: 12 months guaranteed eligibility for children	

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray	Allowable PCPs: -Obstetricians/Gynecologists or Gynecologists -Pediatricians -Family Practitioners -Internists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -General Practitioners
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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 -TITLE XXI SCHIP
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LOUISIANA Community Care

Subpopulations Excluded from Otherwise Included Populations:

- Eligibility Period Less Than 3 Months
- Medicare Dual Eligible
- Enrolled in Another Managed Care Program
- Reside in Nursing Facility or ICF/MR
- Other Insurance
- American Indian/Alaskan Native

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

- Education Agency
- Maternal and Child Health Agency
- 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. The program will statewide by 12/1/2003.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Consumer Self-Report Data
- Enrollee Hotlines
- Focused Studies

Use of Collected Data:

- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal

Consumer Self-Report Data

- State-developed Survey

MAINE

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](http://www.state.me.us/bms/bmshome.htm)

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932 - State Plan Option to Use Managed Care	Implementation Date: May 01, 1999
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: Public Consulting Group, Inc.	Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

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 or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Practitioners -Physician Assistants -Nurse Midwives -Ambulatory Care Clinic or Hospital Based Outpatient Clinic
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Enrollment

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

MaineCare Primary Care Case Management

- Section 1931 (AFDC/TANF) Adults and Related Populations
- TITLE XXI SCHIP
- Pregnant Women
- Special Needs Children (BBA defined)

Subpopulations Excluded from Otherwise

Included Populations:

- Medicare Dual Eligible
- Other Insurance
- Reside in Nursing Facility or ICF/MR
- Eligibility Period Less Than 3 Months
- Participate in HCBS Waiver
- Individuals on Medicaid recipient restriction program
- Individuals eligible for SSI
- Individuals under 19 with special health care needs
- Katie Beckett Eligibles
- Special Needs Children (State defined)
- Special Needs Children (BBA defined)

Lock-In Provision:

12 months lock-in

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/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

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

- Performance Measures (see below for details)

Use of Collected Data:

- Beneficiary Provider Selection
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

- Disenrollment Survey
- State-developed Survey

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Dental services
- Diabetes management
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds

Health Status/Outcomes Quality

- Patient satisfaction with care

MAINE

MaineCare Primary Care Case Management

- Influenza vaccination rate
- Provider Data
- Initiation of prenatal care
- Lead screening rate
- Pregnancy Prevention
- Smoking prevention and cessation
- Vision services for individuals less than 21 years of age

Access/Availability of Care

- Well-child care visit rates
- Average distance to primary care case manager
- Ratio of primary care case managers to beneficiaries

Provider Characteristics

- Languages spoken (other than English)

Use of Services/Utilization

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

Beneficiary Characteristics

- Beneficiary need for interpreter
- Disenrollment rate
- Percentage of beneficiaries who are auto-assigned to PCCM
- Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

Performance Improvement Projects

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPST
- Asthma management
- Breast cancer screening (Mammography)
- Cervical cancer screening (Pap Test)
- Child/Adolescent Dental Screening and Services
- Child/Adolescent Hearing and Vision Screening and Services
- Childhood Immunization
- Diabetes management
- Emergency Room service utilization
- Lead toxicity
- Medical problems of the frail elderly
- Otitis Media management
- Pharmacy management
- Pre-natal care
- Prescription drug abuse
- Prevention of Influenza
- Smoking prevention and cessation
- Well Child Care/EPST

Non-Clinical Topics

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

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	Initial Waiver Approval Date: October 30, 1996
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: June 02, 1997
Statutes Utilized: Not Applicable	Waiver Expiration Date: May 31, 2005
Enrollment Broker: Concera Corporation	Sections of Title XIX Waived: -1902(a)(10)(B) Comparability of Services -1902(a)(13)(E) -1902(a)(23) Freedom of Choice -1902(a)(4)(A) -1902(a)(47) -1902(a)(5) -1903(u)
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(2)(A)(i) -1903(m)(2)(A)(vi) Guaranteed Eligibility, IMD
Guaranteed Eligibility: 6 months guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Case Management, Dental, Diabetes Care, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Outpatient Substance Abuse, Pharmacy, Physician, Primary Mental Health, Skilled Nursing Facility, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Nurse Practitioners -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Other Specialists Approved on a Case-by-Case Basis
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MARYLAND HealthChoice

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Foster Care Children
- TITLE XXI SCHIP
- Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

- Enrolled in Family Planning Waiver Program
- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Institutionalized more than 30 days
- Eligibility for Less Than 6 Months
- If enrolled in Model Waiver for Fragile Children
- If determined Medically Needy Under a Spend Down

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

AMERIGROUP Maryland Inc.
JAI Medical System
Priority Partners MCO

Helix Family Choice
Maryland Physicians Care
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 and hearing services provided for enrollees under 21 years old.
- . There are additional optional services that MCOs provide for their enrollees such as dental services for adults.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

MARYLAND

HealthChoice

State Quality Assessment and Improvement Activities:

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

Consumer Self-Report Data

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

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

Use of HEDIS

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

Encounter Data

Collection: Requirements

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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

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. CMS 1500, UB-92, NCPDP, ADA)
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

State conducts general data completeness assessments

Yes

MARYLAND HealthChoice

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Dental services
- Diabetes management
- Frequency of on-going prenatal care
- HIV/AIDS care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries 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

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of dental providers to beneficiaries
- Ratio of PCPs to beneficiaries

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

Beneficiary Characteristics

None

Health Status/Outcomes Quality

- Patient satisfaction with care

Use of Services/Utilization

- Drug Utilization
- Inpatient admissions/1,000 beneficiary
- Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics

None

Performance Improvement Projects

Project Requirements

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

Non-Clinical Topics

- Children's access to primary care practitioners

Clinical Topics

- Adolescent Well Care/EPSTD
- Childhood Immunization
- Diabetes management
- Lead toxicity
- Well Child Care/EPSTD

MARYLAND HealthChoice

Standards/Accreditation

MCO/PHP Standards

-CMS's Quality Improvement System for Managed Care (QISM) Standards for Medicaid and Medicare

Accreditation for Deeming

-NCQA (National Committee for Quality Assurance)

EQRO Organization

-Peer Review Organization (PRO)

Accreditation Required for Participation

None

EQRO Name

-Delmarva Foundation for Medical Care, Inc.

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

183

MASSACHUSETTS
Mass Health
CONTACT INFORMATION

State Medicaid Contact: Wendy Warring
Division of Medical Assistance
(617) 210-5690

State Website Address: <http://www.state.ma.us/dma/>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: April 15, 1995
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: July 01, 1997
Statutes Utilized: Not Applicable	Waiver Expiration Date: June 30, 2005
Enrollment Broker: MAXIMUS	Sections of Title XIX Waived: -1902(a)(10)(A) -1902(a)(10)(B) Comparability of Services -1902(a)(10)(C) -1902(a)(13)(C) -1902(a)(17) -1902(a)(17)(D) -1902(a)(23) Freedom of Choice -1902(a)(30)(A) -1902(a)(32) -1902(a)(34) -1902(a)(4)(A)
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(2)(A)(vi) Disenrollment -Eligibility Expansion -Inst. For Mental Disease -Insurance Reimbursement
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray	Allowable PCPs: -General Practitioners -Family Practitioners -Pediatricians -Internists -Obstetricians/Gynecologists or Gynecologists -Nurse Practitioners -Federally Qualified Health Centers (FQHCs)
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MASSACHUSETTS

Mass Health

- Other Specialists Approved on a Case-by-Case Basis
- Hospital Outpatient Departments

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 (BH carve-out)
- Blind/Disabled Adults and Related Populations
- TITLE XXI SCHIP
- Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise

Included Populations:

- Medicare Dual Eligible
- Other Insurance
- Reside in Nursing Facility or ICF/MR
- Over 65 years old

Lock-In Provision:

No lock-in

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

Service Delivery

Included Services:

Crisis, Detoxification, IMD, Inpatient Mental Health, Inpatient Substance Abuse, Mental Health Outpatient, Mental Health Residential, Mental Health Support, Opiate Treatment Programs, Outpatient Day Programs, Outpatient Substance Abuse, Residential Substance Abuse Treatment Programs

Allowable PCPs:

-Not applicable, MH/SA PHP network does not provide primary medical care

Contractor Types:

- Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:

Subpopulations Excluded from Otherwise

Included Populations:

- Medicare Dual Eligible
- Other Insurance
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program

Populations Mandatorily Enrolled:

None

Lock-In Provision:

No lock-in

MASSACHUSETTS

Mass Health

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Chiropractic, Durable Medical Equipment, Emergency Transportation, EPSDT, Family Planning, Hearing Aids, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Podiatry, Skilled Nursing Facility, Therapy, Vision (medical), X-Ray

Allowable PCPs:

-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

Subpopulations Excluded from Otherwise**Included Populations:**

-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Over 65 years old

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-Uses eligibility data to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Boston Medical Center HealthNet Plan
MA Behavioral Health Partnership
Network Health

Fallon Community Health Plan
Neighborhood Health Plan
Primary Care Clinician Plan

ADDITIONAL INFORMATION

MASSACHUSETTS

Mass Health

Mass Health has a behavioral carve-out for PCCM enrollees and for children in the care or custody of the Commonwealth. Regarding the MH/SA PHP 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.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Focused Studies
- MCO/PHP Standards (see below for details)
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire (modified)
 - Adult Medicaid SSI Questionnaire (modified)
 - Child Medicaid AFDC Questionnaire (modified)
 - Child Medicaid SSI Questionnaire (modified)

Use of Collected Data

- Beneficiary Plan Selection
- Contract Standard Compliance
- Monitor Quality Improvement
- Program Evaluation
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
- State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous 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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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

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

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

State conducts general data completeness assessments

Yes

MASSACHUSETTS

Mass Health

-Revenue Codes

Performance Measures

Process Quality

- Adolescent immunization rate
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Depression management
- Diabetes management
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation of prenatal care
- Well-child care visit rates

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

- Average wait time for an appointment with PCP

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of

- Actual reserves held by plan
- Days cash on hand
- Revenue Codes
- 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

- Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSTD
- Childhood Immunization
- Coordination of care for persons with physical disabilities
- Coordination of primary and behavioral health care
- Pharmacy management
- Post-natal Care
- Pre-natal care
- Well Child Care/EPSTD

Non-Clinical Topics

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

MASSACHUSETTS Mass Health

Standards/Accreditation

MCO/PHP Standards

-State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-MassPro

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-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
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
Adult Medicaid AFDC Questionnaire (modified)
Adult Medicaid SSI Questionnaire (modified)
Child Medicaid AFDC Questionnaire (modified)
Child Medicaid SSI Questionnaire (modified)

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

Health Status/Outcomes Quality

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

Access/Availability of Care

-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization

-Inpatient admission for MH/SA conditions/1,000 beneficiaries

Provider Characteristics

None

Beneficiary Characteristics

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

MASSACHUSETTS

Mass Health

Performance Improvement Projects

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSTD
- Asthma management
- Breast cancer screening (Mammography)
- Cervical cancer screening (Pap Test)
- Childhood Immunization
- Coordination of primary and behavioral health care
- Diabetes management
- Emergency Room service utilization
- Inpatient maternity care and discharge planning
- Pharmacy management
- Post-natal Care
- Pre-natal care
- Well Child Care/EPSTD

Non-Clinical Topics

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

MICHIGAN Childrens Special Health Care Services

CONTACT INFORMATION

State Medicaid Contact: George Baker, MD
Michigan Department of Community Health
(517) 241-7186

State Website Address: <http://www.michigan.gov>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: September 01, 1998
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: Michigan Enrolls	Sections of Title XIX Waived: None
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: 12 months guaranteed eligibility for children	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Additional Continuity of Care Requirement, Care Coordination, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Individualized Care Planning, Inpatient Hospital, Laboratory, Maternal and Infant Support, 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
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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
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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 covered

Subpopulations Excluded from Otherwise

Included Populations:

- Reside in Nursing Facility or ICF/MR or incarcerated

Lock-In Provision:

- No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Beneficiaries are already identified as special needs as eligibility in the program

Agencies with which Medicaid Coordinates the Operation of the Program:

- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Childrens Choice of Michigan

Kids Care of Michigan

ADDITIONAL INFORMATION

The Children Special Health Services Program serves children who have qualifying conditions under CSHCS. The special needs are the focal point of services versus primary care. The operating authority for this program is Title V of the SSA pa 368 of 1978. Under this program, the State prior authorizes managed care services and providers for these children under two service delivery options either FFS or enrollment in one of two special health plans. The two special health plans that provide services under this program are incorporated, but not licensed in MI and therefore do not provide services to the commercial population.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- 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

Collection: Standardized Forms

None

MCO 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

Collections: Submission Specifications

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

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)

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Site reviews with SHPs to evaluate IHCPs

Access/Availability of Care

- Access to buildings
- Average wait time for an appointment with PCP

Health Plan Stability/ Financial/Cost of

- Actual reserves held by plan
- State minimum reserve requirements

Beneficiary Characteristics

None

Health Status/Outcomes Quality

None

Use of Services/Utilization

None

Health Plan/ Provider Characteristics

- Board Certification
- Experience with pediatric care of special needs population
- Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements

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

Clinical Topics

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

193

MICHIGAN

Childrens Special Health Care Services

Non-Clinical Topics

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

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Delmarva

EQRO Organization

-Planning underway with Delmarva

EQRO Activities

-Planning for Delmarva to review general CSHCS population, asthma, and CP population

MICHIGAN Comprehensive Health Plan

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: May 30, 1997
Operating Authority: 1915(b) - Waiver Program	Implementation Date: July 01, 1997
Statutes Utilized: 1915(b)(1) 1915(b)(2) 1915(b)(4)	Waiver Expiration Date: September 24, 2004
Enrollment Broker: Michigan Enrolls	Sections of Title XIX Waived: -1902(a)(1) Statewideness -1902(a)(23) Freedom of Choice
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: 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: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Nurse Practitioners -Other Specialists Approved on a Case-by-Case Basis -Physician assistants
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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
- Spendedown
- Court Wards
- Kosovo Refugees
- Medicare dual eligibles
- Persons enrolled in CSHCS
- Person with full medicaid coverage, including those in the state medical program or pluscare

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Monthly enrollment file flags SSI and adoptive kids indicators to health plans

Agencies with which Medicaid Coordinates the Operation of the Program:

- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Botsford Health Plan
Care Choices
Community Choice Michigan
Health Plan of Michigan
M-Care HMO
Midwest Health Plan
Omnicare Health Plan
Physicians Health Plan of Southwest Michigan
Total Health Care
Wellness Plan

Cape Health Plan
Community Care Plan
Great Lakes Health Plan
HealthPlus of Michigan
McLaren Health Plan
Molina Healthcare of Michigan
Physicians Health Plan of Mid-Michigan
Priority Health
Upper Peninsula Health Plan

ADDITIONAL INFORMATION

The enrollment basis for included populations will depend if they fall under the Special needs population. Michigan Special Needs Children include children who have one of any 2700 different qualifying physical diagnoses, if the condition has the necessary level of severity and chronicity to qualify.

MICHIGAN

Comprehensive Health Plan

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Deeming (see below for details)
- Accreditation for participation, member or applied for membership
- Complaint and Grievance Monitoring
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Choice Monitoring
- Provider Data
- Provider Selection Monitoring
- Timely and Compliant Claims Reporting
- Timely Provider File Submissions

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid Questionnaire
 - Child Medicaid Questionnaire

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

Use of HEDIS

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

Encounter Data

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to 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

Collection: Standardized Forms

None

Collections: Submission Specifications

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

Validation: Methods

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

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

- Date of Service
- Date of Processing
- 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

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Chlamydia screening
- Diabetes management
- Hearing services for individuals less than 21 years of age
- HIV/AIDS care
- Immunizations for two year olds
- Initiation of prenatal care
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Smoking prevention and cessation
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

- Average 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

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

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Childhood Immunization
- Well Child Care/EPSTD

Non-Clinical Topics

- MSS referrals

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for Participation

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

MICHIGAN

Comprehensive Health Plan

Accreditation for Deeming

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

EQRO Organization

- Peer Review Organization (PRO)

EQRO Name

- Delmarva Foundation for Medical Care, Inc.

EQRO Activities

- Conduct studies on quality and access that focus on a particular aspect of clinical or non-clinical services
- Medstat (collects and validates encounter data)
- Review of MCO compliance with structural and operational standards established by the State
- Validation of client level data, such as claims and encounters

MICHIGAN

Specialty Community Mental Health Services Programs

CONTACT INFORMATION

State Medicaid Contact: Judy Webb
MDCH, Division of Quality Management and Planning
(517) 335-4419

State Website Address: <http://www.mdch.state.mi.us>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: June 26, 1998
Operating Authority: 1915(b) - Waiver Program	Implementation Date: October 01, 1998
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: March 13, 2003
Enrollment Broker: No	Sections of Title XIX Waived: -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: None	

SERVICE DELIVERY

Developmentally Disabled, Mental Health and Substance Abuse PHP – Full Capitation

Service Delivery

Included Services: Crisis, Durable Medical Equipment, Emergency Specialty DD, MH and SA, Home Health, Inpatient Mental Health, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, MH Clinic, Outpatient Mental Health (Partial Hospitalization), Outpatient Substance Abuse, Personal Care, Residential Substance Abuse Rehabilitation, Specialty Services and Supports for persons with DD, Targetted Case Management, Transportation	Allowable PCPs: -Psychiatrists -Psychologists -Clinical Social Workers -Addictionologists -Other Specialists Approved on a Case-by-Case Basis
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Contractor Types:
-County Community Mental Health Services

Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations
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MICHIGAN

Specialty Community Mental Health Services Programs

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

Subpopulations Excluded from Otherwise

Included Populations:

- Residing in ICF/MR
- Children Enrolled in Childrens Waiver (Section 1915(c))

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Identified through other health care agencies
- Outreach
- Referred through other health care practitioners/agencies
- Self-referral

Agencies with which Medicaid Coordinates the Operation of the Program:

- Aging Agency
- Education Agency
- Housing Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Specialty Employment Agency (Supported Employment)
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Allegan County CMH
AuSable Valley CMH
Bay Arenac CMH
CEI CMH
Copper Country CMH
Genesee County CMH
Gratiot County CMH
Hiawatha Behavioral Health Authority
Ionia County CMH
Kent County CMH
Lenawee County CMH
Livingston County CMH
Manistee-Benzie CMH
Montcalm Center Behavioral Health
Newaygo County CMH
Northeast Michigan CMH
Northpointe CMH
Ottawa County CMH
Pines Behavioral Health CMH
Sanilac County CMH
St. Clair County CMH
Summit Pointe
Van Buren County CMH

Antrim Kalkaska CMH
Barry County CMH
Berrien Mental Health
Central Michigan CMH
Detroit-Wayne CMH
Gogebic County CMH
Great Lakes CMH
Huron Behavioral Health
Kalamazoo County CMH
Lapeer County CMH
Lifeways CMH
Macomb County CMH
Monroe County CMH
Muskegon County CMH
North Central CMH
Northern Michigan CMH
Oakland County CMH
Pathways CMH
Saginaw County CMH
Shiawassee County CMH
St. Joseph County CMH
Tuscola County CMH
Washtenaw County CMH

MICHIGAN

Specialty Community Mental Health Services Programs

Western Michigan CMH

Woodland Behavioral Health

ADDITIONAL INFORMATION

Michigan remains one of the very few, if not the only, state to have incorporated services to persons with Developmental Disabilities into a 1915(b) Freedom of Choice "managed care" waiver. Also, all persons adjudicated Medicaid eligible are deemed enrolled in this Specialty Community Mental Health Services and Supports managed care program.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Participation (see below for details)
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Measures (see below for details)

Consumer Self-Report Data

- MHSIP Consumer Survey

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

Use of HEDIS

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

Collection: Standardized Forms

None

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

- Provider ID
- Type of Service
- Medicaid Eligibility
- Diagnosis Codes
- Age-appropriate diagnosis/procedure
- Age
- Gender
- Race/Ethnicity

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 electronic file formats
- Use of Medicaid Identification Number for beneficiaries

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)

State conducts general data completeness assessments

Yes

MICHIGAN

Specialty Community Mental Health Services Programs

-Social Security

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

- Adults living in homes of their own
- Adults working in supported employment
- Children living with family
- Patient satisfaction with care
- Rates of rights complaints/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 NH's 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/SA conditions/1,000 beneficiaries
- Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
- Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Standards/Accreditation

MCO/PHP Standards

- CMS's Quality Improvement System for Managed Care (QISM) Standards for Medicaid and Medicare

Accreditation Required for

- CARF
- COA
- JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
- The Council

Accreditation for Deeming

None

EQRO Name

- Michigan Peer Review Organization

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

- Clinical Record Review
- Validation of performance measures

MINNESOTA

* Consolidated Chemical Dependency Treatment Fund (CCDTF)

CONTACT INFORMATION

State Medicaid Contact:

Mary Kennedy
Minnesota Department of Human Services
(651) 282-9921

State Website Address:

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

PROGRAM DATA

Program Service Area:

Statewide

Initial Waiver Approval Date:

January 01, 1988

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

January 01, 1988

Statutes Utilized:

1915(b)(1)
1915(b)(4)

Waiver Expiration Date:

March 23, 2003

Enrollment Broker:

No

Sections of Title XIX Waived:

-1902(a)(23) Freedom of Choice
-1902(a)(30) Utilization Review

For All Areas Phased-In:

Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

Guaranteed Eligibility:

No guaranteed eligibility

SERVICE DELIVERY

County Case Manager - Fee-for-Service

Service Delivery

Included Services:

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

Allowable PCPs:

-Not Applicable

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

MINNESOTA

* Consolidated Chemical Dependency Treatment Fund (CCDTF)

-TITLE XXI SCHIP

-All Medicaid Recipients Are Eligible For The CCDTF

Subpopulations Excluded from Otherwise

Included Populations:

-Enrolled in Another Managed Care Program that covers CD services

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Mental Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Consolidated Chemical Dependency Treatment Fund (CCDTF)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

None

Performance Measures

Process Quality

-Track number of placements by beneficiary characteristics
-Track number of placements by type of service

Health Status/Outcomes Quality

-Treatment completion rates

Access/Availability of Care

None

Use of Services/Utilization

None

MINNESOTA

* Consolidated Chemical Dependency Treatment Fund (CCDTF)

Provider Characteristics

-Licensing for provider/entity and its staff

Beneficiary Characteristics

-Age

-County of residence

-Household size

-Information of beneficiary ethnicity/race

-Marital status

MINNESOTA

Minnesota Disability Health Options (MnDHO)

CONTACT INFORMATION

State Medicaid Contact: Mary Kennedy
Minnesota Department of Human Services
(651) 282-9921

State Website Address: <http://www.dhs.state.mn.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: September 01, 2001
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: None
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full 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 Abuse, Laboratory, Nursing Facility Are Covered for 180 Days, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -Not Applicable
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Enrollment

Populations Voluntarily Enrolled: -Blind or Disabled, Age 16 through 64, Dually Eligible for Medicaid and Medicare	Populations Mandatorily Enrolled: None
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MINNESOTA

Minnesota Disability Health Options (MnDHO)

Subpopulations Excluded from Otherwise Included Populations:

- Other Insurance
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- Reside in Regional Treatment Center
- QMB or SLMB, Not Otherwise Eligible for Medicaid
- Eligible for Medicare Part A or Part B Only

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- 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

Medica
UCARE

Metropolitan Health Plan

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 geriatric experience. MnDHO provides one month rolling eligibility to provide coverage for enrollees who do not return a scheduled income or redetermination report on a timely basis. Children participating in the Minnesota Department of Health Administered Program For Children With Special Health Needs Under Title V of the Social Security Act.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

- Beneficiary Plan Selection
- Health Services Research
- Monitor Quality Improvement
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

- CAHPS
Adult Medicaid Questionnaire
- 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/PHPs to follow NCQA specifications

MINNESOTA

Minnesota Disability Health Options (MnDHO)

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

Collection: Standardized Forms

- ADA - American Dental Association dental claim form
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Cholesterol screening and management
- Diabetes management
- Influenza Vaccination Rate
- Timeliness of HCBS Reassessments
- Use of Home and Community-Based Services
- Use of Nursing Home Days

Access/Availability of Care

- Average distance to PCP
- Number of PCP Ambulatory Visits

Health Status/Outcomes Quality

- Family Satisfaction with Care - Nursing Home Members
- Patient satisfaction with care

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
- 209

MINNESOTA

Minnesota Disability Health Options (MnDHO)

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

- Board Certification
- Languages Spoken (other than English)
- Provider turnover

Beneficiary Characteristics

- MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Congestive Heart Failure Management
- Diabetes management
- Optimal Medication Management
- Prevention of Influenza and Pneumonia

Non-Clinical Topics

None

Standards/Accreditation

MCO/PHP Standards

- CMS's Quality Improvement System for Managed Care (QISMIC) Standards for Medicaid and Medicare

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

- FMAS (PRO-Like)
- MetaStar (PRO)
- NCQA (Accreditation)
- PRS (PRO)
- Stratis Health (PRO)

EQRO Organization

- Peer Review Organization (PRO)
- Private Accreditation Organization
- PRO-like Entity

EQRO Activities

- Calculation of performance measures
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Coordination of QSMIC Collaboratives Between MSHO Health Plans
- Validation of client level data, such as claims and encounters
- Validation of performance improvement projects
- Validation of performance measures

MINNESOTA

Minnesota Senior Health Options Program (MSHO)

CONTACT INFORMATION

State Medicaid Contact: Mary Kennedy
Minnesota Department of Human Services
(651) 282-9921

State Website Address: <http://www.dhs.state.mn.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: March 01, 1997
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: None
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: All Medicare Services Under Parts A & B, Case Management, Dental, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Nursing Facility Are Covered for 180 Days, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Services Available Under The Home And Community-Based Waiver (Elderly Waiver), Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -Not Applicable
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Enrollment

Populations Voluntarily Enrolled: -Age 65 or Older and Dually Eligible for Medicare and Medicaid, or Eligible for Medicaid without Medi	Populations Mandatorily Enrolled: None
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MINNESOTA

Minnesota Senior Health Options Program (MSHO)

Subpopulations Excluded from Otherwise

Included Populations:

-No populations are excluded

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medica
UCARE

Metropolitan Health Plan

ADDITIONAL INFORMATION

Contractors are not required to identify PCPs. PCP provider types are designated by HMOs rather than State; county staff perform enrollment functions. Health plans have been encouraged to develop networks with professionals with geriatric experience. MSHO provides one month rolling eligibility to provide coverage for enrollees who do not return a scheduled income or redetermination report on a timely basis. Children participating in the Minnesota Department of Health Administered Program For Children With Special Health Needs Under Title V of the Social Security Act.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
 Adult Medicaid Questionnaire
-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/PHPs 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

Collection: Standardized Forms

- ADA - American Dental Association dental claim form
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Cholesterol screening and management
- Diabetes management
- Influenza Vaccination Rate
- Timeliness of HCBS Reassessments
- Use of Home and Community-Based Services
- Use of Nursing Home Days

Access/Availability of Care

- Average distance to PCP
- Number of PCP Ambulatory Visits

Health Status/Outcomes Quality

- Family Satisfaction with Care - Nursing Home Members
- Patient satisfaction with care

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

MINNESOTA

Minnesota Senior Health Options Program (MSHO)

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

- Board Certification
- Languages Spoken (other than English)
- Provider turnover

Beneficiary Characteristics

- MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Congestive Heart Failure Management
- Diabetes management
- Optimal Medication Management
- Prevention of Influenza and Pneumonia

Non-Clinical Topics

None

Standards/Accreditation

MCO/PHP Standards

- CMS's Quality Improvement System for Managed Care (QISMIC) Standards for Medicaid and Medicare

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

- FMAS (PRO-Like)
- MetaStar (PRO)
- NCQA (Accreditation)
- PRS (PRO)
- Stratis Health (PRO)

EQRO Organization

- Peer Review Organization (PRO)
- Private Accreditation Organization
- PRO-like Entity

EQRO Activities

- Coordination of QSMIC Collaboratives Between MSHO Health Plans
- Special Federal Projects on Dual Medicare-Medicaid Eligibles
- Validation of performance measures

MINNESOTA

MinnesotaCare Program For Families And Children

CONTACT INFORMATION

State Medicaid Contact: Mary Kennedy
Minnesota Department of Human Services
(651) 282-9921

State Website Address: <http://www.dhs.state.mn.us>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: April 27, 1995
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: July 01, 1995
Statutes Utilized: Not Applicable	Waiver Expiration Date: June 30, 2005
Enrollment Broker: No	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
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(2)(A)(vi) Eligibility Expansion, Eligibility Simplification, Medical Education Trust Fund
Guaranteed Eligibility: 12 months guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: All other MA Benefits Covered Except NF, ICF/MR and Home And Community Based Waiver, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray	Allowable PCPs: -Not Applicable
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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 income is below 275% of poverty

Subpopulations Excluded from Otherwise Included Populations:

- Medicare Dual Eligible
- Pregnant Women Up to 275 of FPG With Other Insurance
- Enrolled in Another Managed Care Program
- Individuals with household income above 150% of poverty with other health insurance
- Individuals with health insurance available through employment if subsidized at 50% or greater

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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 CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

- Beneficiary Plan Selection
- Health Services Research
- Monitor Quality Improvement
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

MINNESOTA

MinnesotaCare Program For Families And Children

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Child Medicaid AFDC Questionnaire
- Disenrollment Survey

Use of HEDIS

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

Encounter Data

Collection: Requirements

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

Collection: Standardized Forms

- ADA - American Dental Association dental claim form
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

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

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Adolescent immunization rate
- Cervical cancer screening rate
- Cholesterol screening and management
- Depression management
- Diabetes management
- Immunizations for two year olds
- Influenza vaccination rate
- Lead screening rate

Health Status/Outcomes Quality

- Patient satisfaction with care

MINNESOTA

MinnesotaCare Program For Families And Children

-Well-child care visit rates

Access/Availability of Care

-Average distance to PCP

Use of Services/Utilization

-Well-Child Care Visit Rates

Health Plan Stability/ Financial/Cost of

-Actual reserves held by plan
-Medical loss ratio
-Net income
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

-MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements

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

Clinical Topics

-Adolescent Immunization
-Adolescent Well Care
-Childhood Immunization
-Well Child Care

Non-Clinical Topics

None

Standards/Accreditation

MCO/PHP Standards

-CMS's Quality Improvement System for Managed Care (QISM) Standards for Medicaid and Medicare

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-FMAS (PRO-Like)
-MetaStar (PRO)
-Michigan PRO
-MPQRO (PRO)
-NCQA (Accreditation)
-PRS (PRO)
-Stratis Health (PRO)

EQRO Organization

-Peer Review Organization (PRO)
-Private Accreditation Organization
-PRO-like Entity

EQRO Activities

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

MINNESOTA

Prepaid Medical Assistance Program

CONTACT INFORMATION

State Medicaid Contact: Mary Kennedy
Minnesota Department of Human Services
(651) 297-7515

State Website Address: <http://www.dhs.state.mn.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: July 01, 1985
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: July 01, 1985
Statutes Utilized: Not Applicable	Waiver Expiration Date: June 30, 2005
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)(30) Utilization Review -1902(a)(4) Contract-Specific Upper Payment -1902(a)(4)(A) MEQC
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(2)(A) HMO Definition -1903(m)(2)(A)(vi) Medical Education Trust Fund, El
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: All Other MA Benefits Covered Except Nursing Facility Per Diem, ICF/MR And Home And Community Based, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray	Allowable PCPs: -Not Applicable
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MINNESOTA

Prepaid Medical Assistance Program

Enrollment

Populations Voluntarily Enrolled:

- Children with SED
- Enrolled in another managed care program

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Aged and Related Populations
- TITLE XXI SCHIP
- Foster care children

Subpopulations Excluded from Otherwise Included Populations:

- Recipients with terminal or communicable disease at time of enrollment
- Those With Private Coverage With An HMO Not Participating In Medicaid
- Refugee Assistance Program Recipients
- Recipients Residing In State Institutions
- Non-Institutionalized Recipients Who Are Eligible On A Spenddown Basis
- Blind And Disabled Under Age 65
- Non-documented Alien Recipients Who Only Receive Emergency MA Under Minn. Stat. 256B.06(4)
- QMBs And SLMBs Who Are Not Otherwise Receiving MA

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Health Partners
Medica
South Country Health Alliance

First Plan Blue
Itasca Medical Care
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. PMAP provides one month rolling eligibility to provide coverage for enrollees who do not return a scheduled income or redetermination report on a timely basis.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)

Use of Collected Data

- Health Services Research

MINNESOTA

Prepaid Medical Assistance Program

- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

- Monitor Quality Improvement
- Plan Reimbursement
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Child Medicaid AFDC Questionnaire
- Disenrollment Survey

Use of HEDIS

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

- Data submission requirements including documentation describing set of encounter data elements, 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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

- ADA - American Dental Association dental claim form
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods

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

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

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

State conducts general data completeness assessments

Yes

Performance Measures

MINNESOTA

Prepaid Medical Assistance Program

Process Quality

- Adolescent immunization rate
- Cervical cancer screening rate
- Cholesterol screening and management
- Depression management
- Diabetes management
- Immunizations for two year olds
- Lead screening rate
- Well-child care visit rates

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

- Average distance to PCP

Use of Services/Utilization

- Well-Child Care Visit Rates

Health Plan Stability/ Financial/Cost of

- Actual reserves held by plan
- Medical loss ratio
- Net income
- State minimum reserve requirements
- Total revenue

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

- MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care
- Childhood Immunization
- Senior Influenza Immunization
- Well Child Care

Non-Clinical Topics

None

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

- FMAS (PRO-Like)
- MetaStar (PRO)
- Michigan PRO
- NCQA (Accreditation)
- PRS (PRO)
- Stratis Health (PRO)

EQRO Organization

- Peer Review Organization (PRO)
- Private Accreditation Organization
- PRO-like Entity

EQRO Activities

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

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	Initial Waiver Approval Date: April 29, 1998
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: September 01, 1998
Statutes Utilized: Not Applicable	Waiver Expiration Date: March 01, 2004
Enrollment Broker: First Health Services Corporation	Sections of Title XIX Waived: -1902(a)(1) Statewide -1902(a)(10)(B) Comparability of Services -1902(a)(23) Freedom of Choice -1916(a)(1) -1916(a)(2)(A) -1916(a)(3) -1916(c)(3) -1916(e)
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(u) Eligibility Expansion -Expenditures to provide Medicaid coverage to individuals with incomes at or below 300 percent of FPL -Special Programs/CHCCDP
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Case Management, Dental - for 1115 Adults, Trauma or Disease only, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation - Emergency only except for Parents Fairshare Recipients receive both emergency and non-emergency, Vision - Trauma or Disease	Allowable PCPs: -Internists -Nurse Practitioners -Other Specialists Approved on a Case-by-Case Basis -PCP Teams -Obstetricians/Gynecologists or Gynecologists (Health Plans can choose to designate OB/GYNs for PCPs) -PCP Clinics - which can include FQHCs/RHCs -Pediatricians -General Practitioners
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MISSOURI

MC+ Managed Care/1115

only for Adults - Includes one pair of glasses following cataract surgery, X-Ray

-Family Practitioners

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-TITLE XXI SCHIP

-Uninsured Parents with ME Codes 76, 77, 78, 80

Subpopulations Excluded from Otherwise

Included Populations:

- Enrolled in Another Managed Care Program
- Aid to the Blind and Blind Pension individuals
- General Relief Program participants
- AIDS Waiver program participants
- Permanently and Totally Disabled Individuals
- Children enrolled in Developmental Disabilities Program
- Mentally Retarded Developmental Disabled (MRDD) Waiver
- American Indian/Alaskan Native
- Participate in HCBS Waiver
- Presumptive Eligibility Program for Pregnant Women
- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross Blue Shield of Kansas City, Blue Advantage+ Plus

Community Care Plus

FirstGuard

Mercy Health Plans

Care Partners

Family Health Partners

HealthCare USA

Missouri Care

MISSOURI MC+ Managed Care/1115

ADDITIONAL INFORMATION

Implementation Date: 09/01/1998 - Services began for MC+ For Kids. On 02/01/1999, services began for Uninsured Parents.

Medicaid eligibles in the included populations who are receiving Supplemental Security Income (SSI) or who meet the SSI medical disability definition may choose not to enroll or voluntarily disenroll from MC+ at any time.

Transportation: 1115 Adults and Children receive emergency transportation only except for 1115 Parents Fairshare recipients who also receive non-emergency transportation.

EPSDT: Uninsured Parents Age 19 and above do not receive EPDST services.

HealthCare USA participates in Eastern, Central and Western Regions.

Effective January 1, 2002, uninsured parents below 100 percent of the federal poverty level with ME Code 79, were not eligible for coverage under the 1115 waiver. These custodial parents were transitioned to coverage under Section 1931 with ME Code 05.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman (Western and Eastern Region only)
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Consumer Self-Report Data

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

Use of Collected Data

- Beneficiary Plan Selection
- Contract Standard Compliance
- Monitor Quality Improvement
- Plan Reimbursement EPSDT
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Use of HEDIS

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

Encounter Data

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- 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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of "home grown" forms
- Use of Medicaid Identification Number for beneficiaries

MISSOURI

MC+ Managed Care/1115

Collection: Standardized Forms

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

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

Validation: Methods

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

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Cervical cancer screening rate
- Check-ups after delivery
- Chemical Dependency Utilization
- C-Section Rates
- Dental services
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds
- Initiation of prenatal care
- Mental Health Utilization
- Outcomes of Pregnancy
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit
- Pregnancy Prevention
- Preventable Hospitalization under age 18
- Smoking during Pregnancy
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Health Status/Outcomes Quality

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

Access/Availability of Care

- Average distance to PCP

Use of Services/Utilization

- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary
- Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
- Percentage of beneficiaries with at least one dental visit

226

MISSOURI

MC+ Managed Care/1115

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/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

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

Clinical Topics

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

Non-Clinical Topics

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

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-Behavioral Health Concepts (BHC)

EQRO Organization

-Quality Improvement Organization

EQRO Activities

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

MISSOURI

MC+ Managed Care/1915b

CONTACT INFORMATION

State Medicaid Contact: 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: March 14, 2004
Enrollment Broker: First Health Services Corporation	Sections of Title XIX Waived: -1902(a)(1) Statewideness -1902(a)(10)(B) Comparability of Services -1902(a)(23) Freedom of Choice
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Adult Day Care, Ambulatory Surgical Care, Case Management, Clinic - FQHC/RHC, Comprehensive Day Rehabilitation, Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Personal Care, Pharmacy, Physician, Prenatal Case Management, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Nurse Practitioners -Other Specialists Approved on a Case-by-Case Basis -PCP Teams -PCP Clinics - which can include FQHCs/RHCs
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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 participants
- Special Needs Children (State defined)
- MO is a 209(b) State and has no specific eligibility categories for the special needs population

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
- American Indian/Alaskan Native
- Children with Developmental Disabilities Program
- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Presumptive Eligibility Program for Pregnant Women

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross Blue Shield of Kansas City, Blue Advantage+ Plus

Community Care Plus

FirstGuard

Mercy Health Plans

Care Partners

Family Health Partners

HealthCare USA

Missouri Care

MISSOURI

MC+ Managed Care/1915b

ADDITIONAL INFORMATION

HealthCare USA participates in Eastern, Central and Western Regions

Medicaid eligibles in the included populations who are receiving Supplemental Security Income (SSI), who meet the SSI medical disability definition, or who receive adoption subsidy may choose to enroll or voluntarily disenroll from MC+ Managed Care at any time.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman (Western and Eastern Regions only)
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Consumer Self-Report Data

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

Use of Collected Data

- Beneficiary Plan Selection
- Contract Standard Compliance
- Monitor Quality Improvement
- Plan Reimbursement - EPSDT
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Use of HEDIS

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

Encounter Data

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- 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

Collection: Standardized Forms

- ADA - American Dental Association dental claim form
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing

Collections: Submission Specifications

- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of "home grown" forms
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

MISSOURI

MC+ Managed Care/1915b

data between trading partners, such as hospitals, long term care facilities

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Cervical cancer screening rate
- Check-ups after delivery
- Chemical Dependency Utilization
- C-Section Rates
- Dental services
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds
- Initiation of prenatal care
- Mental Health Utilization
- Outcomes of pregnancy
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit
- Pregnancy Prevention
- Preventable Hospitalization under age 18
- Smoking during pregnancy
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Health Status/Outcomes Quality

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

Access/Availability of Care

- Average distance to PCP

Use of Services/Utilization

- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary
- Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
- Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of

- Missouri Department of Insurance monitors and tracks Health Plan stability/financial/cost of care

Health Plan/ Provider Characteristics

- Languages Spoken (other than English)

Beneficiary Characteristics

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

MISSOURI

MC+ Managed Care/1915b

Performance Improvement Projects

Project Requirements

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

Clinical Topics

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

Non-Clinical Topics

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

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-Behavioral Health Concepts (BHC)

EQRO Organization

-Quality Improvement Organization

EQRO Activities

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

MONTANA

Passport To Health

CONTACT INFORMATION

State Medicaid Contact: Mary Angela Collins
Montana Department of Public Health and Human Services
(406) 444-4146

State Website Address: <http://www.dphhs.state.mt.us>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: August 31, 1993
Operating Authority: 1915(b) - Waiver Program	Implementation Date: January 01, 1994
Statutes Utilized: 1915(b)(1) 1915(b)(2)	Waiver Expiration Date: April 24, 2004
Enrollment Broker: MAXIMUS	Sections of Title XIX Waived: -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: 1 month guaranteed eligibility	

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 Abuse, Laboratory, Nursing Homes, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplants, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Practitioners -Indian Health Service (IHS) Providers -Physician Assistants -Other Specialists Approved on a Case-by-Case Basis -Geriatrics -Internal Medicine -Pediatrics -Nephrologist
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MONTANA

Passport To Health

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
- Reside in Nursing Facility or ICF/MR
- Eligibility Period Less Than 3 Months
- Medically Needy
- Restricted Card Program
- Area Without Managed Care
- Subsidized Adoption
- Only Retroactive Eligibility
- Home and Community Waiver

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Nurses
- Social Services Agency
- Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Passport to Health

ADDITIONAL INFORMATION

Program includes a \$3.00 case management fee.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Consumer Self-Report Data
- Enrollee Hotlines
- Focused Studies
- Performance Improvements Projects (see below for details)
- Provider Data
- Performance Measures (see below for details)

Use of Collected Data:

- Beneficiary Provider Selection
- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting

MONTANA

Passport To Health

-Track Health Service provision

Consumer Self-Report Data

- CAHPS
Adult Medicaid AFDC Questionnaire
- State-developed Survey

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Dental services
- Diabetes management
- Immunizations for two year olds
- Initiation of prenatal care
- Well-child care visit rates

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

Provider Characteristics

- Board Certification

Health Status/Outcomes Quality

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

Use of Services/Utilization

- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary
- Number of OB/GYN visits per adult female beneficiary
- Number of primary care case manager visits per beneficiary
- Number of specialist visits per beneficiary

Beneficiary Characteristics

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

Performance Improvement Projects

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSTD
- 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/EPSTD

Non-Clinical Topics

- Native American Adults access to preventative/ambulatory health services
- Native American Children access to preventative/ambulatory health services
- Native American Children's access to primary care practitioners

NEBRASKA

Nebraska Health Connection Combined Waiver Program

CONTACT INFORMATION

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

State Website Address: <http://www.lhss.state.ne.us>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: June 05, 1995
Operating Authority: 1915(b) - Waiver Program	Implementation Date: July 01, 1995
Statutes Utilized: 1915(b)(1) 1915(b)(2) 1915(b)(3) 1915(b)(4)	Waiver Expiration Date: October 31, 2002
Enrollment Broker: Nebraska Health Connection/Access Medicaid	Sections of Title XIX Waived: -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: 6 months guaranteed eligibility	

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 or Gynecologists
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Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -American Indian/Alaskan Native -Special Needs Children (State defined)
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NEBRASKA

Nebraska Health Connection Combined Waiver Program

Subpopulations Excluded from Otherwise

Included Populations:

- Medicare Dual Eligible
- Other Insurance
- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver
- Clients with Excess Income
- Clients Participating in the Subsidized Adoption Program
- Clients Participating in the State Disability Program
- Presumptive Eligibles
- Transplant Recipients
- Women with Cancer

Lock-In Provision:

1 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

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

Allowable PCPs:

- Pediatricians
- General Practitioners
- Family Practitioners
- Internists
- Obstetricians/Gynecologists or Gynecologists

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- American Indian/Alaskan Native
- Special Needs Children (State defined)

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
- Women with Cancer

Lock-In Provision:

1 month lock-in

NEBRASKA

Nebraska Health Connection Combined Waiver Program

Administrative Services Organization (ASO) (non-risk) - Fee-for-Service

Service Delivery

Included Services:

Case Management, Client Assistance Program, Crisis, EPSDT, IMD, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Opiate Treatment Program, Outpatient Mental Health, Outpatient Substance Abuse, Transportation, 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
- Aged and Related Populations
- Foster Care Children
- TITLE XXI SCHIP
- Pregnant Women
- Special Needs Children (State defined)

Subpopulations Excluded from Otherwise**Included Populations:**

- Medicare Dual Eligible
- Other Insurance
- 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
- Presumptive Eligibles
- Transplant Recipients
- Women with Cancer

Lock-In Provision:

1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Magellan Behavioral Health
Share Advantage

Primary Care Plus

NEBRASKA

Nebraska Health Connection Combined Waiver Program

ADDITIONAL INFORMATION

Children on SSI, children in foster care or out-of-home placements and children eligible for and receiving Title V services.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Participation (see below for details)
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Measures (see below for details)

Consumer Self-Report Data

- CAHPS
 - Child Medicaid AFDC Questionnaire
 - Child Medicaid SSI Questionnaire
- Consumer/Beneficiary Focus Groups
- State-developed Survey

Use of Collected Data

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

Use of HEDIS

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

Encounter Data

Collection: Requirements

- 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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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

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

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

State conducts general data completeness assessments

No

NEBRASKA

Nebraska Health Connection Combined Waiver Program

Performance Measures

Process Quality

- Check-ups after delivery
- Frequency of on-going prenatal care
- Initiation of prenatal care
- Lead screening rate
- Well-child care visit rates

Access/Availability of Care

- Average distance to PCP

care facilities,

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

Beneficiary Characteristics

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

Health Status/Outcomes Quality

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

Use of Services/Utilization

None

Health Plan/ Provider Characteristics

- Languages Spoken (other than English)
- Provider turnover

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for

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

Accreditation for Deeming

None

EQRO Name

-None

EQRO Organization

-None

EQRO Activities

-None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Consumer Self-Report Data
- Enrollee Hotlines

Use of Collected Data:

- Beneficiary Provider Selection
- Contract Standard Compliance

NEBRASKA

Nebraska Health Connection Combined Waiver Program

Consumer Self-Report Data

- Consumer/beneficiary Focus Groups
- State-developed Survey

- 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

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Immunizations for two year olds
- Lead screening rate
- Well-child care visit rates

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

- Average distance to primary care case manager

Use of Services/Utilization

None

Provider Characteristics

- Languages spoken (other than English)
- Provider turnover

Beneficiary Characteristics

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

NEVADA

Mandatory Health Maintenance Program

CONTACT INFORMATION

State Medicaid Contact: Mary Pennington
Division of Health Care Financing and Policy
(775) 684-3698

State Website Address: <http://www.state.nv.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932 - State Plan Option to Use Managed Care	Implementation Date: December 01, 1998
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Ambulatory Surgery Center, Case Management, Certified Registered Nurse Practitioner, Chiropractor, 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, Psychologist, 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 or Gynecologists
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Enrollment

NEVADA

Mandatory Health Maintenance Program

Populations Voluntarily Enrolled:

- Severely Emotionally Disabled Children
- Seriously Mentally Ill Adults
- Children with Special Health Care Needs
- American Indian

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

Populations Mandatorily Enrolled:

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

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

- Maternal and Child Health Agency
- Mental Health Agency
- Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Plan of Nevada

NevadaCare DBA Nevada Health Solutions

ADDITIONAL INFORMATION

For the Mandatory Program, Temporary Assistance for Needy Families/Child Health Assurance Program, Severely Emotionally Disturbed Children, Seriously Mentally Ill Adults, Children with Special Health Care Needs and American Indians are provided voluntary enrollment and/or disenrollment at any time.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Deeming (see below for details)
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data

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

NEVADA

Mandatory Health Maintenance Program

Consumer Self-Report Data

- CAHPS
Adult Medicaid AFDC Questionnaire

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
- State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous 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
- Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of "home grown" forms
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Dental services
- Immunizations for two year olds
- Lead screening rate

Health Status/Outcomes Quality

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

NEVADA

Mandatory Health Maintenance Program

- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Well-child care visit rates

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/SA 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/PHP, for women giving birth during the reporting period

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for

None

Accreditation for Deeming

- NCQA (National Committee for Quality Assurance)

EQRO Name

- Health Services Advisory Group

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

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

NEVADA

Voluntary Health Maintenance Program

CONTACT INFORMATION

State Medicaid Contact: Mary Pennington
Division of Health Care Financing & Policy
(775) 684-3698

State Website Address: <http://www.state.nv.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932 - State Plan Option to Use Managed Care	Implementation Date: April 01, 1997
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Ambulatory Surgery Center, Case Management, Certified Registered Nurse Practitioner, Chiropractor, Disposable Medical Supplies, Durable Medical Equipment, Emergency Transportation, End Stage Renal Disease Facilities, EPSDT, Family Planning, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Intravenous Therapy, Laboratory, Medical Rehabilitation Center, Mental Health Rehabilitative Service, Noninvasive Diagnostic Center, Nurse Anesthetist, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Physician Assistant, Podiatrist, Prosthetics, Psychologist, Respiratory Therapy, Rural Health Clinic, Skilled Nursing Facility, Special Clinics, Speech Therapy, Transitional Rehabilitative Center, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists
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Enrollment

NEVADA

Voluntary Health Maintenance Program

Populations Voluntarily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- American Indian
- Severely Emotionally Disturbed Children
- Seriously Mentally Ill Adults
- Children with Special Health Care Needs

Populations Mandatorily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

- Medicare Dual Eligible
- Inpatients in Residential Treatment Facilities
- Residents in Nursing Facilities beyond 45 Days
- Special Needs Children (BBA defined)
- Other Insurance

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

- Maternal and Child Health Agency
- Mental Health Agency
- Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

NevadaCare DBA Nevada Health Solutions

ADDITIONAL INFORMATION

This program only includes beneficiaries in Washoe county.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Deeming (see below for details)
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data

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

NEVADA

Voluntary Health Maintenance Program

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/PHPs to modify some or all NCQA specifications in ways other than continuous 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
- Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of "home grown" forms
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Immunizations for two year olds
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their

Health Status/Outcomes Quality

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

NEVADA

Voluntary Health Maintenance Program

ability to obtain care
-Well-child care visit rates

Access/Availability of Care

-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Drug Utilization
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility

Health Plan Stability/ Financial/Cost of

-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/PHP, for women giving birth during the reporting period

Standards/Accreditation

MCO/PHP Standards

-CMS's Quality Improvement System for Managed Care (QISM) Standards for Medicaid and Medicare
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for

None

Accreditation for Deeming

-NCQA (National Committee for Quality Assurance)

EQRO Name

-Health Services Advisory Group

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

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

NEW HAMPSHIRE

New Hampshire Voluntary Managed Care Program

CONTACT INFORMATION

State Medicaid Contact: Diane Kemp
State of New Hampshire Medicaid Agency
(603) 271-4365

State Website Address: <http://www.dhhs.state.nh.us>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: March 02, 1983
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: None
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: 6 months guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Case Management, Dental, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Organ Transplant, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Skilled Nursing Facility, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Nurse Practitioners
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Enrollment

Populations Voluntarily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Foster Care Children -Section 1931 (AFDC/TANF) Adults and Related Populations -Aid to Permanently and Totally Disabled up to age 21 -TITLE XXI SCHIP	Populations Mandatorily Enrolled: None
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NEW HAMPSHIRE

New Hampshire Voluntary Managed Care Program

Subpopulations Excluded from Otherwise

Included Populations:

- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- In and Out beneficiaries

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Surveys medical needs of enrollee to identify members of these groups
- Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Employment Agency
- Housing Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem Blue Cross/Blue Shield

ADDITIONAL INFORMATION

The SCHIP children aged 0-1 are enrolled voluntary.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data
- QCHIP Study

Use of Collected Data

- Contract Standard Compliance
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

- Parent Satisfaction with Dental Care

Use of HEDIS

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

Performance Measures

NEW HAMPSHIRE

New Hampshire Voluntary Managed Care Program

Process Quality

- Adolescent immunization rate
- Cervical cancer screening rate
- Dental services
- Immunizations for two year olds
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Well-child care visit rates

Access/Availability of Care

None

Health Status/Outcomes Quality

- Parent Satisfaction with Dental Care

Use of Services/Utilization

- After-hours visits
- Average number of visits to MH/SA providers per beneficiary
- Emergency room visits/1,000 beneficiary
- Hospital Days/ 1000 beneficiary
- Inpatient admissions/1,000 beneficiary
- Number of children at least one initial or periodic screen
- Number of children dental treatment services
- Number of children receiving dental treatment services
- Number of children receiving screening blood lead tests
- Number of children who received well-care screening
- Number of re-admissions,same patients,same diagnosis within 7 days
- Number of receiving any dental services
- Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

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

Non-Clinical Topics

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

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

- Northeast Quality Healthcare Foundation

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

- Conduct performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

NEW JERSEY

New Jersey Care 2000+ (1915 {b})

CONTACT INFORMATION

State Medicaid Contact: Susan Welsh
Office of Quality Assurance
(609) 588-7379

State Website Address: <http://www.state.nj.us/humanservices>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: April 18, 2000
Operating Authority: 1915(b) - Waiver Program	Implementation Date: October 01, 2000
Statutes Utilized: 1915(b)(1) 1915(b)(2)	Waiver Expiration Date: September 30, 2002
Enrollment Broker: MAXIMUS	Sections of Title XIX Waived: -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) - Full 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, 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: -Pediatricians -General Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Nurse Practitioners -Nurse Midwives -Other Specialists Approved on a Case-by-Case Basis -Family Practitioners
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Enrollment

NEW JERSEY

New Jersey Care 2000+ (1915 {b})

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Non duals DDD/CCW children <19
-Non dual Blind and Disabled Children and Related Populations <19

Subpopulations Excluded from Otherwise

Included Populations:

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program Without Department of Human Services Contract
-Participate in HCBS Waiver (except DDD/CCW non-duals)
-Eligibility Less Than 3 Months
-Medicare Dual Eligible
-In and out state placements
-Individuals institutionalized in an inpatient psychiatric facility

-Individuals with eligibility period that is only retroactive
-Full-time students attending school but resides outside the country

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of New Jersey, Inc.
Health Net
University Health Plans, Inc.

AMERIGROUP New Jersey, Inc.
Horizon Mercy

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

NEW JERSEY

New Jersey Care 2000+ (1915 {b})

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

-Track Health Service provision

Consumer Self-Report Data

-CAHPS
Adult Medicaid AFDC Questionnaire
Survey - included ABD adult and children specific questions. Results not separated by age group.

Use of HEDIS

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

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-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)
-Electronic format is a modified Fee-for-Service MMIS based on CMS 1500 and UB-92
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

None

Validation: Methods

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

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

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Comparison of reported charges to reasonable and customary fees.

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery

Health Status/Outcomes Quality

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

NEW JERSEY

New Jersey Care 2000+ (1915 {b})

- Cholesterol screening and management
- Dental services
- Diabetes management
- Emergency Room Utilization
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- HIV/AIDS care
- Hypertension
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit
- Smoking prevention and cessation
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of dental providers to beneficiaries
- Ratio of PCPs to 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

Beneficiary Characteristics

None

Use of Services/Utilization

- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Well Care/EPSDT
- Asthma management
- Breast cancer screening (Mammography)
- Child/Adolescent Dental Screening and Services
- Child/Adolescent Hearing and Vision Screening and Services
- Childhood Immunization
- Diabetes management
- Lead toxicity
- Post-natal Care
- Pre-natal care
- Well Child Care/EPSDT

Non-Clinical Topics

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

NEW JERSEY

New Jersey Care 2000+ (1915 {b})

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-The Peer Review Organization of New Jersey, Inc.

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

- Calculation of performance measures
- Conduct performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Medical Record review
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters
- Validation of performance improvement projects
- Validation of performance measures

NEW JERSEY

New Jersey Care 2000+ (1932)

CONTACT INFORMATION

State Medicaid Contact: Susan Welsh
Office of Quality Assurance
(609) 588-7379

State Website Address: <http://www.state.nj.us/humanservices>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932 - State Plan Option to Use Managed Care	Implementation Date: September 01, 1995
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: MAXIMUS	Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full 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: -Pediatricians -General Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Nurse Practitioners -Nurse Midwives -Other Specialists Approved on a Case-by-Case Basis -Family Practitioners
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Enrollment

NEW JERSEY

New Jersey Care 2000+ (1932)

Populations Voluntarily Enrolled:

- Foster Care Children
- Medicare Dual Eligible

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- TITLE XXI SCHIP
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Non Dually Eligible Aged, Blind and Disabled Adults and Related Populations
- Non dual DDD/CCW (adults)

Subpopulations Excluded from Otherwise

Included Populations:

- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program Without Department of Human Services Contract
- Special Needs Children and all Aged, Blind and Disabled were excluded from mandatory enrollment
- American Indian/Alaskan Native
- Participate in HCBS Waiver except DDD/CCW non-duals
- Special Needs Children (BBA defined)
- Medicare Dual Eligibles from mandatory enrollment

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

- Aging Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of New Jersey, Inc.
Health Net
University Health Plans, Inc.

AMERIGROUP New Jersey, Inc.
Horizon Mercy

ADDITIONAL INFORMATION

Initially a 1915(b) converted to a SPA effective 1/1/1999. Effective 4/1/00, 1932(a) program was amended to include SSI, Aged, Blind, Disabled, and Division of Developmental Disabilities Community Care Waiver (DDD/CCW) population. Contract to provide services to newly mandated population was not effective until 10/1/00. Phased-in Enrollment for the Aged, Blind, Disabled and DDD/CCW Population effective 10/01/2000. Lock-in Period: 12-month lock in is for AFDC/TANF and Title XXI population. There is no lock-in for SSI, Aged, Blind, Disabled and DDD and DFYS populations. Children with special Health Care Needs and those children who have or are at increased risk for chronic physical, developmental, or emotional conditions and who also require health

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

NEW JERSEY

New Jersey Care 2000+ (1932)

State Quality Assessment and Improvement Activities:

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

Consumer Self-Report Data

- CAHPS
Adult Medicaid AFDC Questionnaire

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

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
- State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous 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

Collection: Standardized Forms

None

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)
- Electronic format is a modified Fee-For-Service MMIS based on CMS 1500, UB-92 and Home Grown Forms
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of "home grown" forms
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

MCO conducts data accuracy check(s)

and related service.

- Date of Service
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure
- Comparison of reported changes to reasonable and customary fees

State conducts general data completeness on specified data elements assessments

Yes

NEW JERSEY

New Jersey Care 2000+ (1932)

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Cholesterol screening and management
- Dental services
- Diabetes management
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- HIV/AIDS care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit
- Smoking prevention and cessation
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of PCPs to beneficiaries

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

Beneficiary Characteristics

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

Health Status/Outcomes Quality

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

Use of Services/Utilization

- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics

None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Well Care/EPSTD
 - Asthma management
 - Breast cancer screening (Mammography)
 - Child/Adolescent Dental Screening and Services
 - Child/Adolescent Hearing and Vision Screening and Services
 - Childhood Immunization
 - Diabetes management
 - Lead toxicity
 - Post-natal Care
 - Pre-natal care
- 261

NEW JERSEY

New Jersey Care 2000+ (1932)

-Well Child Care/EPSDT

Non-Clinical Topics

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

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-The Peer Review Organization of New Jersey, Inc.

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

- Calculation of performance measures
- Conduct of performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Medical Record Review
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of performance improvement projects
- Validation of performance measures

NEW MEXICO SALUD!

CONTACT INFORMATION

State Medicaid Contact:

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

Initial Waiver Approval Date:

May 13, 1997

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

July 01, 1997

Statutes Utilized:

1915(b)(1)
1915(b)(4)

Waiver Expiration Date:

October 21, 2002

Enrollment Broker:

No

Sections of Title XIX Waived:

-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:

12 months guaranteed eligibility for children

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full 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 Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:

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

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related

NEW MEXICO SALUD!

- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- TITLE XXI SCHIP
- Home and Community Based Waiver

Subpopulations Excluded from Otherwise Included Populations:

- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Poverty Level Pregnant Woman
- Native Americans
- Clients participating in the health insurance premium program (HIPP)
- Children and adolescents in out-of-state foster care or adoption placement

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Uses eligibility data to identify members of these groups
- Uses fee for service claims data
- Uses history of prior authorization of special services

Agencies with which Medicaid Coordinates the Operation of the Program:

- Department of Health
- Mental Health Agency
- Public Health Agency
- Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Cimarron
Presbyterian Salud

Lovelace

ADDITIONAL INFORMATION

HMOs designate PCPs.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Deeming (see below for details)
- Accreditation for Participation (see below for details)
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data

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

NEW MEXICO SALUD!

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/PHPs to modify some or all NCQA specifications in ways other than continuous 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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

- Date of Service
- Provider ID
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

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

- Days in unpaid claims/claims outstanding
- Medical loss ratio
- Net income
- Net worth
- State minimum reserve requirements
- Total revenue

Health Plan/ Provider Characteristics

- Provider turnover

Beneficiary Characteristics

- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Well Child Care/EPSTD

Non-Clinical Topics

- Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for

- NCQA (National Committee for Quality Assurance)

Accreditation for Deeming

- NCQA (National Committee for Quality Assurance)

EQRO Name

- IPRO

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

- Administration or validation of consumer or provider surveys
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters

NEW YORK 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	Initial Waiver Approval Date: January 16, 1996
Operating Authority: 1915(b) - Waiver Program	Implementation Date: July 01, 1996
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: November 14, 2002
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
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Transportation PHP - Full Capitation

Service Delivery

Included Services: Non-Emergency Transportation	Allowable PCPs: -Not Applicable
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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 -All Medicaid Beneficiaries
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267

NEW YORK

Non-Emergency Transportation

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

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

ADDITIONAL INFORMATION

Selective contracting for non-emergency transportation.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

MCO/PHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Activities
-None

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	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: April 01, 1996
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: None
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Mental Health (MH) PHP - Partial Capitation

Service Delivery

Included Services: Mental Health Continuation Day Treatment, Mental Health Intensive Psychiatric Rehabilitation Treatment, Mental Health Outpatient	Allowable PCPs: -Mental Health PHP -Personal Services Coordinator
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Contractor Types:
-New York State Office of Mental Health Hospital

Enrollment

Populations Voluntarily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Section 1931 (AFDC/TANF) Adults and Related Populations -Admitted to an outpatient psychiatric center program -Blind/Disabled Adults and Related Populations -Blind/Disabled Children and Related Populations -Aged and Related Populations -Receiving outpatient (Clinic, CDT, IPRT)	Populations Mandatorily Enrolled: None
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NEW YORK

Office of Mental Health/Partial Capitation Program

Subpopulations Excluded from Otherwise Included Populations:

- Enrolled in Another Managed Care Program
- Eligibility Period Less Than 6 Months
- Participation in HCBS Waiver
- Special Needs Children (BBA defined)

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

- Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

OMH/Partial Capitation

ADDITIONAL INFORMATION

The patients are referred by their hospitals or outpatient programs for mental health services. Due to the nature of the program which is for a limited segment of services, the program does not designate a medical primary care provider. Individuals choose their own providers or rely on the contractor for referral. The contractor acts as the gatekeeper.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Participation (see below for details)
- MCO/PHP Standards (see below for details)
- Performance Measures (see below for details)

Use of Collected Data

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

Consumer Self-Report Data

None

Use of HEDIS

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

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

None

NEW YORK

Office of Mental Health/Partial Capitation Program

Access/Availability of Care

-Number of encounters per provider

Use of Services/Utilization

-Average number of visits to MH/SA providers per beneficiary
-Use of acute sector hospitalization

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Standards/Accreditation

MCO/PHP Standards

-State-Developed/Specified Standards

Accreditation Required for Participation

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

Accreditation for Deeming

None

EQRO Name

-Not Applicable

EQRO Organization

-Private Accreditation Organization

EQRO Activities

-Not Applicable

NEW YORK

Partnership Plan - Family Health Plus

CONTACT INFORMATION

State Medicaid Contact: Linda LeClair
Office of Medicaid Management, New York State
(518) 474-8887

State Website Address: <http://www.health.state.ny.us>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: June 29, 2001
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: September 04, 2001
Statutes Utilized: Not Applicable	Waiver Expiration Date: March 31, 2003
Enrollment Broker: Maximus and Facilitated Enrollers	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) -1902(a)(34) Retroactive Eligibility
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(2)(A)(vi) Eligibility Expansion, Guarantee -1903(u) Special Program (Community Health Care Conversion Demonstration Program)
Guaranteed Eligibility: 6 months guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Case Management, Dental (MCO option), Diabetic supplies and equipment, Durable Medical Equipment, Emergency ambulance transportation, EPSDT, Family Planning (MCO Option), Hearing, Home Health (40 visits), Immunization, Inpatient Hospital, Inpatient Mental Health (30 days per year), Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health (60 days per year), Outpatient Substance Abuse, Physician, Prescription Drugs, Radiation Therapy, chemotherapy and hemodialysis, Smoking cessation products, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Nurse Practitioners -Other Specialists Approved on a Case-by-Case Basis
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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

Subpopulations Excluded from Otherwise**Included Populations:**

- Enrolled in Another Managed Care Program
- Equivalent Insurance
- Medicare Dual Eligible

Populations Mandatorily Enrolled:

None

Lock-In Provision:

12 month lock-in

PPO (Comprehensive Benefits) - Full 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), Immunization, Inpatient Hospital, Inpatient Mental Health (30 days per year), Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health (60 days per year), Outpatient Substance Abuse, 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 or 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

Subpopulations Excluded from Otherwise**Included Populations:**

- Enrolled in Another Managed Care Program
- Other Equivalent Insurance
- Medicare Dual Eligible

Populations Mandatorily Enrolled:

None

Lock-In Provision:

12 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ABC Health Plan
Americhoice
Capital District Physicians Health Plan
Catholic Services Health Plan/Fidelis
Community Premier Plus
GHI
Health Now
LMC/Health Care Plus
MetroPlus Health Plan
NY Hospital Community PHSP

Affinity Health Plan
Buffalo Community Health
CarePlus Health Plan
Community Choice Health Plan
Excellus
Health First
HIP Combined
Manhattan PHSP/Centercare
Neighborhood Health Providers
St. Barnabas/Partners in Health

NEW YORK

Partnership Plan - Family Health Plus

Syracuse PHSP/Total Care
United Healthcare of Upstate
Westchester PHSP

United Healthcare of NY
Wellcare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-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
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

None

Validation: Methods

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

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

-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility

State conducts general data completeness assessments

Yes

NEW YORK

Partnership Plan - Family Health Plus

- Plan Enrollment
- Diagnosis Codes
- Procedure Codes

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Island Peer Review Organization

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

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

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	Initial Waiver Approval Date: July 15, 1997
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: October 01, 1997
Statutes Utilized: Not Applicable	Waiver Expiration Date: March 31, 2003
Enrollment Broker: Maximus	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)
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(2)(A)(vi) Eligibility Expansion, Guarantee -1903(u) Special Program (Community Health Care Conversion Demonstration Program)
Guaranteed Eligibility: 6 months guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Case Management, Dental (MCO Option), Durable Medical Equipment, EPSDT, Family Planning (MCO Option), Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Skilled Nursing Facility, Transportation (Optional), Vision, X-Ray	Allowable PCPs: -Other Specialists Approved on a Case-by-Case Basis -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Nurse Practitioners
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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

Subpopulations Excluded from Otherwise Included Populations:

- Medicare Dual Eligible
- Enrolled in Another Managed Care Program
- Reside in Nursing Facility or ICF/MR
- Participation in LTC Demonstration Program
- Other Insurance
- Eligible less than 6 Months
- Spend downs
- Reside in State Operated Psychiatric facility
- Enrolled in the Restricted Recipient Program
- Admitted to hospice at the time of enrollment
- Foster children in direct care
- Eligible only for TB related services
- Reside in residential treatment facility for children and youth
- Infants weighing less than 1200 grams or infants who meet SSI criteria
- Special Needs Children (BBA defined)

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Adults and Related Populations
- NYS Home Relief Adults
- Section 1931 (AFDC/TANF) Children and Related

Lock-In Provision:

12 month lock-in

NEW YORK

Partnership Plan Medicaid Managed Care Program

PCCM Provider - Partial Capitation

Service Delivery

Included Services:

Case Management, Dental, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray

Allowable PCPs:

- Nurse Practitioners
- Pediatricians
- Internists
- General Practitioners
- Family Practitioners
- Obstetricians/Gynecologists or Gynecologists
- Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:

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

Populations Mandatorily Enrolled:

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

Subpopulations Excluded from Otherwise**Included Populations:**

- Infants weighing less than 1200 grams or other infants who met criteria for SSI
- Other Insurance
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Eligible less than 6 months
- Special Needs Children (BBA defined)
- Spend downs
- Reside in State Operated Psychiatric Facility
- Reside in residential treatment facility for children and youth
- Enrolled in the Restricted Recipient Program
- Admitted to hospice at the time of enrollment
- Foster children in direct care
- Eligible only for TB related services
- Participants in LTC Demonstration Program

Lock-In Provision:

12 month lock-in

NEW YORK

Partnership Plan Medicaid Managed Care Program

PCCM Provider fee for service - Fee-for-Service

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:

- Pediatricians
- General Practitioners
- Family Practitioners
- Internists
- Obstetricians/Gynecologists or Gynecologists
- Other Specialists Approved on a Case-by-Case Basis
- Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:

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

Populations Mandatorily Enrolled:

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

Subpopulations Excluded from Otherwise**Included Populations:**

- Spend downs
- Reside in State Operated Psychiatric Facility
- Reside in residential treatment facility for children and youth
- Enrolled in restricted recipient program
- Other Insurance
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Special Needs Children (BBA defined)
- Admitted to hospices at the time of enrollment
- Foster care children in direct care
- Eligible only for TB services
- Participants in LTC Demonstration Program
- Infants weighing less than 1200 grams or other infants who meet criteria for SSI
- Eligible less than 6 months

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

NEW YORK

Partnership Plan Medicaid Managed Care Program

ABC Health Plan
Americhoice
Buffalo Community Health
CarePlus Health Plan
Community Choice Health Plan
Excellus
Health First
HIP Combined
LMC/Health Care Plus
MetroPlus Health Plan
NY Hospital Community PHSP
Preferred Care
Southern Tier Pediatrics
Suffolk Health Plan
Twin Tier/ Southern Tier Priority
United Healthcare of Upstate
Wellcare

Affinity Health Plan
Broome County MC
Capital District Physicians Health Plan
Catholic Services Health Plan/Fidelis
Community Premier Plus
Health Choice
Health Now
Independent Health/Hudson Valley&WNY
Manhattan PHSP/Centercare
Neighborhood Health Providers
Physician Case Management Program
Primary Health
St. Barnabas/Partners in Health
Syracuse PHSP/Total Care
United Healthcare of NY
Vytra
Westchester PHSP

ADDITIONAL INFORMATION

This program has an enrollment broker in NYC and may also come on board in Long Island. The Physician Case Management Program is a partially capitated PCCM. This provider receives a monthly premium for primary and preventive care and coordinating, locating and monitoring other necessary medical services.

Foster Care Children may be enrolled at the option of the county.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Consumer Self-Report Data

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

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

Use of HEDIS

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

Encounter Data

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission

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)

NEW YORK

Partnership Plan Medicaid Managed Care Program

- 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

Collection: Standardized Forms

None

- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

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

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

- Date of Service
- Date of Processing
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Alcohol and Substance abuse use screening
- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Cholesterol screening and management
- Dental services
- Depression management
- Diabetes management
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- HIV/AIDS care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead Screening
- Lead Screening rate
- Smoking prevention and cessation
- Well-child care visit rates

Health Status/Outcomes Quality

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

Access/Availability of Care

- Average distance to PCP
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiary

281

NEW YORK

Partnership Plan Medicaid Managed Care Program

- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of Care

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

Health Plan/ Provider Characteristics

- Board Certification
- Languages Spoken (other than English)
- Provider turnover

Beneficiary Characteristics

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

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Inpatient maternity care and discharge planning
- Low birth-weight baby
- Newborn screening for heritable diseases
- Post-natal Care
- Pre-natal care

Non-Clinical Topics

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

Standards/Accreditation

MCO/PHP Standards

- State-Developed/Specified Standards

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-Island Peer Review Organization

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

NEW YORK

Partnership Plan Medicaid Managed Care Program

Quality Oversight Activities:

- Consumer Self-Report Data
- Focused Studies
- On-Site Reviews
- Provider Data

Use of Collected Data:

- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

- Provider developed survey

NORTH CAROLINA

Access II/III 1915b

CONTACT INFORMATION

State Medicaid Contact: Deborah Bowen
Division of Medical Assistance
(919) 857-4226

State Website Address: <http://www.dhhs.state.nc.us/dma/>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: July 01, 1998
Operating Authority: 1915(b) - Waiver Program	Implementation Date: July 01, 1998
Statutes Utilized: 1915(b)(1)	Waiver Expiration Date: November 08, 2002
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
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Chiropractor, 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: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Practitioners -Nurse Midwives -Physician Assistants -Health Departments -Hospital Outpatient Clinics -Community Health Centers -Other Specialist Approved on a Case-by-Case Basis -Health Clinics
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NORTH CAROLINA

Access II/III 1915b

Enrollment

Populations Voluntarily Enrolled:

- Foster Care Children
- Native Americans who are members of a Federally-recognized tribes
- Medicare/Medicaid Dual Eligibles
- Adoption Subsidy Children

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Blind/Disabled Children and Related Populations
- Special Needs Children (BBA defined)

Subpopulations Excluded from Otherwise Included Populations:

- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Eligibility Period that is only Retroactive
- Private Insurance and PCP not willing to participate
- Native American choosing to be exempt

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Asks advocacy groups to identify members of these groups
- Pilot Initiative occurring in Buncombe County that integrates and collaborates with all community age
- 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 services. ACCESS II/III manages the highest risk Medicaid enrollees to improve coordination and continuity of care.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

NORTH CAROLINA

Access II/III 1915b

Quality Oversight Activities:

- Care Management
- Consumer Self-Report Data
- Enrollee Hotlines
- Focused Studies
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Utilization Claims Data focusing on High Cost and High Risk
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data:

- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Plan & Provide Education
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling
- Quality Improvement Activities
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

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

Performance Measures

Process Quality

- Annual eye exams for diabetics
- Asthma Action Plans submitted to Schools
- Asthma care
- Diabetes management
- Influenza vaccination rate
- Lead screening rate
- Staging of asthmatics and appropriate use of medication
- Well-child care visit rates

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 primary care case manager
- Complaint Monitoring
- Ratio of primary care case managers to beneficiaries
- Satisfaction Survey

Use of Services/Utilization

- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary
- Inpatient and ED utilization with diagnosis of asthma or diabetes
- Number of home health visits per beneficiary
- Number of primary care case manager visits per beneficiary
- Number of specialist visits per beneficiary

Provider Characteristics

- Bilingual staff and educational material
- Languages spoken (other than English)
- Patient/family satisfaction and understanding services
- Provider turnover

Beneficiary Characteristics

- Beneficiary need for interpreter
- Complaints and Satisfaction Survey
- Disenrollment rate
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries who are auto-assigned to PCCM
- Reason for disenrollment or provider change

Performance Improvement Projects

Clinical Topics

- ADHD Management
- Adolescent Immunization
- Adolescent Well Care/EPSTD
- Asthma management
- Child/Adolescent Hearing and Vision Screening and Services
- Childhood Immunization
- Coordination of primary and behavioral health care
- Depression management
- Diabetes management
- Emergency Room service utilization
- Gastroenteritis

Non-Clinical Topics

- Availability of language interpretation services
- Children's access to primary care practitioners
- Community Communication and Collaboration with High-Risk Clients
- Coordination of Wrap-Around Services

NORTH CAROLINA

Access II/III 1915b

- Lead toxicity
- Otitis Media management
- Pregnancy Prevention
- Pre-natal care
- Prevention of influenza
- Well Child Care/EPST

NORTH CAROLINA
Access II/III1932(a)
CONTACT INFORMATION

State Medicaid Contact: Deborah Bowen
Division of Medical Assistance
(919) 857-4226

State Website Address: <http://www.dhhs.state.nc.us/dma/>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932 - State Plan Option to Use Managed Care	Implementation Date: January 01, 1999
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Chiropractic, Dialysis, 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: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Practitioners -Nurse Midwives -Physician Assistants -Health Departments -Hospital Outpatient Clinics -Community Health Centers -Health Clinics -Other Specialists Approved on a Case-by-Case Basis
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NORTH CAROLINA

Access II/III1932(a)

Enrollment

Populations Voluntarily Enrolled:

- Pregnant Women
- Aged and Related Populations

Subpopulations Excluded from Otherwise**Included Populations:**

- Reside in Nursing Facility or ICF/MR
- Eligibility Period that is only Retroactive
- Refugees
- QMB
- Special Needs Children (BBA defined)
- Medicare Dual Eligible
- American Indian/Alaskan Native

Populations Mandatorily Enrolled:

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

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Asks advocacy groups to identify members of these groups
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses ACCESS II Health assessment form
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Maternal and Child Health Agency
- Public Health Agency
- Social Services 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.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Care Management
- Consumer Self-Report Data
- Enrollee Hotlines
- Focused Studies
- On-Site Reviews

Use of Collected Data:

- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Plan and Provide Education
- Program Evaluation

NORTH CAROLINA

Access II/III1932(a)

- 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
 - Adult with Special Needs Questionnaire

- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision
- Quality Improvement Activities
- Provider Profiling

Performance Measures

Process Quality

- Asthma care
- Cholesterol screening and management
- Depression management
- Diabetes management
- Influenza vaccination rate
- Smoking prevention and cessation

Access/Availability of Care

- Average wait time for an appointment with primary care case manager
- Complaint Monitoring
- Ratio of primary care case managers to beneficiaries
- Satisfaction Survey

Provider Characteristics

- Bilingual staff and educational materials in English and Spanish
- Languages spoken (other than English)
- Patient/family satisfaction and understanding services
- Provider turnover

Health Status/Outcomes Quality

- Inpatient admissions and ER visits
- Patient satisfaction with care

Use of Services/Utilization

- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary
- Inpatient and ED admissions with diagnosis of Asthma or Diabetes
- Number of home health visits per beneficiary
- Number of primary care case manager visits per beneficiary
- Number of specialist visits per beneficiary

Beneficiary Characteristics

- Beneficiary need for interpreter
- Complaints and Satisfaction Survey
- Disenrollment rate
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries who are auto-assigned to PCCM
- Reason for disenrollment of change of PCP

Performance Improvement Projects

Clinical Topics

- Asthma management
- Breast cancer screening (Mammography)
- Cervical cancer screening (Pap Test)
- Cholesterol screening and management
- Diabetes management
- Emergency Room service utilization
- Prevention of Influenza
- Smoking prevention and cessation
- Treatment of Depression in PCP office Pilot

Non-Clinical Topics

- Adults access to preventive/ambulatory health services
- Availability of language interpretation services
- Collaboration and Integration of Wrap-Around Services
- Community Communication and Collaboration with High-Risk Clients

NORTH CAROLINA Carolina ACCESS 1915 (b)

CONTACT INFORMATION

State Medicaid Contact:

Deborah Bowen
Division of Medical Assistance
(919) 857-4226

State Website Address:

<http://www.dhhs.state.nc.us/dma/>

PROGRAM DATA

Program Service Area:

Statewide

Initial Waiver Approval Date:

April 01, 1991

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

April 01, 1991

Statutes Utilized:

1915(b)(1)

Waiver Expiration Date:

November 08, 2002

Enrollment Broker:

No

Sections of Title XIX Waived:

-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

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:

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

NORTH CAROLINA Carolina ACCESS 1915 (b)

Enrollment

Populations Voluntarily Enrolled:

- Foster Care Children
- Pregnant Women
- Medicare/Medicaid Dual Eligibles
- American Indians who are members of Federally-recognized tribes

Subpopulations Excluded from Otherwise Included Populations:

- Reside in Nursing Facility or ICF/MR
- Eligibility Period that is only Retroactive
- Enrolled in Another Managed Care Program
- Native Americans choosing to be exempt
- Terminally Ill
- Private Insurance and PCP Not Willing to Participate

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Blind/Disabled Children and Related Populations
- Special Needs Children (BBA Defined except for "Katie Becket" children)

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Reviews complaints and grievances to identify members of these groups
- 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

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

Enrollment Broker: Public Consulting Group, is only used in Mecklenburg County.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

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

Use of Collected Data:

- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

NORTH CAROLINA

Carolina ACCESS 1915 (b)

Consumer Self-Report Data

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

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Immunizations for two year olds
- Initiation of prenatal care
- Well-child care visit rates

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

Provider Characteristics

None

Health Status/Outcomes Quality

- Patient satisfaction with care

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiaries
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiaries
- Number of specialist visits per beneficiary
- Outpatient visits per 1,000 beneficiaries

Beneficiary Characteristics

- Change of PCP and Reason for Change
- Patient Education
- Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics

- Adolescent Immunization
- Asthma management
- Attention Deficit/Hyperactivity Disorder
- Childhood Immunization
- Pre-natal care
- Well Child Care/EPSTD

Non-Clinical Topics

None

NORTH CAROLINA Carolina ACCESS 1932

CONTACT INFORMATION

State Medicaid Contact: Deborah Bowen
Division of Medical Assistance
(919) 857-4226

State Website Address: <http://www.dhhs.state.nc.us/dma/>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932 - State Plan Option to Use Managed Care	Implementation Date: January 01, 1999
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: Yes	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, 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 or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Practitioners -Nurse Midwives -Physician Assistants
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NORTH CAROLINA Carolina ACCESS 1932

Enrollment

Populations Voluntarily Enrolled:

- Aged and Related Populations
- Medicaid Pregnant Women

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
- American Indian/Alaskan Native
- Special Needs Children (BBA defined)
- Medicare Dual Eligible

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Reviews complaints and grievances to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Maternal and Child Health Agency
- 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 \$2.00 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/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

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

Use of Collected Data:

- Beneficiary Provider Selection
- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

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

NORTH CAROLINA

Carolina ACCESS 1932

Performance Measures

Process Quality

- Breast Cancer screening rate
- Cervical cancer screening rate
- Diabetes management
- Initiation of prenatal 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

Provider Characteristics

None

Health Status/Outcomes Quality

- Patient satisfaction with care

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiaries
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiaries
- Number of Outpatient Visits per 1,000 beneficiaries
- Number of specialist visits per beneficiary

Beneficiary Characteristics

- Change of PCP and Reason for Change
- Patient Education
- Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics

- Congestive Heart Failure Management
- Diabetes management

Non-Clinical Topics

None

NORTH CAROLINA Health Care Connection (1915)b

CONTACT INFORMATION

State Medicaid Contact: Deborah Bowen
Division of Medical Assistance
(919) 857-4226

State Website Address: <http://www.dhhs.state.nc.us/dma/>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: April 01, 1991
Operating Authority: 1915(b) - Waiver Program	Implementation Date: July 01, 1996
Statutes Utilized: 1915(b)(1)	Waiver Expiration Date: November 08, 2002
Enrollment Broker: Public Consulting Group	Sections of Title XIX Waived: -1902(a)(1) Statewide -1902(a)(10)(B) Comparability of Services -1902(a)(23) Freedom of Choice
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Adult Preventative Medicine, Ambulance, Chiropractic, Clinic Services-except for Mental Health and Substance Abuse, Diagnostic, 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 Abuse, Laboratory, Midwife, Occupational, Speech and Physical Therapy, Optical Supplies, Outpatient Hospital, Physician Services including Physician Assistants and Family Nurse Practitioners, Podiatry, Postpartum Newborn Home Visit -Maternal Assessment, Postpartum Newborn Home Visit-EPSDT, Postpartum Newborn Home Visit-Newborn Assessment, Private Duty Nursing, Prosthetics/Orthotics, Sterilization, Total Parenteral Nutrition, Vision, X-Ray	Allowable PCPs: -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Clinics (RHCs) -Nurse Practitioners -Nurse Midwives -Physician Assistants -Pediatricians -Other Specialists Approved on a Case-by-Case Basis
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NORTH CAROLINA Health Care Connection (1915)b

Enrollment

Populations Voluntarily Enrolled:

- Foster Care Children
- Adoption Subsidy Children

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Blind/Disabled Children and Related Populations
- Pregnant Women
- Special Needs Children (BBA defined)

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
- Eligibility Period that is only Retro-active

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these

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

United HealthCare

Wellpath Select, Inc. dba Southcare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

NORTH CAROLINA

Health Care Connection (1915)b

Consumer Self-Report Data

- CAHPS
 - Child Medicaid AFDC Questionnaire
 - Child Medicaid SSI Questionnaire
 - Child with Special Needs 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/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Validation: Methods

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

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure
- Units of Service

State conducts general data completeness assessments

No

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Well-child care visit rates

Health Status/Outcomes Quality

- Children with Special Health Care Needs Assessment
- New Member Health Assessment
- Patient satisfaction with care

NORTH CAROLINA

Health Care Connection (1915)b

Access/Availability of Care

- Average wait time for an appointment with PCP
- Children's Access to Therapy Services
- Involuntary Disenrollment
- Non-authorized Visits
- Ratio of PCPs to beneficiaries
- Referral denials

Use of Services/Utilization

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

Health Plan Stability/ Financial/Cost of Care

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

Health Plan/ Provider Characteristics

- After Hours Survey
- Enrollment by Product Line
- Languages Spoken (other than English)

Beneficiary Characteristics

- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSTD
- Asthma management
- Childhood Immunization
- Pre-natal care
- Well Child Care/EPSTD

Non-Clinical Topics

None

Standards/Accreditation

MCO/PHP Standards

- NCQA (National Committee for Quality Assurance) Standards
- QARI (Quality Assurance Reform Initiative)
- State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

- Medical Review of North Carolina
- Myers and Stauffers

EQRO Organization

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

EQRO Activities

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

NORTH CAROLINA Health Care Connection (1932)a

CONTACT INFORMATION

State Medicaid Contact:

Deborah Bowen
Division of Medical Assistance
(919) 857-4226

State Website Address:

<http://www.dhhs.state.nc.us/dma/>

PROGRAM DATA

Program Service Area:

County

Initial Waiver Approval Date:

Not Applicable

Operating Authority:

1932 - State Plan Option to Use Managed Care

Implementation Date:

July 01, 1996

Statutes Utilized:

Not Applicable

Waiver Expiration Date:

Not Applicable

Enrollment Broker:

Public Consulting Group

Sections of Title XIX Waived:

Not Applicable

For All Areas Phased-In:

Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:

Not Applicable

Guaranteed Eligibility:

No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Adult Preventative Medicine, Ambulance, Chiropractic, Clinic Services-Except for Mental Health and Substance Abuse, Diagnostic, 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 Abuse, 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 or Gynecologists

Enrollment

NORTH CAROLINA

Health Care Connection (1932)a

Populations Voluntarily Enrolled:

-Aged and Related Populations

Populations Mandatorily Enrolled:

-Pregnant Women
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program
-Eligibility Period That Is Only Retro-active
-Special Needs Children (BBA defined)

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-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

United HealthCare

Wellpath Select, Inc. dba Southcare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

NORTH CAROLINA

Health Care Connection (1932)a

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/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Validation: Methods

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

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure
- Units of Service

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Breast Cancer screening rate
- Cervical cancer screening rate
- Diabetes management
- Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality

- New Member Health Assessment
- Patient satisfaction with care

NORTH CAROLINA

Health Care Connection (1932)a

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

Beneficiary Characteristics

- None

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Diabetes management
- Pre-natal care

Non-Clinical Topics

- None

Standards/Accreditation

MCO/PHP Standards

- NCQA (National Committee for Quality Assurance) Standards
- QARI (quality Assurance Reform Initiative)
- State-Developed/Specified Standards

Accreditation Required for Participation

- None

Accreditation for Deeming

- None

EQRO Name

- Medical Review of North Carolina
- Myers and Stauffers

EQRO Organization

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

EQRO Activities

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

NORTH DAKOTA

North Dakota Access and Care Program

CONTACT INFORMATION

State Medicaid Contact: Tom Solberg
Department of Human Services, Medical Assistance
(701) 328-1884

State Website Address: <http://www.state.nd.us/hms/dhs.htm>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932 - State Plan Option to Use Managed Care	Implementation Date: January 01, 1994
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

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 Abuse, Laboratory, Mid-level Practitioner, Non-Emergency Transportation, Nutritional, Occupational, Physical, and Speech Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Podiatry, Private Duty Nursing, Public Health Unit, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:

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

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

- 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
- Eligibility Period that is only Retroactive
- Special Needs Children (BBA defined)

Lock-In Provision:

6 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Chiropractic, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Mid-Level Practitioner, Non-Emergency Transportation, Nutritional, Occupational, Physical, and Speech Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Podiatry, Public Health Unit, Transportation, X-Ray

Allowable PCPs:

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

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Optional Categorically Needy
- Poverty Level

Subpopulations Excluded from Otherwise

Included Populations:

- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- Medically Needy
- Foster Care
- Refugee Assistance
- Adoption Assistance
- Eligibility Period that is only Retroactive
- Special Needs Children (BBA defined)

Lock-In Provision:

6 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AltruCare

North Dakota Access and Care Program

NORTH DAKOTA

North Dakota Access and Care Program

ADDITIONAL INFORMATION

AltruCare is only offered in Grand Forks county. Program was converted from a 1915(a) to a 1932(a) on July 1, 2001.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Focused Studies
- MCO/PHP Standards (see below for details)
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Consumer Self-Report Data

- Health Plan Developed Survey with State Approval

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

Use of HEDIS

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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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

None

Collections: Submission Specifications

- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Per member per month analysis and comparisons across MCOs/PHPs

State conducts general data completeness assessments

No

Performance Measures

Process Quality

- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Diabetes management
- Frequency of on-going prenatal care

Health Status/Outcomes Quality

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

NORTH DAKOTA

North Dakota Access and Care Program

- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Well-child care visit rates

Access/Availability of Care

- Average wait time for an appointment with PCP
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

- 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
- Total revenue

Health Plan/ Provider Characteristics

- Number and Type of Services Provided

Beneficiary Characteristics

- MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Asthma management
- Breast cancer screening (Mammography)
- Cervical cancer screening (Pap Test)
- Childhood Immunization
- Diabetes management
- Emergency Room service utilization
- Lead toxicity
- Low birth-weight baby
- Pre-natal care
- Well Child Care/EPSTD

Non-Clinical Topics

- Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards

- State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-North Dakota Health Care Review

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

-Yet To Be Determined

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Consumer Self-Report Data
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data:

- Beneficiary Provider Selection
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling

NORTH DAKOTA

North Dakota Access and Care Program

-Track Health Service provision

Consumer Self-Report Data

-State-developed Survey

Performance Measures

Process Quality

- Breast Cancer screening rate
- Cervical cancer screening rate
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Lead screening rate
- Well-child care visit rates

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

Provider Characteristics

None

Health Status/Outcomes Quality

- Patient satisfaction with care

Use of Services/Utilization

None

Beneficiary Characteristics

None

OHIO PremierCare

CONTACT INFORMATION

State Medicaid Contact:

Cynthia Burnell
Bureau of Managed Health Care
(614) 466-4693

State Website Address:

<http://www.state.oh.us/odjfs/index.stm>

PROGRAM DATA

Program Service Area:

County

Initial Waiver Approval Date:

May 23, 2001

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

July 01, 2001

Statutes Utilized:

1915(b)(1)
1915(b)(2)
1915(b)(4)

Waiver Expiration Date:

June 30, 2003

Enrollment Broker:

Automated Health Systems

Sections of Title XIX Waived:

-1902(a)(1) Statewide
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30)

For All Areas Phased-In:

Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Disenrollment
-1903(m)(I)(A)

Guaranteed Eligibility:

No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

All other Ohio Medicaid services, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Vision, X-Ray

Allowable PCPs:

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

OHIO PremierCare

Enrollment

Populations Voluntarily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Special Needs Children (State defined)
- 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

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- TITLE XXI SCHIP
- Special Needs Children (BBA defined)
- Special Needs Children (State defined)

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Surveys medical needs of enrollee to identify members of these groups
- Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

CareSource
Paramount Health Care
Qualchoice Health Plan
Summacare

Family Health Plan
Peoples Health Plan
Renaissance

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 four 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. An enrollee under the age of 21 which has one or more of the following medical conditions: In selected counties enrollment is voluntary, mandatory, or "preferred option."

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

- Beneficiary Plan Selection
- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement

OHIO

PremierCare

- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

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

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous enrollment requirement for some or all of the measures
- State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous 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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of "home grown" forms
- Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

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

Validation: Methods

- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills)
- Manual analysis of encounter data submission to help determine data completeness
- Medical record validation
- Per member per month analysis and comparisons across MCOs/PHPs

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

- Date of Service
- Provider ID
- Type of Service
- 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

OHIO PremierCare

Process Quality

- Asthma care
- Check-ups after delivery
- Dental services
- Diabetes management
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation of prenatal care
- Percentage of beneficiaries with at least one dental visit
- Postpartum Visits
- Well-child care visit rates

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP

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

Beneficiary Characteristics

- Beneficiary need for interpreter
- Information on primary languages spoken by beneficiaries
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
- Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Health Status/Outcomes Quality

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

Use of Services/Utilization

- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics

- Provider turnover

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Well Care/EPSTD
- Asthma management
- Child/Adolescent Dental Screening and Services
- Childhood Immunization
- Diabetes management
- Low birth-weight baby
- Post-natal Care
- Pre-natal care
- Well Child Care/EPSTD

Non-Clinical Topics

- Adults access to preventive/ambulatory health services
- Children's access to primary care practitioners
- Customer Service
- Fraud & Abuse

OHIO PremierCare

Standards/Accreditation

MCO/PHP Standards

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

Accreditation for Deeming

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

EQRO Organization

- PRO-like Entity

Accreditation Required for Participation

None

EQRO Name

- Delmarva Foundation for Medical Care

EQRO Activities

- Administration or validation of consumer or provider surveys
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters

OKLAHOMA SoonerCare

CONTACT INFORMATION

State Medicaid Contact: Rebecca Pasternik-Ikard
Oklahoma Health Care Authority
(405) 522-7200

State Website Address: <http://www.ohca.state.ok.us>

PROGRAM DATA

Program Service Area: County Region	Initial Waiver Approval Date: October 12, 1995
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: January 01, 1996
Statutes Utilized: Not Applicable	Waiver Expiration Date: December 31, 2003
Enrollment Broker: FirstHealth	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: -1903(m)(2)(A)(vi) Guaranteed Eligibility
Guaranteed Eligibility: 6 months guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -Internists -Obstetricians/Gynecologists or Gynecologists -Pediatricians -General Practitioners -Family Practitioners -Federally Qualified Health Centers (FQHCs) -Other Specialists Approved on a Case-by-Case Basis
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Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations
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OKLAHOMA

SoonerCare

- 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:

- Children in permanent custody
- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- Other Insurance

Lock-In Provision:

12 month lock-in

PCCM Provider - Partial Capitation

Service Delivery

Included Services:

Case Management, EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

Allowable PCPs:

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

- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- Children In State Custody
- Medicare Dual Eligible
- Other Insurance

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

OKLAHOMA

SoonerCare

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 groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Aging Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Social Services Agency
- Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Communitycare
Prime Advantage
UNICARE

Heartland
SoonerCare PCCM

ADDITIONAL INFORMATION

Beneficiaries are auto assigned to either PCCM or MCO models depending on where they live.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Adult Medicaid SSI Questionnaire
 - Child Medicaid AFDC Questionnaire
 - Child Medicaid SSI Questionnaire
- Consumer/Beneficiary Focus Groups

Use of Collected Data

- Contract Standard Compliance
- Fraud and Abuse
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Reimbursement
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Use of HEDIS

- The State uses ALL of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State use/requires MCOs/PHPs to follow NCQA specifications

Encounter Data

Collection: Requirements

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

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Use of "home grown" forms
- Use of Medicaid Identification Number for beneficiaries

OKLAHOMA

SoonerCare

data submission

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

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

- Date of Service
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

Validation: Methods

- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills)
- Per member per month analysis and comparisons across MCOs/PHPs
- Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Dental services
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit
- Well-child care visit rates

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care

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

Health Status/Outcomes Quality

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

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of PCP visits per beneficiary
- Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics

- Board Certification
- Languages Spoken (other than English)
- Provider turnover

OKLAHOMA SoonerCare

-Total revenue

Beneficiary Characteristics

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

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSTD
- Asthma management
- Childhood Immunization
- Coordination of care for persons with physical disabilities
- Depression management
- Emergency Room service utilization
- Newborn screening for heritable diseases
- Pre-natal care
- Prescription drug abuse
- Prevention of Influenza
- Well Child Care/EPSTD

Non-Clinical Topics

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

Standards/Accreditation

MCO/PHP Standards

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

Accreditation Required for

- State recognizes accreditation but it is not required.

Accreditation for Deeming

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

EQRO Name

- Oklahoma Foundation for Medical Quality

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

- Administration or validation of consumer or provider surveys
- Conduct performance improvement projects
- Conducts QISM Reviews of MCOs and PCCM program
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters
- Validation of performance improvement projects

OREGON
Oregon Health Plan
CONTACT INFORMATION

State Medicaid Contact: Joan Kapowich
Office of Medical Assistance Programs
(503) 945-6500

State Website Address: <http://www.omap.hr.state.or.us>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: March 19, 1993
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: February 01, 1994
Statutes Utilized: Not Applicable	Waiver Expiration Date: January 31, 2005
Enrollment Broker: No	Sections of Title XIX Waived: -1902(a)(10) -1902(a)(10)(A) -1902(a)(10)(B) Comparability of Services -1902(a)(10)(C) -1902(a)(13)(e) -1902(a)(17) -1902(a)(23) Freedom of Choice -1902(a)(30) -1902(a)(43)(A) -1905(a)(13)
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(4) -1903(m)(1)(A) -1903(m)(2)(A) -1903(m)(2)(A)(vi) Eligibility Expansion, Guarantee
Guaranteed Eligibility: 6 months guaranteed eligibility	

SERVICE DELIVERY

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

Service Delivery

Included Services: Crisis, IMD, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Outpatient Substance Abuse	Allowable PCPs: -Does not apply
Contractor Types: -Behavioral Health MCO (Private) -CMHC Operated Entity (Public)	

OREGON

Oregon Health Plan

- County Operated Entity (Public)
- Regional Authority Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
None

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

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

Lock-In Provision:
6 month lock-in

PCCM Provider - Partial Capitation

Service Delivery

Included Services:
Case Management

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

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Aged and Related Populations
-TITLE XXI SCHIP
-Pregnant Women and Optional Children
-Medicare Dual Eligible
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

Lock-In Provision:
No lock-in

OREGON

Oregon Health Plan

Dental PHP - Full Capitation

Included Services:

Dental

Service Delivery**Allowable PCPs:**

-Does not apply

Enrollment**Populations Voluntarily Enrolled:**

-American Indian/Alaskan Native

Populations Mandatorily Enrolled:

-Medicare Dual Eligible
-American Indian/Alaskan Native
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Pregnant Women and Optional Children

Subpopulations Excluded from Otherwise**Included Populations:**

-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

Lock-In Provision:

6 month lock-in

OREGON

Oregon Health Plan

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

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

Allowable PCPs:

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

Enrollment

Populations Voluntarily Enrolled:

-American Indian/Alaskan Native

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- TITLE XXI SCHIP
- Pregnant Women and Optional Children
- Medicare Dual Eligible
- American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:

- Other Insurance
- Enrolled in Another Managed Care Program
- QMB and MN Spenddown

Lock-In Provision:

6 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

- Asks advocacy groups to identify members of these groups
- Health Plans use multiple means to identify such members
- Reviews complaints and grievances to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Aging Agency
- Education Agency
- Housing Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency
- Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

OREGON

Oregon Health Plan

Accountable Behavioral Health
Care Oregon
Central Oregon Independent Health Services
Deschutes County CDO
Douglas County IPA
FamilyCare Health Plans
Hayden Family Dentistry
Jefferson Behavioral Health
Lane Care MHO
Managed Dental Care of Oregon
Mid Valley Behavioral Care Network
Multicare Dental
Northwest Dental Services
Oregon Health Management Service
Providence Behavioral
Tuality Health Alliance (Mental Health)
Willamette Dental

Capitol Dental Care Inc.
Cascade Comprehensive Care
Clackamas County Mental Health
Doctors of the Oregon Coast South
FamilyCare (Mental Health)
Greater Oregon Behavioral Health, Inc.
Inter-Community Health Network
Kaiser Permanente
Lane Individual Practice Association
Marion Polk Community Health Plan
Mid-Rogue Independent Practice Assoc.
Multnomah County Verity
Oregon Dental Service
PCCM
Providence Health Plan
Tuality Health Care

ADDITIONAL INFORMATION

1902(a)(1) Statewideness was waived under the uniformity section.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- External Quality Review
- Focused Studies
- MCO/PHP Standards (see below for details)
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Consumer Self-Report Data

- CAHPS
Adult/Child Survey with selected Medicaid, Special Needs, and Oregon Specific Questions

Use of Collected Data

- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Use of HEDIS

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

Encounter Data

Collection: Requirements

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

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

OREGON

Oregon Health Plan

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

- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

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

Validation: Methods

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

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

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Asthma care
- Dental services
- Diabetes management
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit
- Well-child care visit rates

Health Status/Outcomes Quality

- Patient satisfaction with care
- Patient self reporting health status

Access/Availability of Care

- Adult access to ambulatory and preventive care
- Average wait time for an appointment with PCP
- Child Access to PCP's
- Percentage of eligibles enrolled in a FCHP or PCCM

Use of Services/Utilization

- 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.)

Health Plan/ Provider Characteristics

- Board Certification
- Languages Spoken (other than English)

OREGON

Oregon Health Plan

- Medical loss ratio
- Net income
- Net worth
- State minimum reserve requirements
- Total revenue

Beneficiary Characteristics

- Beneficiary need for information in an alternate format
- Information of beneficiary ethnicity/race

Performance Improvement Projects

Project Requirements

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

Clinical Topics

- Childhood Immunization
- Coordination of primary and behavioral health care
- Early childhood cavities prevention
- Smoking prevention and cessation

Non-Clinical Topics

Care None

Standards/Accreditation

MCO/PHP Standards

- State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-TBA

EQRO Organization

- PRO-like Entity

EQRO Activities

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

OREGON

* Transportation Program

CONTACT INFORMATION

State Medicaid Contact:

Larry Daimler
Office of Medical Assistance Programs
(503) 945-6493

State Website Address:

<http://www.omap.hr.state.or.us>

PROGRAM DATA

Program Service Area:

County

Initial Waiver Approval Date:

September 01, 1994

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

September 01, 1994

Statutes Utilized:

1915(b)(4)

Waiver Expiration Date:

July 25, 2003

Solely Reimbursement Arrangement:

Yes

Sections of Title XIX Waived:

-1902(a)(1) Statewide
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

Guaranteed Eligibility:

None

ADDITIONAL INFORMATION

The State contracts with brokers on a per ride fee-for-service basis. The brokers subcontract with providers on a per ride fee-for-service basis who provide non-emergency transportation services.

PENNSYLVANIA
Family Care Network
CONTACT INFORMATION

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

State Website Address: <http://state.pa.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: October 14, 1993
Operating Authority: 1915(b) - Waiver Program	Implementation Date: February 01, 1994
Statutes Utilized: 1915(b)(1)	Waiver Expiration Date: June 16, 2004
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
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Psychiatrists -Other Specialists Approved on a Case-by-Case Basis -Specialist Who Meets Special Needs of Client
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Enrollment

PENNSYLVANIA

Family Care Network

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

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

Subpopulations Excluded from Otherwise

Included Populations:

- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Eligibility Period Less Than 3 Months
- Restricted Beneficiaries
- State Blind Pension Recipients

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

- Aging Agency
- Education Agency
- Housing Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency
- Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Family Care Network

ADDITIONAL INFORMATION

Enrollment focuses on Medicaid recipients under age 21. There is a monthly patient fee of \$3.00.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

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

Use of Collected Data:

- Contract Standard Compliance
- Program Evaluation
- Regulatory Compliance/Federal Reporting

Consumer Self-Report Data

- State-developed Survey

Performance Measures

PENNSYLVANIA

Family Care Network

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-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

PENNSYLVANIA HealthChoices

CONTACT INFORMATION

State Medicaid Contact: Mike Jacobs
Pennsylvania Department of Welfare
(717) 772-6300

State Website Address: <http://www.state.pa.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: December 31, 1996
Operating Authority: 1915(b) - Waiver Program	Implementation Date: February 01, 1997
Statutes Utilized: 1915(b)(1) 1915(b)(2) 1915(b)(3) 1915(b)(4)	Waiver Expiration Date: June 16, 2004
Enrollment Broker: Benova	Sections of Title XIX Waived: -1902(a)(1) Statewideness -1902(a)(10)(B) Comparability of Services -1902(a)(23) Freedom of Choice -1902(a)(30) Upper Payment Limit
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) - Full Capitation

Service Delivery

Included Services: Case Management, Dental, Durable Medical Equipment, Emergency Ambulance Transportation, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility for First 30 Days, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Midwives -Other Specialists Approved on a Case-by-Case Basis
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PENNSYLVANIA

HealthChoices

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- State Only Categorically and Medically Needy

Subpopulations Excluded from Otherwise**Included Populations:**

- State Blind Pension Recipients
- Monthly Spend Downs
- Reside in Nursing Facility or ICF/MR

Lock-In Provision:

No lock-in

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

Service Delivery

Included Services:

Behavioral Health Rehab Svcs for children & adolescents, Case Management, Crisis, Detoxification, Family Based, IMD, Inpatient Mental Health, Inpatient Substance Abuse, Mental Health Outpatient, Mental Health Residential, Opiate Treatment Programs, Outpatient Substance Abuse, Residential Substance Abuse Treatment Programs

Allowable PCPs:

- Not applicable, contractors not required to identify PCPs

Contractor Types:

- Behavioral Health MCO (Private)
- County Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- State Only Categorically and Medically Needy

Subpopulations Excluded from Otherwise**Included Populations:**

- State Blind Pension Recipients
- Monthly Spend Downs
- Reside in Nursing Facility or ICF/MR

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

Agencies with which Medicaid Coordinates the Operation of the Program:

- Aging Agency
- Education Agency
- Housing Agency

PENNSYLVANIA

HealthChoices

Groups

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of Pennsylvania

County of Adams - Community Care Behavioral Health (CCBH)

County of Armstrong - Value Behavioral Health of PA

County of Berks - Community Care Behavioral Health (CCBH)

County of Butler - Value Behavioral Health of PA

County of Cumberland - HASPA/CBHNP

County of Delaware - Magellan Behavioral Health of PA, Inc.

County of Indiana - Value Behavioral Health of PA

County of Lawrence - Value Behavioral Health of PA

County of Lehigh - Magellan Behavioral Health of PA,

County of Northampton - Magellan Behavioral Health of PA, Inc.

County of Philadelphia - Community Behavioral

County of Westmoreland - Value Behavioral Health of PA

Gateway Health Plan, Inc.

Keystone Mercy Health Plan

UPMC Health Plan, Inc. / Best Health Care of Western PA

AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan

County of Allegheny - Community Care Behavioral

County of Beaver - Value Behavioral Health of PA

County of Bucks - Magellan Behavioral Health of PA, Inc.

County of Chester - Magellan Behavioral Health

County of Dauphin - HASPA/CBHNP

County of Fayette - Value Behavioral Health of PA

County of Lancaster - HASPA/CBHNP

County of Lebanon - HASPA/CBHNP

County of Montgomery - Magellan Choice Behavioral

County of Perry - HASPA/CBHNP

County of Washington - Value Behavioral Health of PA

County of York - Community Care Behavioral Health (CCBH)

Health Partners of Philadelphia

Three Rivers Health Plans, Inc. / MedPLUS

Value Behavioral Health of PA (Greene County)

ADDITIONAL INFORMATION

The HealthChoices Program expanded into the Lehigh/Capital zone (counties of Adams, Berks Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry, York) on October 1, 2001.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Consumer Self-Report Data

- CAHPS
2.0H adult and children

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

Use of HEDIS

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

PENNSYLVANIA

HealthChoices

-State-developed Survey

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

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

Collection: Standardized Forms

None

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills)
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes management

Health Status/Outcomes Quality

-Patient satisfaction with care

PENNSYLVANIA

HealthChoices

- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- HIV/AIDS care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit
- Pregnancy Prevention
- Smoking prevention and cessation
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Access/Availability of Care

- Average distance to PCP
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

- All use of services in HEDIS measures
- Average number of visits to MH/SA providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
- Percentage of beneficiaries with at least one dental visit
- Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of Care

- Actual reserves held by plan
- Days cash on hand
- Days in unpaid claims/claims outstanding
- Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- Net worth
- State minimum reserve requirements
- Total revenue

Health Plan/ Provider Characteristics

- Board Certification
- Languages Spoken (other than English)
- Provider turnover

Beneficiary Characteristics

- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
- Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

- MCOs/PHPs are required to conduct a project(s) of their own choosing
- Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

PENNSYLVANIA

HealthChoices

Standards/Accreditation

MCO/PHP Standards

- CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
- JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
- NAIC (National Association of Insurance Commissioners) Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-IPRO

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

- Conduct performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities

PENNSYLVANIA

Voluntary HMO Contracts

CONTACT INFORMATION

State Medicaid Contact: Mike Jacobs
Pennsylvania Department of Welfare
(717) 772-6300

State Website Address: <http://www.state.pa.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: January 01, 1972
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: None
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Case Management, Dental, Durable Medical Equipment, Emergency Ambulance Transportation, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility for First 30 Days, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Midwives -Other Specialists Approved on a Case-by-Case Basis
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Enrollment

Populations Voluntarily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Section 1931 (AFDC/TANF) Adults and Related Populations	Populations Mandatorily Enrolled: None
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PENNSYLVANIA

Voluntary HMO Contracts

- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- State Only Categorically Needy
- State Only Medically Needy

Subpopulations Excluded from Otherwise

Included Populations:

- State Blind Pension Recipients
- Monthly Spend Downs
- Reside in Nursing Facility or ICF/MR

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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 VOL
Three Rivers Health Plans, Inc./MedPlus - VOL

Gateway Health Plan, Inc. -VOL
UPMC Health Plan, Inc./Best Health Care - VOL

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data

- Beneficiary Plan Selection
- Contract Standard Compliance
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation
- Track Health Service provision

Consumer Self-Report Data

- CAHPS
2.0H Adult and Children

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid

PENNSYLVANIA

Voluntary HMO Contracts

-State-developed Survey

-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Cholesterol screening and management
- Dental services
- Diabetes management
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- HIV/AIDS care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit
- Pregnancy Prevention
- Smoking prevention and cessation
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

- All use of services 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

Beneficiary Characteristics

- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
- Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

PENNSYLVANIA

Voluntary HMO Contracts

Performance Improvement Projects

Project Requirements

-MCOs/PHPs are required to conduct a project(s) of their own choosing
-Multiple, but not all, MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency. (For instance: regional projects)

Clinical Topics

None

Non-Clinical Topics

-Availability of language interpretation services

Standards/Accreditation

MCO/PHP Standards

-CMS's Quality Improvement System for Managed Care (QISM) Standards for Medicaid and Medicare

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-IPRO

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

PUERTO RICO

Puerto Rico Health Care Reform

CONTACT INFORMATION

State Medicaid Contact: Orlando Gonzalez
Puerto Rico Health Insurance Administration
(787) 474-3300

State Website Address: None

PROGRAM DATA

Program Service Area: Region	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: February 01, 1994
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: None
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full 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 or Gynecologists -Federally Qualified Health Centers (FQHCs)
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Enrollment

Populations Voluntarily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Section 1931 (AFDC/TANF) Adults and Related Populations -Foster Care Children -Blind/Disabled Children and Related Populations -Blind/Disabled Adults and Related Populations -Aged and Related Populations	Populations Mandatorily Enrolled: None
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PUERTO RICO

Puerto Rico Health Care Reform

-TITLE XXI SCHIP
-Individual/Families up to 200% of Puerto Rico poverty level
-Police

Subpopulations Excluded from Otherwise

Included Populations:

-Enrolled in Another Managed Care Program

Lock-In Provision:

No lock-in

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:

Case Management, Inpatient Mental Health, Inpatient Substance Abuse, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation

Allowable PCPs:

-Psychiatrists
-Psychologists

Contractor Types:

-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Police
-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

Populations Mandatorily Enrolled:

None

Subpopulations Excluded from Otherwise

Included Populations:

-Enrolled in Another Managed Care Program

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

APS Healthcare
FHC Healthcare
La Cruz Azul de Puerto Rico
Triple-S, Inc.

Behavioral Health Partners
Humana Health Plans of Puerto Rico, Inc.
MCS Health Management Options, Inc.

PUERTO RICO

Puerto Rico Health Care Reform

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.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Encounter Data (see below for details)
- On-Site Reviews

Consumer Self-Report Data

None

Use of Collected Data

- Program Evaluation

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements

- Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- 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 conducts data accuracy check(s) on specified data elements

- Date of Service
- Date of Processing
- Date of Payment
- Type of Service
- Diagnosis Codes
- Procedure Codes

State conducts general data completeness assessments

Yes

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-QIPRO

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

- Validation of client level data, such as claims and encounters

RHODE ISLAND

Rite Care

CONTACT INFORMATION

State Medicaid Contact: Sharon Penkala
Center for Child & Family Health
(401) 462-2187

State Website Address: <http://www.state.ri.us>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: November 01, 1993
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: August 01, 1994
Statutes Utilized: Not Applicable	Waiver Expiration Date: July 31, 2005
Enrollment Broker: No	Sections of Title XIX Waived: -1902(a)(10) -1902(a)(10)(A)(ii)(I)(II) -1902(a)(10)(B) Comparability of Services -1902(a)(13)(E) -1902(a)(14) -1902(a)(17)(b) -1902(a)(23) Freedom of Choice -1902(a)(34)
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(1)(A) -1903(m)(2)(A)(i) -1903(m)(2)(A)(vi) Eligibility Expansion, Family Planning, IMD
Guaranteed Eligibility: 6 months guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Interpreter, Laboratory, Nutrition, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, 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 or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Midwives -Nurse Practitioners -Physician Assistants
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RHODE ISLAND

Rite Care

Enrollment

Populations Voluntarily Enrolled:

-Foster Care Children

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

-Participate in HCBS Waiver
-Medicare Dual Eligible
-American Indian/Alaskan Native

Lock-In Provision:

12 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coordinated Health Partners
United HealthCare of NE

Neighborhood Health Plan of RI

ADDITIONAL INFORMATION

Effective May 1, 1997, eligibility was expanded to include children in families with income up to 250% federal poverty level to age 18. Program has a one month open enrollment period every 12 months. Enrollees are "locked in" from the date of enrollment. As of 7/1/99, 18 year olds are eligible regardless of school status. Also, as of 11/1/98, parents of eligible children may be found eligible at family incomes up to 185% FPL under the States implementation of Section 1931. As of January, 2001, these parents and pregnant/pp women between 185-250% FPL are included under a waiver to RIs SCHIP program. The Rhode Island SCHIP program operates as a part of Rite Care.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Grievances and Appeals
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-Consumer Advisory Committee
-Consumer/Beneficiary Focus Groups
-State-developed Survey

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous enrollment

RHODE ISLAND

Rite Care

Encounter Data

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for data validation
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

None

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
- Use of Medicaid Identification Number for beneficiaries

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-specific data
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills)
- Medical record validation
- Monitoring submission processes from providers to health plans to assure complete and timely submissions
- Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Cervical cancer screening rate
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit
- Smoking prevention and cessation
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Health Status/Outcomes Quality

- Patient satisfaction with care
- Percentage of low birth weight infants

Access/Availability of Care

- Average wait time for an appointment with PCP

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary 346

RHODE ISLAND

Rite Care

- Complaint Resolution Statistics
- Patient/Member Satisfaction with Access to Care
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Percentage of beneficiaries with at least one dental visit
- Re-admission rates of MH/SA

Health Plan Stability/Financial/Cost of Care

- Actual reserves held by plan
- Days cash on hand
- Days in unpaid claims/claims outstanding
- Expenditures by medical category of services (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ration
- 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
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
- Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

- MCOs/PHPs are required to conduct a project(s) of their own choosing

Clinical Topics

- Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics

- Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards

- NAIC (National Association of Insurance Commissioners) Standards
- NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation

- None

Accreditation for Deeming

- None

EQRO Name

- Undetermined at this time

EQRO Organization

- Undetermined at this time

EQRO Activities

- Administration or validation of consumer or provider surveys
- Calculation of performance measures
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Review of MCO compliance with structural and operational standards established by the State
- Validation of client level data, such as claims and encounters
- Validation of performance measures

SOUTH CAROLINA Health Maintenance Organization (HMO)

CONTACT INFORMATION

State Medicaid Contact: Bruce Harbaugh
Division of Medical Services
(803) 898-2618

State Website Address: <http://www.dhhs.state.sc.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: August 01, 1996
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: None
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, X-Ray	Allowable PCPs: -Rural Health Centers (RHCs) -Federally Qualified Health Centers (FQHCs) -Nurse Practitioners -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists
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Enrollment

Populations Voluntarily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Section 1931 (AFDC/TANF) Adults and Related Populations -Blind/Disabled Children and Related Populations -Blind/Disabled Adults and Related Populations	Populations Mandatorily Enrolled: None
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SOUTH CAROLINA Health Maintenance Organization (HMO)

Subpopulations Excluded from Otherwise

Included Populations:

- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver
- Age 65 Or Older
- Hospice Recipients
- Enrolled In An HMO Through Third Party Coverage

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- 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

The State does not require the MCO to have accreditation for deeming. However, Select Health, the MCO that State is contracted with has NCQA accreditation. Program provides ambulatory transportation only.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Encounter Data (see below for details)
- Enrollee Hotlines
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data

- Contract Standard Compliance
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

None

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous enrollment requirement for some or all of the measures

Encounter Data

SOUTH CAROLINA

Health Maintenance Organization (HMO)

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- 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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure
- Date of Admission Invalid
- Date of Discharge Invalid
- Dollar amount billed not greater than zero
- Drug Quantity Units not greater than zero
- Invalid Drug Unit Type
- Prescribing Provider Number Not on File

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Use of Medicaid Identification Number for beneficiaries

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

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Asthma care
- Check-ups after delivery
- Diabetes management
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Well-child care visit rates

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of PCPs to beneficiaries

Health Status/Outcomes Quality

- Patient satisfaction with care
- Percentage of low birth weight infants

Use of Services/Utilization

- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary
- 350

SOUTH CAROLINA

Health Maintenance Organization (HMO)

Health Plan Stability/ Financial/Cost of Care

- Actual reserves held by plan
- State minimum reserve requirements

Health Plan/ Provider Characteristics

- Board Certification
- Provider turnover

Beneficiary Characteristics

- Information on primary languages spoken by beneficiaries
- MCO/PCP-specific disenrollment rate
- Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

- MCOs/PHPs are required to conduct a project(s) of their own choosing
- Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics

- Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics

- Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards

- NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation

- None

Accreditation for Deeming

- None

EQRO Name

- Carolina Medical Review

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

- Calculation of performance measures
- Conduct performance improvement projects
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters
- Validation of performance improvement projects
- Validation of performance measures

SOUTH CAROLINA Physicians Enhanced Program (PEP)

CONTACT INFORMATION

State Medicaid Contact: Marsha Marze
Department of Physician Services
(803) 898-2544

State Website Address: <http://www.dhhs.state.sc.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: May 01, 1996
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: None
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Medical-only PHP (risk, non-comprehensive) - Partial Capitation

Service Delivery

Included Services: EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Practitioners
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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
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SOUTH CAROLINA

Physicians Enhanced Program (PEP)

- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

- Medicare Dual Eligible
- Poverty Level Pregnant Woman
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Education Agency
- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Physicians Enhanced Program (PEP)

ADDITIONAL INFORMATION

Only physician services are partially capitated for this program. All other services are fee-for-service.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Not applicable

SOUTH CAROLINA

Physicians Enhanced Program (PEP)

EQRO Organization
-Not applicable

EQRO Activities
-Not applicable

**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	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: July 01, 1996
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: None
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Dental PHP - Full Capitation

Service Delivery

Included Services: Dental	Allowable PCPs: -Not Applicable
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Enrollment

Populations Voluntarily 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 -Aged and Related Populations	Populations Mandatorily Enrolled: None
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SOUTH DAKOTA Dental Program

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Delta Dental

ADDITIONAL INFORMATION

Most of the Medicaid eligibles are automatically included in the program except beneficiaries with limited benefits.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Encounter Data (see below for details)
- 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 MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements

- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- State 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 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)

MCO conducts data accuracy check(s) on specified data elements

None

State conducts general data completeness assessments

No

Performance Measures

SOUTH DAKOTA Dental Program

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

None

Performance Improvement Projects

Project Requirements

-Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Not Applicable

EQRO Organization

-Not Applicable

EQRO Activities

-Not Applicable

SOUTH DAKOTA PRIME

CONTACT INFORMATION

State Medicaid Contact: Scott Beshara
Office of Medical Services
(605) 773-3495

State Website Address: <http://www.state.sd.us/Social/Medicaid/>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: June 30, 1993
Operating Authority: 1915(b) - Waiver Program	Implementation Date: September 01, 1993
Statutes Utilized: 1915(b)(1)	Waiver Expiration Date: December 28, 2002
Enrollment Broker: No	Sections of Title XIX Waived: -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

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Laboratory, Ophthalmology, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Residential Treatment Centers, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Indian Health Service (IHS) Providers -Other Specialists Approved on a Case-by-Case Basis
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Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Section 1931 (AFDC/TANF) Adults and Related Populations
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SOUTH DAKOTA PRIME

- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- TITLE XXI SCHIP
- Pregnant Women

Subpopulations Excluded from Otherwise

Included Populations:

- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Provider contacts - Medically fragile protocol

Agencies with which Medicaid Coordinates the Operation of the Program:

- Aging Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

PRIME

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Consumer Self-Report Data
- Focused Studies
- Performance Improvements Projects (see below for details)
- Provider Data
- Performance Measures (see below for details)

Use of Collected Data:

- Beneficiary Provider Selection
- Monitor Quality Improvement
- Program Evaluation
- Provider Profiling

Consumer Self-Report Data

- State-developed Survey

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

None

SOUTH DAKOTA PRIME

Access/Availability of Care

- Average distance to primary care case manager
- Average wait time for an appointment with primary care case manager
- Ratio of primary care case managers to beneficiaries

Provider Characteristics

None

Use of Services/Utilization

None

Beneficiary Characteristics

None

Performance Improvement Projects

Clinical Topics

- Adolescent Immunization
- Asthma management
- Breast cancer screening (Mammography)
- Cervical cancer screening (Pap Test)
- Childhood Immunization
- Low birth-weight baby
- Well Child Care/EPSTD

Non-Clinical Topics

None

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

Initial Waiver Approval Date:

November 18, 1993

Operating Authority:

1115 - Demonstration Waiver Program

Implementation Date:

January 01, 1994

Statutes Utilized:

Not Applicable

Waiver Expiration Date:

June 30, 2007

Enrollment Broker:

No

Sections of Title XIX Waived:

- 1902(a)(10)
- 1902(a)(10)(B) Comparability of Services
- 1902(a)(13)(A)
- 1902(a)(13)(C)
- 1902(a)(23) Freedom of Choice
- 1902(a)(30)
- 1902(a)(34)
- 1902(a)(54)

For All Areas Phased-In:

Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:

- 1903(m)(1)(A)
- 1903(m)(2)(A)(i)
- 1903(m)(2)(A)(vi) Eligibility Expansion, IMD

Guaranteed Eligibility:

12 months guaranteed eligibility for children

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

All Title XIX Medicaid services are covered except Long Term Care and Medicare crossovers., Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:

- Pediatricians
- General Practitioners
- Family Practitioners
- Obstetricians/Gynecologists or Gynecologists
- Rural Health Centers (RHCs)
- Public Health Departments and Clinics
- Internists
- Federally Qualified Health Centers (FQHCs)
- Nurse Midwives
- Indian Health Service (IHS) Providers

TENNESSEE

TennCare

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- TITLE XXI SCHIP
- Medically Needy
- Uninsured
- Uninsurable

Subpopulations Excluded from Otherwise**Included Populations:**

-Individuals not qualifying under traditional Medicaid criteria and have access to private insurance

Lock-In Provision:

12 month lock-in

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:

Crisis, Detoxification, Inpatient Mental Health, Inpatient Substance Abuse, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Abuse, Residential Substance Abuse Treatment Programs

Allowable PCPs:

- Public Health Departments and Clinics
- Internists
- Obstetricians/Gynecologists or Gynecologists
- Federally Qualified Health Centers (FQHCs)
- Rural Health Centers (RHCs)
- Nurse Midwives
- Indian Health Service (IHS) Providers
- Pediatricians
- General Practitioners
- Family Practitioners

Contractor Types:

-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- TITLE XXI SCHIP
- Medically needy
- Uninsured
- Uninsurable

Subpopulations Excluded from Otherwise**Included Populations:**

-Individuals not qualifying under traditional Medicaid criteria and have access to private insurance

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

TENNESSEE

TennCare

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Reviews complaints and grievances to identify members of these groups
- Uses eligibility data to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

- Maternal and Child Health Agency
- Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Better Health Plan
Memphis Managed Care Corp. (TLC)
Preferred Health Partnership/PHP
Tennessee Behavioral Health, Inc.
Volunteer State Health Plan (Bluecare)
Xantus Health Care

John Deere/Heritage National Health Plan
Omnicare Health Plan
Premier Behavioral Systems of TN
Universal Care Plan
VUMC Care (VHP Community Care)

ADDITIONAL INFORMATION

All medically necessary services are provided through the managed care organizations. All mental health and substance abuse services are provided through behavioral health organizations. The State has carved out Pharmacy services for those individuals who are both TennCare enrollees and eligible for Medicare.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Encounter Data (see below for details)
- Enrollee Hotlines
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Consumer Self-Report Data

None

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

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

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

TENNESSEE

TennCare

data submission

Collection: Standardized Forms

-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

-Per member per month analysis and comparisons across MCOs/PHPs

-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Dental services
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Pregnancy Prevention
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Access/Availability of Care

- Average distance to PCP
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

Health Status/Outcomes Quality

- Patient satisfaction with care
- Percentage of low birth weight infants

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of days in ICF or SNF per beneficiary over 64 years
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Percentage of beneficiaries with at least one dental visit
- Re-admission rates of MH/SA

364

TENNESSEE

TennCare

Health Plan Stability/ Financial/Cost of Care

- Actual reserves held by plan
- Annual Financial Statements
- Days cash on hand
- Days in unpaid claims/claims outstanding
- Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- Net worth
- Quarterly Financial Statements
- State minimum reserve requirements
- Total revenue
- Weekly Claims Inventory Reports

Health Plan/ Provider Characteristics

- Provider turnover

Beneficiary Characteristics

- Information of beneficiary ethnicity/race
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Performance Improvement Projects

Project Requirements

- MCOs/PHPs are required to conduct a project(s) of their own choosing
- All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
- Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics

- Asthma management
- Breast cancer screening (Mammography)
- Cervical cancer screening (Pap Test)
- Child/Adolescent Hearing and Vision Screening and Services
- Childhood Immunization
- Cholesterol screening and management
- Coordination of primary and behavioral health care
- Coronary artery disease prevention
- Diabetes management
- Emergency Room service utilization
- Hospital Discharge Planning
- Lead toxicity
- Low birth-weight baby
- Newborn screening for heritable diseases
- Pharmacy management
- Post-natal Care
- Pre-natal care
- Prescription drug abuse
- Sickle cell anemia management
- Well Child Care/EPSTD

Non-Clinical Topics

- Adults access to preventive/ambulatory health services
- Availability of language interpretation services
- Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards

- NCQA(National Committee for Quality Assurance) Standards
- State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-First Health
365

TENNESSEE

TennCare

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

- Administration or validation of consumer or provider surveys
- Conduct performance improvement projects
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters

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	Initial Waiver Approval Date: September 01, 1994
Operating Authority: 1915(b) - Waiver Program	Implementation Date: September 01, 1994
Statutes Utilized: 1915(b)(4)	Waiver Expiration Date: September 03, 2004
Solely Reimbursement Arrangement: Yes	Sections of Title XIX Waived: -1902(a)(1) Statewideness -1902(a)(23) Freedom of Choice
Guaranteed Eligibility: None	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

Initial Waiver Approval Date:
March 10, 1995

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
March 10, 1995

Statutes Utilized:
1915(b)(4)

Waiver Expiration Date:
March 04, 2004

Solely Reimbursement Arrangement:
Yes

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

Guaranteed Eligibility:
None

ADDITIONAL INFORMATION

Lonestar Select II is a program that enables the State of Texas to selectively contract with freestanding psychiatric facilities for inpatients services to children. Under Lonestar Select II, providers must bid all inclusive per diem rates for Medicaid reimbursement. The State of Texas then either accepts or negotiates those rates so that providers may serve the under 21 Medicaid population for a period of three years.

TEXAS NorthSTAR

CONTACT INFORMATION

State Medicaid Contact:

Linda Wertz
Texas Health and Human Services Commission
(512) 424-6500

State Website Address:

<http://www.hhsc.state.tx.us>

PROGRAM DATA

Program Service Area:

Region

Initial Waiver Approval Date:

November 01, 1999

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

November 01, 1999

Statutes Utilized:

1915(b)(1)
1915(b)(2)
1915(b)(4)

Waiver Expiration Date:

November 05, 2003

Enrollment Broker:

Maximus Incorporated

Sections of Title XIX Waived:

-1902(a)(1) Statewide
-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:

None

SERVICE DELIVERY

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:

Assertive Community Treatment Team, Crisis, Detoxification, Dual Diagnosis, Inpatient Mental Health, Inpatient Substance Abuse, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Abuse, Residential Substance Abuse Treatment Programs, Targeted Case Management

Allowable PCPs:

-Not applicable, contractors not required to identify PCP

Contractor Types:

-Behavioral Health MCO (Private)

Enrollment

TEXAS NorthSTAR

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations

Subpopulations Excluded from Otherwise**Included Populations:**

- Reside in Nursing Facility or ICF/MR
- Children in Protective Foster Care
- Individuals Residing Outside of the Service Region
- Individuals Eligible as Medically Needy
- Individuals Receiving Inpatient Medicaid IMD Services
- Qualified Medicare Beneficiaries
- Other Insurance

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Reviews complaints and grievances to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- 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

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data

- Contract Standard Compliance
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

TEXAS NorthSTAR

Consumer Self-Report Data

- 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 MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous enrollment

Encounter Data

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills)

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Depression management
- Follow-up after hospitalization for mental illness

Access/Availability of Care

- Number and types of providers
- Time Distance to Providers

Health Plan Stability/ Financial/Cost of Care

- Actual reserves held by plan
- Days in unpaid claims/claims outstanding

Health Status/Outcomes Quality

- Patient satisfaction with care

Use of Services/Utilization

- Drug Utilization
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Re-admission rates of MH/SA

Health Plan/ Provider Characteristics

- Behavioral Health Specialty Network
- Languages Spoken (other than English)

TEXAS NorthSTAR

- 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
- Provider turnover

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics

-Coordination of primary and behavioral health care

Non-Clinical Topics

None

Standards/Accreditation

MCO/PHP Standards

-CMS's Quality Improvement System for Managed Care (QISM) Standards for Medicaid and Medicare
-NCQA Standards for Treatment Records

Accreditation Required for

None

Accreditation for Deeming

None

EQRO Name

-Institute for Child Health Policy (IHP)

EQRO Organization

-PRO-like Entity

EQRO 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
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters
- Validation of performance improvement projects

372

TEXAS STAR

CONTACT INFORMATION

State Medicaid Contact: Love Rodger
Texas Health and Human Services Commission
(512) 338-6505

State Website Address: <http://www.hhsc.state.tx.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: August 01, 1993
Operating Authority: 1915(b) - Waiver Program	Implementation Date: August 01, 1993
Statutes Utilized: 1915(b)(1) 1915(b)(2) 1915(b)(3) 1915(b)(4)	Waiver Expiration Date: August 31, 2003
Enrollment Broker: Maximus	Sections of Title XIX Waived: -1902(a)(1) Statewide -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

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 Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Nurse Midwives -Other Specialists Approved on a Case-by-Case Basis -Physician Assistants -Nurse Practitioners
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TEXAS STAR

Enrollment

Populations Voluntarily Enrolled:

- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise

Included Populations:

- Reside in Nursing Facility or ICF/MR
- Medicare Dual Eligible
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- TITLE XXI SCHIP

Lock-In Provision:

No lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Transportation, Vision, X-Ray

Allowable PCPs:

- Federally Qualified Health Centers (FQHCs)
- Rural Health Centers (RHCs)
- Nurse Practitioners
- Obstetricians/Gynecologists or Gynecologists
- Nurse Midwives
- Indian Health Service (IHS) Providers
- Other Specialists Approved on a Case-by-Case Basis
- Physician Assistants
- Pediatricians
- General Practitioners
- Family Practitioners
- Internists

Enrollment

Populations Voluntarily Enrolled:

- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations

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

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- TITLE XXI SCHIP

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Mental Health Agency
- Public Health Agency
- Substance Abuse Agency

TEXAS STAR

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmCare
Community First
El Paso First Health
HMO Blue - STAR
Parkland Community Health Plan
Superior Health Plan

Amerigroup Texas
Community Health Choice
First Care
JPS Star
Seton Health Plan
Texas Health Network - Birch & Davis (STAR)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Adult Medicaid SSI Questionnaire
 - Child Medicaid AFDC Questionnaire
 - Child Medicaid SSI Questionnaire
- Disenrollment Survey
- State-developed Survey

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

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous 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)
- MCO to submit encounter data to the External Quality Review Organization.
- Requirements for data validation
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

- Data submission requirements including documentation describing set of encounter data elements, 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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

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Collection: Standardized Forms

- ADA - American Dental Association dental claim form
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

MCO 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
- Preparing HEDIS and risk adjustment software

Validation: Methods

- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills)
- Medical record validation
- Per member per month analysis and comparisons across MCOs/PHPs

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Cholesterol screening and management
- Dental services
- Depression management
- Diabetes management
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- HIV/AIDS care
- Immunizations for two year olds
- Initiation of prenatal care
- 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
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Access/Availability of Care

- Average wait time for an appointment with PCP
- Ratio of dental providers to beneficiaries
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

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

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
 - Drug Utilization
 - Emergency room visits/1,000 beneficiary
 - Inpatient admission for MH/SA conditions/1,000 beneficiaries
 - Inpatient admissions/1,000 beneficiary
 - Number of days in ICF or SNF per beneficiary over 64 years
 - Number of home health visits per beneficiary
 - Number of OB/GYN visits per adult female beneficiary
- 376

TEXAS STAR

- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
- Percentage of beneficiaries with at least one dental visit
- Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of Care

- Days in unpaid claims/claims outstanding
- Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- 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/PHPs
- Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

- MCOs/PHPs are required to conduct a project(s) of their own choosing
- Multiple, but not all, MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency. (For instance: regional projects)
- Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSTD
- Asthma management
- Childhood Immunization
- Depression management
- Diabetes management
- Well Child Care/EPSTD

Non-Clinical Topics

- Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards

- CMS's Quality Improvement System for managed Care (QISM) Standards for Medicaid and Medicare
- State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Institute for Child Health Policy, University of Florida

EQRO Organization

- PRO-like Entity

EQRO Activities

- Administration or validation of consumer or provider surveys
- Calculation of performance measures
- Conduct of performance improvement projects
- Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services

TEXAS STAR

- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters
- Validation of performance improvement projects
- Validation of performance measures

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Consumer Self-Report Data
- Enrollee Hotlines
- Focused Studies
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Provider Data
- Performance Measures (see below for details)

Use of Collected Data:

- Beneficiary Provider Selection
- Contract Standard Compliance
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling
- Track Health Service provision

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Adult Medicaid SSI Questionnaire
 - Child Medicaid AFDC Questionnaire
 - Child Medicaid SSI Questionnaire
- State-developed Survey

Performance Measures

Process Quality

- Check-ups after delivery
- Depression management
- Diabetes management
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Well-child care visit rates

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

- Average distance to primary care case manager
- Average wait time for an appointment with primary care case manager
- Ratio of mental health providers to number of beneficiaries
- Ratio of primary care case managers to beneficiaries

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Number of home health visits per beneficiary
- Number of OB/GYN visits per adult female beneficiary
- Number of primary care case manager visits per beneficiary
- Number of specialist visits per beneficiary
- Re-admission rates of MH/SA

Provider Characteristics

- Board Certification
- Languages spoken (other than English)
- Provider turnover

Beneficiary Characteristics

- Disenrollment rate
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

TEXAS STAR

Clinical Topics

- Adolescent Immunization
- Childhood Immunization

Non-Clinical Topics

- Availability of language interpretation services
- Children's access to primary care practitioners

TEXAS STAR+PLUS

CONTACT INFORMATION

State Medicaid Contact:

Pam Coleman
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

Initial Waiver Approval Date:

February 01, 1998

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

January 01, 1998

Statutes Utilized:

1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Waiver Expiration Date:

August 31, 2004

Enrollment Broker:

Maximus

Sections of Title XIX Waived:

-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

For All Areas Phased-In:

Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

Guaranteed Eligibility:

No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Vision, X-Ray

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Internists
-Physician Assistants
-Nurse Practitioners
-Nurse Midwives
-Rural Health Clinics (RHCs)
-Federally Qualified Health Centers (FQHCs)

TEXAS STAR+PLUS

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Substance Abuse, Physician, X-Ray

Allowable PCPs:
-Nurse Midwives
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Poverty Level Pregnant Woman

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-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

TEXAS STAR+PLUS

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup- STAR+PLUS
Texas Health Network - Birch & Davis

HMO Blue
Texas Health Network - Birch & Davis

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- On-Site Reviews
- Provider Data

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Adult Medicaid SSI Questionnaire
- State-developed Survey

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

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for data validation
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Date of Payment
- Provider ID

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

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 general data completeness assessments

Yes

TEXAS STAR+PLUS

-Type of Service

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Texas Health Quality Alliance

EQRO Organization

-Private Accreditation Organization

EQRO Activities

- Administration or validation of consumer or provider surveys
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-On-Site Reviews

Use of Collected Data:

- Program Evaluation
- Program Modification, Expansion, or Renewal

Consumer Self-Report Data

None

UTAH

Choice Of Health Care Delivery

CONTACT INFORMATION

State Medicaid Contact: Julie Olson
Utah State Health Department
(801) 538-6503

State Website Address: <http://www.state.ut.us>

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
March 23, 1982

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
July 01, 1982

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Waiver Expiration Date:
July 23, 2003

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Diabetes self-management, Durable Medical Equipment, Emergency Transportation, Enhanced Services to Pregnant Women, EPSDT, ESRD, Family Planning, Hearing, HIV Prevention, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient medical detoxification, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Private Duty Nursing, Skilled Nursing Facility (less than 30 days), Speech Therapy, Vision, Well-adult care, X-Ray

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

UTAH

Choice Of Health Care Delivery

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- Pregnant Women
- Medically Needy Children and Adults

Subpopulations Excluded from Otherwise Included Populations:

- Reside in Nursing Facility or ICF/MR
- Eligibility Less Than 3 Months
- Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)
- During Retroactive Eligibility Period
- If Approved as Exempt from Mandatory Enrollment

Lock-In Provision:

1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Use fee-for-service claims to identify members who received a carve-out service such as Early Intervention
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

- Aging Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Substance Abuse Agency
- Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy U
MedChoice (UnitedHealthcare)

IHC Health Plans Inc.
Molina Healthcare of Utah (AFC UTAH)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Deeming (see below for details)
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines

Use of Collected Data

- Contract Standard Compliance
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation

UTAH

Choice Of Health Care Delivery

- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Adult with Special Needs Questionnaire
 - Child Medicaid AFDC Questionnaire
 - Child with Special Needs Questionnaire

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
- State use/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to promote completeness, accuracy, and/or timeliness of encounter data submission
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards for completeness, accuracy, and/or timeliness of 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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

- ANSI ASC X12 837 - transaction set format for transmitting health care claims data
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities.

Validation: Methods

- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to aggregate data submitted by plans
- Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Adolescent immunization rate
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Diabetes management
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation of prenatal care

Health Status/Outcomes Quality

- Patient satisfaction with care
- Percentage of low birth weight infants

UTAH

Choice Of Health Care Delivery

- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Smoking prevention and cessation
- Well-child care visit rates

Access/Availability of Care

- Ratio of PCPs to beneficiaries

Use of Services/Utilization

None

Health Plan Stability/ Financial/Cost of Care

- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- Net worth
- Total revenue

Health Plan/ Provider Characteristics

- Board Certification
- Languages Spoken (other than English)

Beneficiary Characteristics

- Beneficiary need for interpreter
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Performance Improvement Projects

Project Requirements

- MCOs/PHPs are required to conduct a project(s) of their own choosing

Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards

- State-Developed/Specified Standards

Accreditation Required for

None

Accreditation for Deeming

- JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
- NCQA (National Committee for Quality Assurance)

EQRO Name

- HealthInsight

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

- Conduct performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

UTAH

Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact: Don Hawley
Bureau of Coverage and Reimbursement, Utah State
(801) 538-6483

State Website Address: www.health.state.ut.us/medicaid

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: September 19, 2000
Operating Authority: 1915(b) - Waiver Program	Implementation Date: July 01, 2001
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: September 18, 2004
Enrollment Broker: No	Sections of Title XIX Waived: -1902(a)(23) Freedom of Choice
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Transportation PHP - Full Capitation

Service Delivery

Included Services: Non-Emergency Transportation	Allowable PCPs: -Not applicable, contractors not required to identify PCPs
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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 (State defined) -Special Needs Children (BBA defined)
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388

UTAH

Non-Emergency Transportation

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-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 CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of MCO/PHP Standards

Use of Collected Data

-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data

None

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

None

Validation: Methods

-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills)

UTAH

Non-Emergency Transportation

**MCO conducts data accuracy check(s)
on specified data elements**
None

**State conducts general data completeness
assessments**
No

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Independent accounting firm

EQRO Organization
-Independent cost-effectiveness study

EQRO Activities
-Validation of client level data, such as claims and encounters

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	Initial Waiver Approval Date: July 01, 1991
Operating Authority: 1915(b) - Waiver Program	Implementation Date: July 01, 1991
Statutes Utilized: 1915(b)(4)	Waiver Expiration Date: December 26, 2003
Enrollment Broker: No	Sections of Title XIX Waived: -1902(a)(1) Statewideness -1902(a)(23) Freedom of Choice
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Mental Health (MH) PHP - Full Capitation

Service Delivery

Included Services: Crisis, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Transportation	Allowable PCPs: -Not applicable, contractors not required to identify PCPs
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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) Children and Related Populations -Section 1931 (AFDC/TANF) Adults and Related Populations -Blind/Disabled Adults and Related Populations -Blind/Disabled Children and Related Populations -Aged and Related Populations -Pregnant Women
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UTAH

Prepaid Mental Health Program

-Foster Care (inpatient services only)

Subpopulations Excluded from Otherwise

Included Populations:

- Resident of the Utah State Hospital (IMD)
- Resident of the State Developmental Center (DD/MR facility)

Lock-In Provision:

1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Use fee-for-service claims data to identify clients received Early Intervention services
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

- Education Agency
- Maternal and Child Health Agency
- Public Health Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Bear River Mental Health
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 Utah's 10 mental health service areas.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data

- Contract Standard Compliance
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Track Health Service provision

Consumer Self-Report Data

- State-developed Survey

Use of HEDIS

- The State DOES NOT use any of the HEDIS measures
- The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

UTAH

Prepaid Mental Health Program

Encounter Data

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

- ANSI ASC X12 837 - transaction set format for transmitting health care claims data
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills)

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Continuity of care
- Symptom reduction

Access/Availability of Care

- Average wait time for intake
- Use of Services/Utilization

Health Plan Stability/ Financial/Cost of Care

- Actual reserves held by plan
- Days cash on hand
- Days in unpaid claims/claims outstanding
- Medical loss ratio
- Net worth
- State minimum reserve requirements

Beneficiary Characteristics

- Information of beneficiary ethnicity/race
- Information on age and gender
- Information on primary languages spoken by beneficiaries

Health Status/Outcomes Quality

- Patient satisfaction with care
- Recidivism
- Symptom reduction

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Re-admission rates of MH/SA

Health Plan/ Provider Characteristics

- Languages Spoken (other than English)

UTAH

Prepaid Mental Health Program

Performance Improvement Projects

Project Requirements

-MCOs/PHPs are required to conduct a project(s) of their own choosing

Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards

-State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-State of Utah

EQRO Organization

-In-house

EQRO Activities

- Administration or validation of consumer or provider surveys
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters
- Validation of performance improvement projects
- Validation of performance measures

UTAH

Voluntary PCCM/Managed Care Organization Program

CONTACT INFORMATION

State Medicaid Contact: Julie Olson
Utah State Health Department
(801) 538-6503

State Website Address: None

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932 - State Plan Option to Use Managed Care	Implementation Date: October 01, 2000
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: Yes	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: Case Management, EPSDT, Family Planning, Immunization, Physician	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Nurse Practitioners -Nurse Midwives -Other Specialists Approved on a Case-by-Case Basis -Federally Qualified Health Centers (FQHCs) -Rural Health Clinics (RHCs)
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Enrollment

Populations Voluntarily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Section 1931 (AFDC/TANF) Adults and Related Populations	Populations Mandatorily Enrolled: None
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UTAH

Voluntary PCCM/Managed Care Organization Program

- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- Pregnant Women

Subpopulations Excluded from Otherwise

Included Populations:

- Reside in Nursing Facility or ICF/MR
- Eligibility Less Than 3 Months
- During Retroactive Eligibility Period
- Reside in the State Hospital (IMD) or in the State Development Center (DD/MR)
- Special Needs Children (BBA defined)

Lock-In Provision:

1 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Diabetes Self-Management, Durable Medical Equipment, Emergency Transportation, EPSDT, Family Planning, Hearing, Hospice, Immunization, Inpatient Hospital, Inpatient Medical Detoxification, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility (less than 30 days), Vision, Well-Adult Care, X-Ray

Allowable PCPs:

- Pediatricians
- General Practitioners
- Internists
- Obstetricians/Gynecologists or Gynecologists
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Nurse Practitioners
- Nurse Midwives
- Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Pregnant Women
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children

Populations Mandatorily Enrolled:

None

Subpopulations Excluded from Otherwise

Included Populations:

- Reside in Nursing Facility or ICF/MR
- Eligibility Less Than 3 Months
- Reside in State Hospital (IMD) or in the State Developmental Center (DD/MR)
- During Retroactive Eligibility Period
- Special Needs Children (BBA defined)

Lock-In Provision:

1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

UTAH

Voluntary PCCM/Managed Care Organization Program

Strategies Used to Identify Persons with Complex (Special) Needs:

- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Aging Agency
- Maternal and Child Health Agency
- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Molina Healthcare of Utah (AFC Plus)

Voluntary PCCM/MCO Program

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Deeming (see below for details)
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data

- Contract Standard Compliance
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Adult with Special Needs Questionnaire
 - Child Medicaid AFDC Questionnaire
 - Child with Special Needs Questionnaire

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
- State use/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- 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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Required use of Medicaid Identification Number for

UTAH

Voluntary PCCM/Managed Care Organization Program

Collection: Standardized Forms

- ANSI ASC X12 837 - transaction set format for transmitting health care claims data
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data
- UB-92 (CMS 1450) – (Uniform Billing) – the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities.

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes

Validation: Methods

- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to aggregate data submitted by plans
- Per member per month analysis and comparisons across beneficiaries

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Adolescent immunization rate
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Diabetes management
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation of prenatal care
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Smoking prevention and cessation
- Well-child care visit rates

Health Status/Outcomes Quality

- Patient satisfaction with care
- Percentage of low birth weight infants

Access/Availability of Care

- Ratio of PCPs to beneficiaries

Use of Services/Utilization

None

Health Plan Stability/ Financial/Cost of

- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- Net worth
- Total revenue

Health Plan/ Provider Characteristics

- Board Certification
- Languages Spoken (other than English)

Beneficiary Characteristics

- Beneficiary need for interpreter
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Performance Improvement Projects

Project Requirements

- MCOs/PHPs are required to conduct a project(s) of their own choosing

Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

UTAH

Voluntary PCCM/Managed Care Organization Program

Non-Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards

-State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name

-Peer Review Organization

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-Enrollee Hotlines

Use of Collected Data:

-Provider Profiling
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data

-CAHPS
Adult Medicaid AFDC Questionnaire
Adult with Special Needs Questionnaire
Child Medicaid AFDC Questionnaire
Child with Special Needs Questionnaire

VERMONT
Vermont Health Access
CONTACT INFORMATION

State Medicaid Contact: Ann E. Rugg
Vermont Health Access Plan
(802) 241-2766

State Website Address: <http://www.dsw.state.vt.us>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: July 28, 1995
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: January 01, 1996
Statutes Utilized: Not Applicable	Waiver Expiration Date: December 31, 2003
Enrollment Broker: MAXIMUS	Sections of Title XIX Waived: -1902(a)(10) -1902(a)(10)(B) Comparability of Services -1902(a)(13)(A) -1902(a)(13)(C) -1902(a)(13)(E) -1902(a)(14) -1902(a)(23) Freedom of Choice -1902(a)(30)(A) -1902(a)(34)
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1903(m)(2)(A)(vi) Eligibility Expansion, Guaranteed Eligibility, IMD
Guaranteed Eligibility: 6 months guaranteed eligibility	

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -Nurse Practitioners -Other Specialists Approved on a Case-by-Case Basis -Indian Health Service (IHS) Providers -Obstetricians/Gynecologists or Gynecologists -General Practitioners -Family Practitioners -Internists
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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 Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Spendedown
-Children who participate in Vermont High Tech Home Care Program
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

PC PLUS

ADDITIONAL INFORMATION

Allowable PCP Specialists: OB/GYNs or GYNs may be approved to be PCPs on a case-by-case basis.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting

VERMONT

Vermont Health Access

Consumer Self-Report Data

-CAHPS

Adult Medicaid AFDC Questionnaire

Performance Measures

Process Quality

-Asthma care
-Depression management
-Diabetes management

Health Status/Outcomes Quality

None

Access/Availability of Care

None

Use of Services/Utilization

None

Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Clinical Topics

-Coordination of primary and behavioral health care
-Depression management
-Pharmacy management

Non-Clinical Topics

None

VIRGINIA Medallion

CONTACT INFORMATION

State Medicaid Contact: Adrienne Fegans
Department of Medical Assistance Services
(804) 225-4714

State Website Address: <http://www.dmas.state.va.us/>

PROGRAM DATA

Program Service Area: City County	Initial Waiver Approval Date: December 23, 1991
Operating Authority: 1915(b) - Waiver Program	Implementation Date: March 01, 1992
Statutes Utilized: 1915(b)(1) 1915(b)(2)	Waiver Expiration Date: March 24, 2004
Enrollment Broker: Affiliated Computer Services	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

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Clinics (RHCs) -Other Specialists Approved on a Case-by-Case Basis
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Enrollment

VIRGINIA Medallion

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children

Subpopulations Excluded from Otherwise**Included Populations:**

- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Eligibility Less Than 3 Months
- Participate in HCBS Waiver
- Subsidized Adoption
- Refugees
- Spendedown
- Hospice

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Initial Interview with Enrollees
- Reviews claims activity of anew enrollees for special indicators
- 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

Medallion

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Consumer Self-Report Data
- Enrollee Hotlines
- Focused Studies

Use of Collected Data:

- Contract Standard Compliance
- Monitor Quality Improvement
- Program Evaluation

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Child Medicaid AFDC Questionnaire
 - Child Medicaid SSI Questionnaire
 - Child with Special Needs 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.state.va.us/>

PROGRAM DATA

Program Service Area: City County	Initial Waiver Approval Date: December 18, 1995
Operating Authority: 1915(b) - Waiver Program	Implementation Date: January 01, 1996
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: December 26, 2002
Enrollment Broker: Affiliated Computer Services (ACS)	Sections of Title XIX Waived: -1902(a)(1) Statewideness -1902(a)(10)(B) Comparability of Services -1902(a)(23) Freedom of Choice
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Clinics (RHCs) -Other Specialists Approved on a Case-by-Case Basis
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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

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
- Participate in HCBS Waiver
- Eligibility Less Than 3 Months
- Hospice

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- 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
- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HealthKeepers Plus, Inc.
HealthKeepers Plus, Priority
Southern Health, Carenet
Virginia Premier Health Plan

HealthKeepers Plus, Peninsula
Sentara Family Care
Unicare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Encounter Data (see below for details)
- Focused Studies
- On-Site Reviews
- Performance Measures (see below for details)

Use of Collected Data

- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Track Health Service provision

VIRGINIA

Medallion II

Consumer Self-Report Data

None

Use of HEDIS

- The State uses ALL of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
- State use/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

- 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

Collection: Standardized Forms

- ADA - American Dental Association dental claim form
- ANSI ASC X12 837 - transaction set format for transmitting health care claims data
- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

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., CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Medical record validation
- Per member per month analysis and comparisons across MCOs/PHPs
- Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

None

Access/Availability of Care

- Average distance to PCP
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

None

Health Plan Stability/ Financial/Cost of Care

- 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)

VIRGINIA Medallion II

- Net worth
- Total revenue

Beneficiary Characteristics

- Information of beneficiary ethnicity/race
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Delmarva

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters

408

WASHINGTON Healthy Options

CONTACT INFORMATION

State Medicaid Contact:

Michael Paulson
Division of Program Support
(360) 725-1641

State Website Address:

<http://www.dshs.wa.gov>

PROGRAM DATA

Program Service Area:

Statewide

Initial Waiver Approval Date:

July 01, 1993

Operating Authority:

1915(b) - Waiver Program

Implementation Date:

October 01, 1993

Statutes Utilized:

1915(b)(1)
1915(b)(4)

Waiver Expiration Date:

February 24, 2003

Enrollment Broker:

No

Sections of Title XIX Waived:

-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

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:

Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Vision, X-Ray

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants

Enrollment

WASHINGTON

Healthy Options

Populations Voluntarily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Pregnant Women and Optional Children

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Pregnant Women and Optional Children

Subpopulations Excluded from Otherwise Included Populations:

- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- American Indian/Alaskan Native
- Retroactive Eligibility
- Reside in Nursing Facility or ICF/MR
- Medicare Dual Eligible

Lock-In Provision:

No lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, X-Ray

Allowable PCPs:

- Obstetricians/Gynecologists or 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
- Pregnant Women and Optional Children

Subpopulations Excluded from Otherwise Included Populations:

- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- Retroactive Eligibility

Lock-In Provision:

No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna US Healthcare Of Washington
Columbia United Providers
Group Health
Premera Blue Cross

BHP Plus
Community Health Plans of Washington
Molina
Regence Blue Shield

WASHINGTON

Healthy Options

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Consumer Self-Report Data

- CAHPS
Child Medicaid AFDC Questionnaire

Use of Collected Data

- Beneficiary Plan Selection
- Contract Standard Compliance
- Monitor Quality Improvement
- Program Evaluation
- Regulatory Compliance/Federal Reporting

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
- State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous 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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Date of Processing
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment

Collections: Submission Specifications

- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for 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

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)

State conducts general data completeness assessments

Yes

WASHINGTON

Healthy Options

- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure

Performance Measures

Process Quality

- Breast Cancer screening rate
- Check-ups after delivery
- Diabetes management
- Immunizations for two year olds
- Initiation of prenatal care
- Well-child care visit rates

Access/Availability of Care

- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care

- Actual reserves held by plan
- Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- State minimum reserve requirements
- Total revenue

Beneficiary Characteristics

- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
- Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Health Status/Outcomes Quality

- Patient satisfaction with care
- Percentage of low birth weight infants

Use of Services/Utilization

- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary

Health Plan/ Provider Characteristics

- Board Certification
- Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements

- MCOs/PHPs are required to conduct a project(s) of their own choosing
- All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics

None

Clinical Topics

- Childhood Immunization
- Well Child Care/EPSTD

WASHINGTON

Healthy Options

Standards/Accreditation

MCO/PHP Standards

- NCQA (National Committee for Quality Assurance) Standards
- State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-OMPRO

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

- Administration or validation of consumer or provider surveys
- Calculation of performance measures
- Conduct performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Validation of client level data, such as claims and encounters
- Validation of performance measures

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Consumer Self-Report Data
- Enrollee Hotlines

Use of Collected Data:

- Program Evaluation

Consumer Self-Report Data

- Promoting Healthy Development

WASHINGTON

The Integrated Mental Health Services

CONTACT INFORMATION

State Medicaid Contact: Judy Gosney
Mental Health Division
(360) 902-0827

State Website Address: <http://www.mhdsq1.mhd.dshs.wa.gov>

PROGRAM DATA

Program Service Area: County	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)(4)	Waiver Expiration Date: November 04, 2004
Enrollment Broker: No	Sections of Title XIX Waived: -1902(a)(10)(B) Comparability of Services -1902(a)(23) Freedom of Choice -1902(a)(30)
For All Areas Phased-In: No	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Mental Health (MH) PHP - Full Capitation

Service Delivery

Included Services: Case Management, Crisis, EPSDT, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support	Allowable PCPs: -Psychologists -Clinical Social Workers -Nurse Practitioners -Federally Qualified Health Centers (FQHCs) -Indian Health Service (IHS) Providers
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Contractor Types:
-Regional Authority Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Section 1931 (AFDC/TANF) Adults and Related Populations -Blind/Disabled Adults and Related Populations
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WASHINGTON

The Integrated Mental Health Services

- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- Other Insurance

Subpopulations Excluded from Otherwise

Included Populations:

- Medicare Dual Eligible
- Residents of State-owned institutions
- Eligibles for Tribal Health services who elect not to participate
- American Indian/Alaska Native can at their option disenroll

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Reviews complaints and grievances to identify members of these groups
- Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Aging Agency
- Education Agency
- Employment Agency
- Housing Agency
- Maternal and Child Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency
- Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Chelan/Douglas Regional Support Network
Grays Harbor Regional Support Network
King County Regional Support Network
North Sound Regional Support Network
Pierce County Regional Support Network
Spokane County Regional Support Network
Thurston/Mason Regional Support Network

Clark County Regional Support Network
Greater Columbia Regional Support Network
North Central Washington Regional Support Network
Northeast Washington Regional Support Network
Southwest Regional Support Network
The Peninsula Regional Support Network
Timberland Regional Support Network

ADDITIONAL INFORMATION

Due to the nature of the waiver which is for a limited segment of services, the program does designate a primary care provider. Individuals choose their own providers. Pregnant women in the Basic Health program (state funded program) are excluded from the Mental Health program.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and

Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PHP Standards (see below for details)

Use of Collected Data

- Contract Standard Compliance
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation

WASHINGTON

The Integrated Mental Health Services

- Monitoring of MCO/PHP Standards
- Ombudsman
- On-Site Reviews
- Performance Measures (see below for details)
- Quality Review Team

- Regulatory Compliance/Federal Reporting

Consumer Self-Report Data

- "MHSIP CHILD, FAMILY AND ADULT SURVEY"
- Consumer/Beneficiary Focus Groups
- State-developed Survey

Use of HEDIS

- The State DOES NOT use any of the HEDIS measures
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

None

Access/Availability of Care

- Average distance to PCP
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
- Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Standards/Accreditation

MCO/PHP Standards

- 16 state pilot indicator project
- JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
- NCQA (National Committee for Quality Assurance) Standards
- State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

- Does not Apply

EQRO Organization

- State Mental Health Authority

EQRO Activities

- Calculation of performance measures
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Validation of client level data, such as claims and encounters

WEST VIRGINIA
Mountain Health Trust
CONTACT INFORMATION

State Medicaid Contact: 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	Initial Waiver Approval Date: April 29, 1996
Operating Authority: 1915(b) - Waiver Program	Implementation Date: September 01, 1996
Statutes Utilized: 1915(b)(1) 1915(b)(4)	Waiver Expiration Date: March 22, 2004
Enrollment Broker: Automated Health Systems, Inc.	Sections of Title XIX Waived: -1902(a)(1) Statewide -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) - Full Capitation

Service Delivery

Included Services: Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray	Allowable PCPs: -Pediatricians -General Practitioners -Obstetricians/Gynecologists or Gynecologists -Family Practitioners -Federally Qualified Health Centers (FQHCs) -Rural Health Clinics (RHCs) -Internists
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Enrollment

Populations Voluntarily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations	Populations Mandatorily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations
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WEST VIRGINIA Mountain Health Trust

-Section 1931 (AFDC/TANF) Adults and Related Populations

-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise

Included Populations:

- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- Medically Needed

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- 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

Agencies with which Medicaid Coordinates the Operation of the Program:

- Maternal and Child Health Agency
- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carelink Health Plan

Health Plan of the Upper Ohio Valley

ADDITIONAL INFORMATION

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 CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Complaints, grievances and disenrollment data
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Focused Studies
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data

- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

- Disenrollment Survey
- State-developed Survey
- State-developed Survey of Children with Special Health Needs

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State use/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

WEST VIRGINIA

Mountain Health Trust

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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Validation: Methods

- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills)
- Medical record validation
- Per member per month analysis and comparisons across MCOs/PHPs
- Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Diabetes management
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Smoking prevention and cessation
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Health Status/Outcomes Quality

- Patient satisfaction with care
- Percentage of low birth weight infants

WEST VIRGINIA Mountain Health Trust

Access/Availability of Care

- Average distance to PCP
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

- Days/1000 and average length of stay for IP administration, ER visits, Ambulatory surgery, maternity care, newborn care
- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary
- Number of home health visits per beneficiary
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary

Health Plan Stability/Financial/Cost of Care

- Actual reserves held by plan
- Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- Net worth
- State minimum reserve requirements
- Total revenue
- Total Third Party Liability Collections Made By Source

Health Plan/Provider Characteristics

- Board Certification
- Provider turnover

Beneficiary Characteristics

- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
- Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

- MCOs/PHPs are required to conduct a project(s) of their own choosing
- All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics

- Coordination of care for persons with physical disabilities
- Post-natal Care

Non-Clinical Topics

None

Standards/Accreditation

MCO/PHP Standards

- CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
- JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
- NAIC (National Association of Insurance Commissioners) Standards
- NCQA (National Committee for Quality Assurance) Standards
- QARI (Quality Assurance Reform Initiative) Standards
- State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Delmarva
420

WEST VIRGINIA Mountain Health Trust

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

- Administration or validation of consumer or provider surveys
- Calculation of performance measures
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Review of MCO compliance with structural and operational standards established by the State
- Sentinel Event Review
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters

WEST VIRGINIA Physician Assured Access System

CONTACT INFORMATION

State Medicaid Contact: 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	Initial Waiver Approval Date: August 29, 1991
Operating Authority: 1915(b) - Waiver Program	Implementation Date: June 01, 1992
Statutes Utilized: 1915(b)(1)	Waiver Expiration Date: April 27, 2004
Enrollment Broker: Automated Health Systems, Inc.	Sections of Title XIX Waived: -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: 12 months guaranteed eligibility for children	

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: -Pediatricians -General Practitioners -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Clinics (RHCs) -Nurse Practitioners
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Enrollment

Populations Voluntarily Enrolled: -Blind/Disabled Adults and Related Populations -Blind/Disabled Children and Related Populations -Foster Care Children	Populations Mandatorily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Pregnant Women -Section 1931 (AFDC/TANF) Adults and Related Populations
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WEST VIRGINIA Physician Assured Access System

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

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 solely 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. The state granted one year eligibility for any child, under the age of 19, who is eligible for Medicaid, beginning June 1, 2001.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Consumer Self-Report Data
- Enrollee Hotlines
- Focused Studies
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data:

- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling
- Regulatory Compliance/Federal Reporting

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Child Medicaid AFDC Questionnaire
- Consumer/Beneficiary Focus Groups
- State-developed Survey

Performance Measures

Process Quality

- Adolescent immunization rate
- Asthma care
- Check-ups after delivery
- Diabetes management
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age

Health Status/Outcomes Quality

- Patient satisfaction with care
- Percentage of low birth weight infants

WEST VIRGINIA

Physician Assured Access System

- Immunizations for two year olds
- Initiation of prenatal care
- Lead screening rate
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Access/Availability of Care

- Average distance to primary care case manager
- Ratio of primary care case managers to beneficiaries

Provider Characteristics

None

Use of Services/Utilization

- Drug Utilization
- Emergency room visits
- Inpatient admissions
- Number of primary care case manager visits per beneficiary

Beneficiary Characteristics

None

424

WISCONSIN
BadgerCare [SCHIP]
CONTACT INFORMATION

State Medicaid Contact: Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address: <http://www.dhfs.state.wi.us>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: April 01, 1999
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: July 01, 1999
Statutes Utilized: Not Applicable	Waiver Expiration Date: March 31, 2004
Enrollment Broker: Automated Health Systems	Sections of Title XIX Waived: -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: -1916(a) Cost Sharing -Eligibility Expansion
Guaranteed Eligibility: 12 months guaranteed eligibility for children	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -General Practitioners -Pediatricians -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Indian Health Service (IHS) Providers
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Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -TITLE XXI SCHIP -Custodial Parents (And Their Spouses) Of Children Eligible
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WISCONSIN BadgerCare [SCHIP]

Through TTLE 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

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
Group Health Cooperative Of Eau Claire -- BadgerCare SCHIP
Health Tradition Health Plan -- BadgerCare SCHIP
MercyCare Insurance Company -- BadgerCare SCHIP
Security Health Plan -- BadgerCare SCHIP
UnitedHealthcare of WI -- BadgerCare SCHIP
Valley Health Plan -- BadgerCare SCHIP

Dean Health Plan -- BadgerCare SCHIP
Group Health Cooperative Of South Central WI -- BadgerCare SCHIP
Managed Health Services -- BadgerCare SCHIP
Network Health Plan -- BadgerCare SCHIP
Touchpoint Health Plan -- BadgerCare SCHIP
Unity Health Insurance -- 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.

BadgerCare also received waiver authority on 04/01/1999, and as later amended on 01/18/2001, regarding Title XIX and Title XXI requirements as follows:

- * T-19=Retroactive Eligibility, waiving Section 1902(a)(34)
- * T-19=Costs Not Otherwise Matchable for three Demonstration Populations, under Section 1115(a)(2) authority
- * T-19=Freedom of Choice, waiving Section 1902(a)(23)
- * T-19=Comparability of Services, waiving Section 1902(a)(10)(B)
- * T-19=Eligibility, waiving Sections 1902(a)(17), 1902(a)(34), and 1931(b)
- * T-19=Cost Sharing Limitations, waiving Section 1916(a)
- * T-21=Costs Not Otherwise Matchable for Demonstration Population #3, under Section 1115(a)(2) authority
- * T-21=General Requirements, Eligibility and Outreach, waiving Section 2102

WISCONSIN BadgerCare [SCHIP]

* T-21=Restrictions on Coverage and Eligibility to Targeted Low Income Children, waiving Sections 2103 and 2110 431

* T-21=Federal Matching Payment and Family Coverage Limits, waiving Section 2105

* T-21=Annual Reporting Requirements, waiving Section 2108

Other special circumstances: enrollment varies by county; summary and detailed claims data required; HMOs required to coordinate with WIC, county non-MA programs, and other local agencies and programs.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Deeming (see below for details)
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Child Medicaid AFDC Questionnaire
- State-developed Survey

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

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous 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

Collection: Standardized Forms

-CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Date of Payment
- Provider ID

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of "home grown" forms
- Use of Medicaid Identification Number for beneficiaries

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/PHPs

State conducts general data completeness assessments

Yes

WISCONSIN BadgerCare [SCHIP]

- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Admission Source
- Admission Type
- Days Supply
- Modifier Codes
- Patient Status Code
- Place of Service Codes
- Quantity

Performance Measures

Process Quality

- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Dental services
- Diabetes management
- Follow-up after hospitalization for mental illness
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds
- 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

Access/Availability of Care

- Average distance to PCP
- Provider network data on geographic distribution
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care

None

Beneficiary Characteristics

None

Health Status/Outcomes Quality

- Breast malignancies detected
- Cervix/uterus malignancies detected
- HPV infections detected
- Patient satisfaction with care

Use of Services/Utilization

- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
- Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics

- Board Certification
- Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements

- MCOs/PHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

WISCONSIN BadgerCare [SCHIP]

Standards/Accreditation

MCO/PHP Standards

-State-Developed/Specified Standards

Accreditation Required for

None

Accreditation for Deeming

-AAAHC (Accreditation Association for Ambulatory Health Care)

-All accrediting body standards are subject to review/acceptance for deeming

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

-NCQA (National Committee for Quality Assurance)

EQRO Name

-MetaStar

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

-Calculation of performance measures

-Review of MCO compliance with structural and operational standards established by the State

-Technical assistance to MCOs to assist them in conducting quality activities

-Validation of client level data, such as claims and encounters

-Validation of performance improvement projects

-Validation of performance measures

429

WISCONSIN Children Come First (CCF)

CONTACT INFORMATION

State Medicaid Contact:

Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:

<http://www.dhfs.state.wi.us>

PROGRAM DATA

Program Service Area:

County

Initial Waiver Approval Date:

Not Applicable

Operating Authority:

Voluntary - No Authority

Implementation Date:

April 01, 1993

Statutes Utilized:

Not Applicable

Waiver Expiration Date:

Not Applicable

Enrollment Broker:

No

Sections of Title XIX Waived:

None

For All Areas Phased-In:

No

**Sections of Title XIX Costs Not Otherwise Matchable
Granted:**

None

Guaranteed Eligibility:

None

SERVICE DELIVERY

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services:

Crisis, IMD, Inpatient Mental Health, Inpatient Substance Abuse, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Abuse

Allowable PCPs:

-Not applicable, contractors not required to identify PCPs

Contractor Types:

-County Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children
-Blind/Disabled Children and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:

None

WISCONSIN

Children Come First (CCF)

Subpopulations Excluded from Otherwise Included Populations:

- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- All Enrollees Must Have Special Needs To Be Eligible For Enrollment.
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Community Partnerships
- Dane County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
- Mental Health Agency
- Other Public And Private Agencies Are On The Statewide Children Come First Advisory Committee.
- Social Services 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.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data

- Contract Standard Compliance
- Monitor Quality Improvement
- Program Evaluation
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

- State-developed Survey

Use of HEDIS

- The State DOES NOT use any of the HEDIS measures
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

WISCONSIN

Children Come First (CCF)

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- 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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes

Collections: Submission Specifications

- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- 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

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

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

Access/Availability of Care

- Internal And External Quality Assurance Audits Of Access And Of Monitoring Plans Of Care

Health Plan Stability/ Financial/Cost of Care

None

Beneficiary Characteristics

- Information of beneficiary ethnicity/race
- MCO/PCP-specific disenrollment rate

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

Use of Services/Utilization

- Internal And External Quality Assurance Audits Of Monitoring Plans Of Care And Tracking Actual Service Utilization

Health Plan/ Provider Characteristics

- Internal Quality Assurance Review Of Sub-Contracted Providers

WISCONSIN

Children Come First (CCF)

-Other Demographic, Clinical, And Service System
Characteristics Of Enrollees.

Performance Improvement Projects

Project Requirements

-MCOs/PHPs are required to conduct a project(s) of their own
choosing

Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct
common project(s)

Non-Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct
common project(s)

Standards/Accreditation

MCO/PHP Standards

-State-Developed/Specified Standards

Accreditation Required for

None

Accreditation for Deeming

None

Care EQRO Name

-MetaStar

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

-Quality Of Care Reviews
-Review of MCO compliance with structural and operational
standards established by the State
-Validation of performance improvement projects

WISCONSIN

Independent Care (iCare)

CONTACT INFORMATION

State Medicaid Contact:

Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:

<http://www.dhfs.state.wi.us>

PROGRAM DATA

Program Service Area:

County

Initial Waiver Approval Date:

Not Applicable

Operating Authority:

Voluntary - No Authority

Implementation Date:

July 01, 1994

Statutes Utilized:

Not Applicable

Waiver Expiration Date:

Not Applicable

Enrollment Broker:

Automated Health Systems

Sections of Title XIX Waived:

None

For All Areas Phased-In:

No

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

Guaranteed Eligibility:

No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Coordination With Non-Medicaid Services (Social & Vocational Services, Recreational & Wellness Progr, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Skilled Nursing Facility Only Covered Up To 90 Days., Transportation, Vision, X-Ray

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:

None

WISCONSIN

Independent Care (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
- Children Under Age 15
- Reside in Nursing Facility or ICF/MR

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Asks advocacy groups to identify members of these groups
- Comprehensive Assessment Required At Time of Enrollment
- Only SSI-Disabled Recipients May Enroll
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Local Public Health Agency
- Mental Health Agency
- Milwaukee County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Humana/Wisconsin Health Organization (Voluntary, iCare)

ADDITIONAL INFORMATION

Humana/Wisconsin Health Organization (an HMO) and the Milwaukee Center for Independence (a community vocational services agency) are partners in a joint venture agreement to operate Independent Care (iCare). 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 excluded from this program.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data

- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

WISCONSIN

Independent Care (iCare)

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid SSI Questionnaire
 - Adult with Special Needs Questionnaire
- Consumer/Beneficiary Focus Groups
- Disenrollment Survey

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous enrollment requirement for some or all of the measures
- State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous 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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- 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/PHPs

MCO 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

Performance Measures

Process Quality

- Asthma care
- Breast Cancer screening rate

Health Status/Outcomes Quality

- Patient satisfaction with care

WISCONSIN

Independent Care (iCare)

- Cervical cancer screening rate
- Dental services
- Diabetes management
- Follow-up after hospitalization for mental illness
- Influenza Vaccination Rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit

Access/Availability of Care

- Monitoring Voluntary Disenrollments
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

- Average number of visits to MH/SA providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Hospitalization Rate For Ambulatory Sensitive Conditions
- Inpatient admission for MH/SA conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of home health visits per beneficiary
- Percentage of beneficiaries with at least one dental visit
- Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of Care

None

Health Plan/ Provider Characteristics

- Board Certification
- Languages Spoken (other than English)

Beneficiary Characteristics

- Beneficiary need for interpreter
- MCO/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements

- MCOs/PHPs are required to conduct a project(s) of their own choosing
- Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards

- State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

- MetaStar

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

- Calculation of performance measures
- Review of MCO compliance with structural and operational standards established by the State
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of client level data, such as claims and encounters
- Validation of performance improvement projects
- Validation of performance measures

WISCONSIN Medicaid HMO Program

CONTACT INFORMATION

State Medicaid Contact: Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address: <http://www.dhfs.state.wi.us>

PROGRAM DATA

Program Service Area: Statewide	Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932 - State Plan Option to Use Managed Care	Implementation Date: March 31, 1997
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: Automated Health Systems	Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable
Guaranteed Eligibility: 12 months guaranteed eligibility for children	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -General Practitioners -Pediatricians -Family Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Federally Qualified Health Centers (FQHCs) -Rural Health Centers (RHCs) -Indian Health Service (IHS) Providers
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Enrollment

Populations Voluntarily Enrolled: None	Populations Mandatorily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Pregnant Women -Section 1931 (AFDC/TANF) Adults and Related Populations
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WISCONSIN Medicaid HMO Program

Subpopulations Excluded from Otherwise Included Populations:

- American Indian/Alaskan Native
- Residents residing in FFS counties
- Migrant workers
- 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:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses enrollment forms to identify members of these 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 CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Accreditation for Deeming (see below for details)
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)

Use of Collected Data

- Beneficiary Plan Selection
- Contract Standard Compliance
- Health Services Research

WISCONSIN

Medicaid HMO Program

- Enrollee Hotlines
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid AFDC Questionnaire
 - Child Medicaid AFDC Questionnaire
- State-developed Survey

- Monitor Quality Improvement
- Program Evaluation
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Use of HEDIS

- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continuous 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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

MCO 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

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. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of "home grown" forms
- Use of Medicaid Identification Number for beneficiaries

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/PHPs

State conducts general data completeness assessments

Yes

Performance Measures

WISCONSIN Medicaid HMO Program

Process Quality

- Asthma care
- Breast Cancer screening rate
- Cervical cancer screening rate
- Dental services
- Diabetes management
- Follow-up after hospitalization for mental illness
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit
- Vision services for individuals less than 21 years of age
- Well-child care visit rates

Health Status/Outcomes Quality

- 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
- Ratio of PCPs to beneficiaries

Use of Services/Utilization

- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
- Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care

None

Health Plan/ Provider Characteristics

- Board Certification
- Languages Spoken (other than English)

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

- MCOs/PHPs are required to conduct a project(s) of their own choosing

Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards

- State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

- AAAHC (Accreditation Association for Ambulatory Health Care)
- All accrediting body standards are subject to review/acceptance for deeming
- JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
- NCQA (National Committee for Quality Assurance)

EQRO Name

- MetaStar

EQRO Organization

- Peer Review Organization (PRO)

EQRO Activities

- Calculation of performance measures
- Review of MCO compliance with structural and operational standards established by the State

WISCONSIN

Medicaid HMO Program

- Technical assistance to MCOs to assist them in conducting
- Validation of client level data, such as claims and encounters
- Validation of performance improvement projects
- Validation of performance measures

WISCONSIN Wisconsin Partnership Program

CONTACT INFORMATION

State Medicaid Contact: Steven Landkamer
Office of Strategic Finance, Center for Delivery Systems
(608) 261-7811

State Website Address: <http://www.dhfs.state.wi.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: January 01, 1996
Operating Authority: 1115 - Demonstration Waiver Program	Implementation Date: January 01, 1996
Statutes Utilized: Not Applicable	Waiver Expiration Date: December 31, 2002
Enrollment Broker: No	Sections of Title XIX Waived: -1902(a)(10)(B) Comparability of Services -1902(a)(17) -1902(a)(23) Freedom of Choice -1902(a)(34)
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: -1916(a) Cost Sharing -HCBS
Guaranteed Eligibility: No guaranteed eligibility	

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services: All Other WI Medicaid Services, Case Management, Durable Medical Equipment, Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray	Allowable PCPs: -Internists -Other Specialists Approved on a Case-by-Case Basis
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Enrollment

WISCONSIN

Wisconsin Partnership Program

Populations Voluntarily Enrolled:

- Aged and Related Populations
- Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:

None

Subpopulations Excluded from Otherwise

Included Populations:

- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Must Meet Nursing Home Level-Of-Care Or Have Substantial Illness Or Disability.
- Uses eligibility data to identify members of these groups
- Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

- Aging Agency
- Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care For The Elderly - Partnership
Community Living Alliance -- Partnership

Community Health Partnership -- Partnership
Elder Care Of Dane County - Partnership

ADDITIONAL INFORMATION

Wisconsin Partnership Project began operating under a dual Medicaid--Medicare waiver in January 1999. This demonstration project provides comprehensive Medicaid and Medicare services for older adults (ages 65+) and people with physical disabilities (ages 18-64). The Partnership Program integrates health and long-term support services and includes home- and community-based care, physician services, and all other medical care. Services are delivered in the participants home or a setting of his or her choice. Team-based care management is a key component of the program.

Partnership Program goals are to: improve quality of health care and service delivery while containing costs; reduce fragmentation and inefficiency in the existing health care delivery system; increase the ability of people to live in the community and participate in decisions regarding their own health care.

Other special characteristics: same goals as PACE Program; nurse practitioners play a key role in linking services; recipients can bring their own provider as PCP; external committee evaluation data techniques.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Monitoring of MCO/PHP Standards
- Ombudsman
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data

- Contract Standard Compliance
- Monitor Quality Improvement

WISCONSIN

Wisconsin Partnership Program

Consumer Self-Report Data

- CAHPS
 - Adult Medicaid SSI Questionnaire
 - Adult with Special Needs Questionnaire
- State-developed Survey

Use of HEDIS

- The State DOES NOT use any of the HEDIS measures
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Encounter Data

Collection: Requirements

- CMS Requirements

Collections: Submission Specifications

None

Collection: Standardized Forms

None

Validation: Methods

- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

None

Use of Services/Utilization

- Number of hospital admissions per member per year
- Number of hospital days per member per year
- Percentage of beneficiaries with at least one dental visit
- Percentage of people living at home, CBRF/group home, nursing home

Health Plan Stability/ Financial/Cost of Care

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

WISCONSIN

Wisconsin Partnership Program

Project Requirements

-MCOs/PHPs are required to conduct a project(s) of their own choosing

Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-MetaStar

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

-Calculation of performance measures
-Validation of performance improvement projects
-Validation of performance measures

WISCONSIN
Wraparound Milwaukee
CONTACT INFORMATION

State Medicaid Contact: Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address: <http://www.dhfs.state.wi.us>

PROGRAM DATA

Program Service Area: County	Initial Waiver Approval Date: Not Applicable
Operating Authority: Voluntary - No Authority	Implementation Date: March 01, 1997
Statutes Utilized: Not Applicable	Waiver Expiration Date: Not Applicable
Enrollment Broker: No	Sections of Title XIX Waived: None
For All Areas Phased-In: Yes	Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: None	

SERVICE DELIVERY

Mental Health and Substance Abuse (MH/SA) PHP - Full Capitation

Service Delivery

Included Services: Crisis, IMD, Inpatient Mental Health, Inpatient Substance Abuse, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Abuse	Allowable PCPs: -Not applicable, contractors not required to identify PCPs
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Contractor Types:
-County Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled: -Section 1931 (AFDC/TANF) Children and Related Populations -Foster Care Children -Blind/Disabled Children and Related Populations -TITLE XXI SCHIP	Populations Mandatorily Enrolled: None
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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

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 CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- MCO/PHP Standards (see below for details)
- Monitoring of MCO/PHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data

- Contract Standard Compliance
- Monitor Quality Improvement
- Program Evaluation
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

- State-developed Survey

Use of HEDIS

- The State DOES NOT use any of the HEDIS measures
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

WISCONSIN

Wraparound Milwaukee

Collection: Requirements

- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- 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

Collection: Standardized Forms

- CMS 1500 - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
- UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

MCO conducts data accuracy check(s) on specified data elements

- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes

Collections: Submission Specifications

- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. CMS 1500, UB-92, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- 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. CMS 1500, UB-92, NCPDP, ADA)
- Required 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

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

Access/Availability of Care

- Internal And External Quality Assurance Audits Of Access And Of Monitoring Plans Of Care

Health Plan Stability/ Financial/Cost of Care

None

Beneficiary Characteristics

- Information of beneficiary ethnicity/race

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

Use of Services/Utilization

- Internal And External Quality Assurance Audits Of Monitoring Plans Of Care And Tracking Actual Service Utilization

Health Plan/ Provider Characteristics

- Internal Quality Assurance Review Of Sub-Contracted Providers

WISCONSIN

Wraparound Milwaukee

-MCO/PCP-specific disenrollment rate
-Other Demographic, Clinical, And Service System
Characteristics Of Enrollees.

Performance Improvement Projects

Project Requirements

-MCOs/PHPs are required to conduct a project(s) of their own choosing

Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics

Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards

-State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-MetaStar

EQRO Organization

-Peer Review Organization (PRO)

EQRO Activities

-Conduct performance improvement projects
-Quality Of Care Reviews
-Validation of performance improvement projects

**National Summary of State Medicaid Managed Care
Programs
Glossary as of June 30, 2002**

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, 2002**

1902(a)(23)

Freedom of Choice. This section of the Act requires State Medicaid plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted.

Section: Service Delivery--Managed Care Entity Terms

PCCM

Primary Care Case Management (PCCM) Provider is usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants who contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category include PCCMs and those PHPs which act as PCCMs.

PHP

Prepaid Health Plan is a prepaid managed care entity that provides less than comprehensive services on an at risk basis or one that provides any benefit package on a non-risk basis. Comprehensive services are defined in 42 CFR 434.21(B). There are several types of PHPs that States use to deliver a range of services. For example, a Mental Health (MH) PHP is a managed care entity that provides only mental health services. This category does not include those PHPs which contract as primary care case management.

MCO

Managed Care Organization is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare-Choice organization, a provider sponsored organization or any other private or public organization which meets the requirements of §1902 (w) to provide comprehensive services.

HIO

Health Insuring Organization is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

**National Summary of State Medicaid Managed Care
Programs
Glossary as of June 30, 2002**

Section: Service Delivery--Reimbursement Arrangement Terms

<i>Fee-For-Service</i>	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.
<i>Full Capitation</i>	The plan or Primary Care Case Manager is paid for providing services to enrollees solely through capitation.
<i>Partial Capitation</i>	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

<i>Accreditation for Deeming</i>	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.
<i>Accreditation for Participation</i>	State requirement that plans must be accredited to participate in the Medicaid managed care program.
<i>Consumer Self-Report Data</i>	Data collected through survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a MCO or PHP. The survey may be conducted by the State or a contractor to the State.
<i>Encounter Data</i>	Detailed data about individual services provided to individual beneficiaries at the point of the beneficiary's interaction with a MCO or PHP institutional or practitioner provider. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims".

***National Summary of State Medicaid Managed Care
Programs
Glossary as of June 30, 2002***

<i>Enrollee Hotlines</i>	Toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their MCO/PHP. The people who staff hotlines are knowledgeable about program policies and may play an "intake and triage" role or may assist in resolving the problem.
<i>Focused Studies</i>	State required studies that examine a specific aspect of health care (such as prenatal care) for a defined point in time. These projects are usually based on information extracted from medical records or MCO/PHP administrative data such as enrollment files and encounter /claims data. State staff, EQRO staff, MCO/PHP staff or more than one of these entities may perform such studies at the discretion of the State.
<i>MCO/PHP Standards</i>	These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each MCO/PHP must have in order to participate in the Medicaid program.
<i>Monitoring of MCO/PHP Standards</i>	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.
<i>Ombudsman</i>	An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PHP, and the provider (as appropriate) to resolve individual enrollee problems.
<i>On-Site Reviews</i>	Reviews performed on-site at the MCO/PHP health care delivery system sites to assess the physical resources and operational practices in place to deliver health care.
<i>Performance Improvement Projects</i>	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

National Summary of State Medicaid Managed Care Programs

Glossary as of June 30, 2002

and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MCO/PHPs choosing or prescribed by the State.

Performance Measures

Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PHP.

Provider Data

Data collected through a survey or focus group of providers who participate in the Medicaid program and have provided services to enrolled Medicaid beneficiaries. The State or a contractor of the State may conduct survey.

HEDIS Measures from Encounter Data

Health Plan Employer Data and Information Set (HEDIS) measures from encounter data as opposed to having the plans generate HEDIS measures. HEDIS is a collection of performance measures and their definitions produced by the National Committee for Quality Assurance (NCQA).

EQRO

Federal law and regulations require States to use an *External Quality Review Organization (EQRO)* to review the care provided by capitated managed care entities. EQROs may be Peer Review Organizations (PROs), another entity that meets PRO requirements, or a private accreditation body.