National Summary of State Medicaid Managed Care Programs as of June 30, 2000

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

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ALABAMA
Maternity Care Program

CONTACT INFORMATION

State Medicaid Contact:
Kim Davis-Allen
Alabama Medicaid Agency
(334)242-5012

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

PROGRAM DATA

Program Service Area:
County

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

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
June 01, 1999

Implementation Date:
June 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Inpatient Hospital, Outpatient Hospital, Physician

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

Enrollment

Populations Voluntarily Enrolled:
None

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

ALABAMA
Maternity Care Program

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
3 months lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Maternity Care Program

ADDITIONAL INFORMATION

-Poverty Level Pregnant Women

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

The payment methology for Maternity Waiver is a global rate based on a percentage of the historical cost of providing specified maternity care services. Patient are required to receive services through the network and can choose any provider in the network. Maternity patients may be exempted for medical reasons.

Special needs children refer to SSI Recipients 19 and under.

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

Performance Improvement Projects

Clinical Topics
None

Non-Clinical Topics
-Access to early prenatlal care

ALABAMA
Partnership Hospital Program

CONTACT INFORMATION

State Medicaid Contact:
Vicki Huff
Alabama Medicaid Agency
(334)242-5012

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
October 01, 1996

Implementation Date:
October 01, 1996

Waiver Expiration Date:
March 29, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Medical-only - Limited Benefits) - Capitation

Service Delivery

Included Services:
Inpatient Hospital

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

Enrollment

Populations Voluntarily Enrolled:
None

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

ALABAMA
Partnership Hospital Program

Populations Mandatory Enrolled with a Sole Source Provider:

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

-Aged and Related Populations

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

-Reviews complaints and grievances to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Partnership Hospital Program

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies

Use of Collected Data

-Monitor Quality Improvement

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

None

Collection: Standardized Forms

None

Validation: Methods

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

ALABAMA
Partnership Hospital Program

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

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Alabama Quality Assurance Foundation

EQRO Organization
-Peer Review Organization (PRO)

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

ALABAMA
Patient 1st

CONTACT INFORMATION

State Medicaid Contact:
Kim Davis-Allen
Alabama Medicaid Agency
(334)242-5012

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1997

Implementation Date:
January 01, 1997

Waiver Expiration Date:
June 29, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

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

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

Enrollment

ALABAMA
Patient 1st

Populations Voluntarily Enrolled:
None

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
July 13, 1982

Implementation Date:
October 01, 1982

Waiver Expiration Date:
September 30, 2002

Sections of Title XIX Waived:
-1902(a)(10)(A)(ii)(V)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(B)(i)
-1902(a)(13)
-1902(a)(14)
-1902(a)(17)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(4)
-1902(a)(54)

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)(i)
-1903(m)(2)(A)(ix)
-1903(m)(2)(A)(vi)
-1903(m)(2)(A)(viii)
-1903(m)(4)(A)&(B) HCBS

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

Allowable PCPs:
-Pediatricians
-General Practitioners

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

only), Home Health, Hospice (EPSDT only), 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 (EPSDT only), X-Ray

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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)

PHP (Mental Health and Substance Abuse (MH/SA) - Limited Benefits) -

Service Delivery

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

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

Contractor Types:
-Regional Authority Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-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:
-No populations are excluded

Lock-In Provision:
No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Arizona Health Concepts (Acute)
Arizona Health Concepts (Family Planning Extension)
AZ Physicians IPA (Family Planning Extension)
AZ Physicians IPA (HP)
Cigna Community Choice (Family Planning Extension)
Cigna Community Choice (HP)
Department of Economic Security/Childrens Medical and Dental Program (Family Planning Extension)
Department of Economic Security/Childrens Medical and Dental Program (HP)
Department of Economic Security/Division of Developmental Disabilities (PC)
Department of Health Services (Behavioral Health)
Family Health Plan of North Eastern Arizona (Family Planning Extension)
Family Health Plan of North Eastern Arizona (HP)
Health Choice Arizona (Family Planning Extension)
Health Choice Arizona (HP)
Maricopa Managed Care Systems (Family Planning Extension)
Maricopa Managed Care Systems (PC)
Mercy Care Plan (Family Planning Extension)
Mercy Care Plan (HP)
Phoenix Health Plan/Community Connection (Family Planning Extension)
Phoenix Health Plan/Community Connection (HP)
Pima Health System (Family Planning Extension)
Pima Health System (PC)
Pinal County Long Term Care (PC)
University Family Care (Family Planning Extension)
University Family Care (HP)
Ventana Health Systems (PC)

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

Yavapai County Long Term Care (PC)

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms

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

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

Validation: Methods

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

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

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

State conducts general data completeness assessments

Yes

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality

-ADL (Activity of Daily Living) functional ability
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Universal Form C for Retail Pharmacy Services -Check-ups after delivery
-Dental services
-Diabetes management
-Family Planning
-Follow-up after hospitalization for mental illness
-Fractures related to falls
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Influenza vaccination rate
-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
-Pressure sores care and treatment
-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

-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 benificiary
-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.)
-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

Use of HEDIS

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

Consumer Self-Report Data

-CAHPS
Adult Medicaid AFDC Questionnaire

ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

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

Performance Improvement Projects

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

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

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

Standards/Accreditation

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

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
- Health Services Advisory Group

EQRO Organization
-Private Accreditation Organization

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

ARKANSAS
Non-Emergency Transportation

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
February 19, 1998

Implementation Date:
March 01, 1998

Waiver Expiration Date:
February 23, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Transportation - Limited Benefits) - 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:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

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

-Foster Care Children
-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:
None

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

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

ARKANSAS

Non-Emergency Transportation

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

State conducts general data completeness assessments
Yes

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:
None

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 30, 1996

Implementation Date:
November 01, 1996

Waiver Expiration Date:
June 20, 2002

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
None

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

ARKANSAS
Primary Care Physician

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

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Eligibility Period that is Retroactive
-Medically Needy "Spenddown" Categories
-Managed by Children's Medical Services
-Residing Out-of-State
-Eligibility only in Family Planning Demonstration(1115)

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
-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

CALIFORNIA
Altamed Health Senior Buenacare

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
September 28, 1998

Implementation Date:
November 01, 1998

Waiver Expiration Date:
November 24, 2001

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

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

SERVICE DELIVERY

Long Term Care HMO - Full Capitation

Service Delivery

Included Services:
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
-Family Practitioners
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Physician Assistants
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

CALIFORNIA
Altamed Health Senior Buenacare

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

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Altamed Senior BuenaCare

ADDITIONAL INFORMATION

If the potential participant meets the eligibility requirements for enrollment into the PACE program, which is 55 years and older, lives in the plans approved service area, and is cetified 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.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-Not Applicable

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

CALIFORNIA
Altamed Health Senior Buenacare

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA
Caloptima

CONTACT INFORMATION

State Medicaid Contact:
Susanne M. Hughes
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)(2)
1915(b)(4)

Waiver Expiration Date:
January 31, 2001

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(4)
-1902(a)(5)

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
6 months 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

CALIFORNIA
Caloptima

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

CALIFORNIA
Caloptima

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

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

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

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

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

project(s) prescribed by State Medicaid agency

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 NCQA accredited auditors

EQRO Organization
-Private Accreditation Organization

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

CALIFORNIA
Center For Elders Independence

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 04, 1995

Implementation Date:
April 01, 1995

Waiver Expiration Date:
January 24, 2001

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

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

SERVICE DELIVERY

Long Term Care HMO - Full Capitation

Service Delivery

Included Services:
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
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Physician Assistants
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Addictionologists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

CALIFORNIA
Center For Elders Independence

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

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Centers for Elders Independence

ADDITIONAL INFORMATION

This is a Health and Social Service program for persons who are certified by CA for Nursing Home Levels of care.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-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
Central Coast Alliance for Health

CONTACT INFORMATION

State Medicaid Contact:
Susanne M. Hughes
Medi-Cal Managed Care Division
(916)654-8076

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1996

Implementation Date:
January 01, 1996

Waiver Expiration Date:
November 19, 2000

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(A)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(4)
-1902(a)(5)
-OBRA 1985 & 1990

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

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, 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

CALIFORNIA
Central Coast Alliance for 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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

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

CALIFORNIA
Central Coast Alliance for Health

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

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

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

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

Performance Improvement Projects

CALIFORNIA
Central Coast Alliance for Health

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

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

-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 NCQA accredited auditors

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:
Susanne Hughes
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)(2)
1915(b)(3)
1915(b)(4)

Waiver Expiration Date:
April 03, 2002

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(4)
-1902(a)(5)

For All Areas Phased-In:
Yes

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

CALIFORNIA
Health Plan of San Mateo

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

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

Encounter Data

CALIFORNIA
Health Plan of San Mateo

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

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

Collection: Standardized Forms
None

Validation: Methods
None

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

State conducts general data completeness assessments
No

Performance Measures

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

Health Status/Outcomes Quality
None

Access/Availability of Care
None

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

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

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

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

Performance Improvement Projects

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

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

CALIFORNIA
Health Plan of San Mateo

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 NCQA accredited auditors

EQRO Organization
-Private Accreditation Organization

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

CALIFORNIA
Hudman

CONTACT INFORMATION

State Medicaid Contact:
Virgil J. Toney, Jr.
Medi-Cal Operations Division
(916)323-0081

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
April 24, 1992

Implementation Date:
April 24, 1992

Waiver Expiration Date:
January 19, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

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

CALIFORNIA
Managed Care Network

CONTACT INFORMATION

State Medicaid Contact:
Susanne M. Hughes
Medi-Cal Managed Care Division
(916)654-8076

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 28, 1997

Implementation Date:
March 01, 1997

Waiver Expiration Date:
November 19, 2000

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)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

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

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

CALIFORNIA
Managed Care Network

Enrollment

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

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Placer County Managed Care Network
Sonoma County Managed Care Network

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-None

Use of Collected Data:
-None

CALIFORNIA
Medi-Cal Mental Health Care Field Test

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 13, 1995

Implementation Date:
April 01, 1995

Waiver Expiration Date:
December 22, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

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

Service Delivery

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

Contractor Types:
-County Operated Entity (Public)

Allowable PCPs:
-Psychiatrists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-Section 1931 (AFDC/TANF) Children and Related Populations

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Not Applicable

-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)

Lock-In Provision:
No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Not Applicable

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Does Not Collect Quality Data

Use of Collected Data:
-Not Applicable

CALIFORNIA
Medi-Cal Specialty Mental Health Services Consolidation

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 02, 1995

Implementation Date:
March 15, 1995

Waiver Expiration Date:
November 27, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

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

Service Delivery

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

Contractor Types:
None

Allowable PCPs:
-Psychiatrists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Not Applicable

CALIFORNIA
Medi-Cal Specialty Mental Health Services Consolidation

-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)

Lock-In Provision:
No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Not Applicable

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Does not Collect Quality Data

Use of Collected Data:
-Not Applicable

CALIFORNIA
On Lock Senior Health Services

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 01, 1983

Implementation Date:
November 01, 1983

Waiver Expiration Date:
November 24, 2001

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

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

SERVICE DELIVERY

Long Term Care HMO - Full Capitation

Service Delivery

Included Services:
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
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Physician Assistants
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

CALIFORNIA
On Lock Senior Health Services

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

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

On Lok

ADDITIONAL INFORMATION

This is a Health and Social Service program for persons who are certified by CA for Nursing Home levels of care.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-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
Partnership Health Plan of California

CONTACT INFORMATION

State Medicaid Contact:
Susanne M. Hughes
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)(2)
1915(b)(4)

Waiver Expiration Date:
February 10, 2001

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(4)
-1902(a)(5)
-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, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Long Term Care - Couselilng and Social Support, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

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

CALIFORNIA
Partnership Health Plan of California

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Partnership Health Plan

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

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

CALIFORNIA
Partnership Health Plan of California

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

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

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

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

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

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 NCQA accredited auditors

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:
Susanne Hughes
Medi-Cal Managed Care Division
(916)654-8076

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1972

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Dental - Limited Benefits) - Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Dentists

Enrollment

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

Populations Mandatorily Enrolled:
None

CALIFORNIA
Prepaid Health Plan Program

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

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

Lock-In Provision:

No lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

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

Allowable PCPs:

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

Enrollment

Populations Voluntarily Enrolled:

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

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

Populations Mandatorily Enrolled:

None

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:

No lock-in

CALIFORNIA
Prepaid Health Plan Program

PHP ((Only for Emotional Support) - Limited Benefits) - Capitation

Service Delivery

Included Services:
Emotional Support Services

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Disabled Children

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
None

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 Period Less Than 3 Months
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

ADDITIONAL INFORMATION

San Francisco City & CO/Family Mosiac under this program only provides emotional support to severe emotional disturbed

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-PHP
Molina Medical Centers
Tower Health Care-Dental PHP
Universal Care-Dental
American health Guard-Dental Plan
Denticare of California
Maxicare Dental PHP
San Francisco City & CO/Family Mosiac
UHP Healthcare-Dental
Western Dental Services

CALIFORNIA
Prepaid Health Plan Program
QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-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:
Susanne M. Hughes
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)(2)
1915(b)(3)
1915(b)(4)

Waiver Expiration Date:
August 09, 2001

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)

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

PHP (Medical-only - Limited Benefits) - Capitation

Service Delivery

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

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

Enrollment

CALIFORNIA
Primary Care Case Management Program

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

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Positive Healthcare/Aids Healthcare

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-Not Applicable

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

CALIFORNIA
Sacramento Geographic Managed Care

CONTACT INFORMATION

State Medicaid Contact:
Susanne M. Hughes
Medi-Cal Managed Care Division
(916)654-8076

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 22, 1996

Implementation Date:
April 01, 1994

Waiver Expiration Date:
August 12, 2002

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Dental - Limited Benefits) - Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Dentists

Enrollment

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

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

CALIFORNIA
Sacramento Geographic Managed Care

Populations Mandatory Enrolled with a Sole Source Provider:

None

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:

6 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

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

Allowable PCPs:

-Blind/Disabled Adults and Related Populations
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Psychiatrists
-Pediatricians
-Family Practitioners
-Internists

Enrollment

Populations Voluntarily Enrolled:

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

Populations Mandatorily Enrolled:

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

Populations Mandatory Enrolled with a Sole Source Provider:

None

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:

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 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

CALIFORNIA
Sacramento Geographic Managed Care

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

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. HCFA 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
-HCFA 1500 - the HCFA 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 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods

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

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

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility

State conducts general data completeness assessments

No

CALIFORNIA
Sacramento Geographic Managed Care

-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for Participation
None

Performance Measures

Process Quality
-Check-ups after delivery
-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

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

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

Performance Improvement Projects

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

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

CALIFORNIA
Sacramento Geographic Managed Care

Accreditation for Deeming
None

EQRO Name
-Health Services Advisory Group NCQA accredited auditors

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
San Diego Geographic Managed Care

CONTACT INFORMATION

State Medicaid Contact:
Susanne M. Hughes
Medi-Cal Managed Care Division
(916)654-8076

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 17, 1998

Implementation Date:
October 17, 1998

Waiver Expiration Date:
October 16, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

CALIFORNIA
San Diego Geographic Managed Care

Enrollment

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

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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:
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 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

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

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)

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

CALIFORNIA
San Diego Geographic Managed Care

-Performance Measures (see below for details)

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. HCFA 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
-HCFA 1500 - the HCFA 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 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

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

State conducts general data completeness assessments
No

Performance Measures

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

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

CALIFORNIA
San Diego Geographic Managed Care

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

Consumer Self-Report Data
-Adult and child English and Spanish
-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

Performance Improvement Projects

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

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Health Services Advisory Group NCQA accredited auditors

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
Santa Barbara Health Initiative

CONTACT INFORMATION

State Medicaid Contact:
Susanne M. Hughes
Medi-Cal Managed Care Division
(916)654-8076

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
September 01, 1987

Implementation Date:
September 01, 1987

Waiver Expiration Date:
January 11, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(A)
-1902(a)(23) Freedom of Choice
-1902(A)(30)
-1902(A)(4)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

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

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

CALIFORNIA
Santa Barbara Health Initiative

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Santa Barbara Health Initiative

ADDITIONAL INFORMATION
Established under State Statute of 1982.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

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

CALIFORNIA
Santa Barbara Health Initiative
Encounter Data

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

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

Collection: Standardized Forms
None

Validation: Methods
None

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

State conducts general data completeness assessments
No

Performance Measures

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

Health Status/Outcomes Quality
None

Access/Availability of Care
None

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

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

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

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

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

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

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 NCQA accredited auditors

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:
Virgil J.. Toney, Jr.
Medi-Cal Operations
(916)323-0081

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Initial Waiver Approval Date:
September 21, 1982

Implementation Date:
September 21, 1982

Waiver Expiration Date:
December 12, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

ADDITIONAL INFORMATION

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

CALIFORNIA
Senior Care Action Network

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
June 07, 1985

Implementation Date:
January 01, 1985

Waiver Expiration Date:
September 30, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Social HMO - Full Capitation

Service Delivery

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

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

Enrollment

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

Populations Mandatorily Enrolled:
None

CALIFORNIA
Senior Care Action Network

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Senior Care Action Network

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-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
-Not Applicable

CALIFORNIA
Sutter Senior Care

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 14, 1994

Implementation Date:
May 01, 1994

Waiver Expiration Date:
November 24, 2001

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

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

SERVICE DELIVERY

Long Term Care HMO - Full Capitation

Service Delivery

Included Services:
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
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Physician Assistants
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

CALIFORNIA
Sutter Senior Care

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

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

This is a Health and Social Service program for persons who are certified by CA for Nursing Home levels of care.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
None

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

CALIFORNIA
Two-Plan Model Program

CONTACT INFORMATION

State Medicaid Contact:
Susanne M. Hughes
Medi-Cal Managed Care Division
(916)654-8076

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 22, 1996

Implementation Date:
January 22, 1996

Waiver Expiration Date:
December 16, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

CALIFORNIA
Two-Plan Model Program

Enrollment

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

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

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

CALIFORNIA
Two-Plan Model Program

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

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. HCFA 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
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
-National Drug Codes assigned by the Federal Drug Administration
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

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

State conducts general data completeness assessments
No

Performance Measures

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

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

CALIFORNIA
Two-Plan Model Program

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

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

Performance Improvement Projects

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

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

HEDIS measures listed for Medicaid in the future

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 NCQA accredited auditors

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

COLORADO
Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:
Gary Snider
Department of Health Care Policy and Financing
(303) 866-4722

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
August 01, 1982

Implementation Date:
May 01, 1983

Waiver Expiration Date:
November 26, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Emergency Transportation, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Substance Abuse, 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

COLORADO
Managed Care Program

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Presumptive Eligible

Lock-In Provision:

6 month lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:

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

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Blind/Disabled Children and Related Populations
-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
-Foster Care Children
-Dual Eligibles

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

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Presumptive Eligible

Lock-In Provision:

6 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-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

COLORADO
Managed Care Program

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Colorado Access
Kaiser
Rocky Mountain HMO
United Healthcare of Colorado
Community Health Plan of the Rockies
Primary Care Physician Program
Total Long Term Care

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation

Encounter Data

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

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

Collection: Standardized Forms
None

Validation: Methods
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
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management

Health Status/Outcomes Quality
-Patient satisfaction with 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

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

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

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate
-Weeks of pregnancy at time of enrollment in MCO/PHP, for

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

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

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 of performance improvement projects
-Conduct of 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

COLORADO
Managed Care Program

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

-Performance Measures (see below for details)

Use of Collected Data:
-Monitor Quality Improvement
-Provider Profiling
-Track Health Service provision

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

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

Performance Improvement Projects

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

Non-Clinical Topics
-Availability of language interpretation services

COLORADO
Mental Health Capitation Program

CONTACT INFORMATION

State Medicaid Contact:
Bill Bush
Mental Health Services
(303)762-4085

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
October 04, 1993

Implementation Date:
July 01, 1995

Waiver Expiration Date:
December 03, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Mental Health (MH) - Limited Benefits) - Capitation

Service Delivery

Included Services:
Crisis, IMD Services, Inpatient Mental Health Services, 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:
None

COLORADO
Mental Health Capitation Program

Populations Mandatory Enrolled with a Sole Source Provider:

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

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-Uses eligibility data to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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

ADDITIONAL INFORMATION

Due to the nature of the waiver which is for a limited segment of services, the program does not designate a primary care provider. Individuals choose their own providers or rely on the contractor (Mental Health and Service Agency (MHASA)) for referal. 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)
-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
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

COLORADO
Mental Health Capitation Program

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-DID NOT provide any requirements for encounter data collection
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data

Collections: Submission Specifications
None

Collection: Standardized Forms
None

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

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

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

Consumer Self-Report Data
-Mental Health Statistics Improvement Program (MHSIP)

Performance Improvement Projects

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

Clinical Topics
None

COLORADO
Mental Health Capitation Program

-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
-Availability of language interpretation services

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for participation
None

Accreditation for Deeming
None

EQRO Name
-NA

EQRO Organization
-Do Not use EQRO

EQRO Activities
-Validation of performance improvement projects

CONNECTICUT
Husky A

CONTACT INFORMATION

State Medicaid Contact:
James Linnane
Department of Social Services
(860)424-5111

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
July 20, 1995

Implementation Date:
October 01, 1995

Waiver Expiration Date:
May 31, 2002

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

Enrollment

CONNECTICUT
Husky A

Populations Voluntarily Enrolled:
None

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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 these

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

BlueCare Family Plan
HealthChoice of Connecticut/Preferred One
Community Health Network of Connecticut
Physicians Health Service

ADDITIONAL INFORMATION

State decides which guranteed 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)

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

CONNECTICUT
Husky A

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

Encounter Data

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

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

Collection: Standardized Forms
None

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

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-25 Pages of critical edits

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Depression management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality
None

CONNECTICUT
Husky A

Access/Availability of Care

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

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-EPSDT Visit Rates
-Inpatient admission for MH/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 Care

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

Health Plan/Provider Characteristics

None

Beneficiary Characteristics

None

Use of HEDIS

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

Consumer Self-Report Data

-CAHPS
Adult Questionnaire
Child Medicaid AFDC Questionnaire

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
-Childhood Immunization

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 of performance improvement projects
-Conduct of 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 activites
-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:
None

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

Initial Waiver Approval Date:
July 27, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
March 15, 2004

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

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)

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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
-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:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Social Services 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. This program covers emergency

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement

DELAWARE
Diamond State Health Plan

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

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

Collection: Standardized Forms
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

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

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

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

State conducts general data completeness assessments
Yes

Performance Improvement Projects

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

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

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

Standards/Accreditation

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

Accreditation Required for Participation
None

DELAWARE
Diamond State Health Plan

Accreditation for Deeming
None

EQRO Name
-Delmarva Foundation/Mercer

EQRO Organization
-PRO-like Entity

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

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 1993

Implementation Date:
April 01, 1994

Waiver Expiration Date:
December 27, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

Enrollment

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

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

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
1 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Advantage Health Incorporated
American Preferred Provider
DC Chartered Health Plan, Incorporated
Health Right, Incorporated
Americaid Community Care
Capital Community Health Plan
George Washington University Health Plan

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

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

Encounter Data

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

Collections: Submission Specifications
None

Collection: Standardized Forms
None

Validation: Methods
None

DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

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

State conducts general data completeness assessments
No

Performance Measures

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

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

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

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

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

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

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

Consumer Self-Report Data
None

Standards/Accreditation

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

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Delmarva Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of 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
Department of Health, Medical Assisstance
(202) 442-9074

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
February 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP ((non-risk) - Limited Benefits) - Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance 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

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Children and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

DISTRICT OF COLUMBIA
Health Services for Children With Special Needs

Populations Mandatory Enrolled with a Sole Source Provider:

None

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
-Special Needs Children
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver

Lock-In Provision:

1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Services For Children with Special Needs

ADDITIONAL INFORMATION

Skilled Nursing Facility For First 30 Days. Program Provides Emergency Transportation Only.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

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

DISTRICT OF COLUMBIA
Health Services for Children With Special Needs

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

Collections: Submission Specifications
None

Collection: Standardized Forms
None

Validation: Methods
None

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

State conducts general data completeness assessments
Yes

Performance Measures

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

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

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

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

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

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

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

Consumer Self-Report Data
None

Standards/Accreditation

DISTRICT OF COLUMBIA
Health Services for Children With Special Needs

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

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Delmarva Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

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

FLORIDA
MediPass/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

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
October 01, 1992

Implementation Date:
October 01, 1992

Waiver Expiration Date:
December 28, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
None

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

FLORIDA
MediPass/Managed Health Care

-Title XXI SCHIP
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-State Hospital Services
-Adult Day Health
-Hospice
-Medically Needy
-Medicaid Eligibles in Residential Committment Facilities
-Eligibles in Residential Group Care
-Children in Residential Treatment Facilities
-Residents in ADM Residential Treatment Facilities

Lock-In Provision:

12 month lock-in\

FLORIDA
MediPass/Managed Health Care

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Advanced Registered Nurse Practitioner, Ambulatory Surgical Center, Chiropractic (limited direct access), County Health Department, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Outpatient Hospital, Physician, Podiatric (limited direct access), Therapy, X-Ray

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

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

FLORIDA
MediPass/Managed Health Care

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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

ADDITIONAL INFORMATION

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

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

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)

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

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

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

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

Validation: Methods

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

FLORIDA
MediPass/Managed Health Care

facilities

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Age-apropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
care facilities
-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
-Immunizations for two year olds
-Lead screening rate
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality
-Adolescent immunization rate
-Patient satisfaction with care

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

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Days 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 and Hospital expenses
-Medical loss ratio
-Net income
-Net worth
-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

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

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire

FLORIDA
MediPass/Managed Health Care

Performance Improvement Projects

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

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-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
-Diabetes management
-Emergency Room service utilization
-Lead toxicity
-Pharmacy management
-Pre-natal care
-Well Child Care/EPSDT

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

Standards/Accreditation

MCO/PHP Standards
-HCFA'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)
-State-Developed/Specified Standards

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

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

EQRO Name
-Keystone Peer Review Organization, Inc.

EQRO Organization
-Peer Review Organization (PRO)

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

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

FLORIDA
MediPass/Managed Health Care

-Performance Measures (see below for details)

-Program Modification, Expansion, or Renewal
-Provider Profiling
-Track Health Service provision

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-HIV/AIDS 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
-Drug Utilization
-Inpatient and outpatient / 100 beneficiaries
-Number of primary care case manager visits per beneficiary

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

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

Consumer Self-Report Data
-State-developed Survey

Performance Improvement Projects

Clinical Topics
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Diabetes management
-Hepatitis B screening and treatment
-HIV/AIDS Prevention and/or Management

Non-Clinical Topics
None

FLORIDA
Prepaid Mental Health Plan

CONTACT INFORMATION

State Medicaid Contact:
Wendy Smith
Agency for Health Care Administration
(850) 488-8711

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 31, 1996

Implementation Date:
March 01, 1996

Waiver Expiration Date:
June 30, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Mental Health (MH) - Limited Benefits) - Capitation

Service Delivery

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

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

Allowable PCPs:
-Psychiatrists

Enrollment

Populations Voluntarily Enrolled:
None

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

FLORIDA
Prepaid Mental Health Plan

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

Populations Mandatory Enrolled with a Sole Source Provider:

None

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:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Florida Health Partners, Inc.

ADDITIONAL INFORMATION

Medicaid recipients who do not voluntarily choose a managed care plan are mandatorily assigned. In five counties, recipients who choose or are mandatorily assigned to Medipass are automatically enrolled in the Prepaid Mental Health Plan.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

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

FLORIDA
Prepaid Mental Health Plan

Encounter Data

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

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

Collection: Standardized Forms
None

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

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

State conducts general data completeness assessments
Yes

Performance Measures

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

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

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

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

Health Plan Stability/ Financial/Cost of
None

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

Beneficiary Characteristics
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 measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

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

FLORIDA
Prepaid Mental Health Plan

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
-Deprssion management
-Primary and behavioral health care coordination

Non-Clinical Topics
-Availability of language interpretation services
-Availability of specialty therapies

Standards/Accreditation Care

MCO/PHP Standards
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-State-Developed/Specified Standards

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

Accreditation for Deeming
None

EQRO Name
-State completes contract and quality of care monitoring
-The University of South Florida performs the independent evaluation of the project

EQRO Organization
-State monitors PMHP provider

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

FLORIDA
Sub-Acute Inpatient Psychiatric Program

CONTACT INFORMATION

State Medicaid Contact:
Wendy Smith
Agency for Health Care Administration
(850) 488-8711

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 23, 1998

Implementation Date:
April 01, 1999

Waiver Expiration Date:
December 20, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Alternative or Step-down for inpatient psychiatric for children and adolescents, Case Management, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Pharmacy, Transportation, Vision, X-Ray

Allowable PCPs:
-Psychiatrists

Enrollment

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

Populations Mandatorily Enrolled:
None

FLORIDA
Sub-Acute Inpatient Psychiatric Program

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

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

Lock-In Provision:

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 provider referrals 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

Charter Glade

Daniel Memorial

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

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

Use of Collected Data:

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

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

-Patient satisfaction with care

FLORIDA
Sub-Acute Inpatient Psychiatric Program

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

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

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

Beneficiary Characteristics
-Complaints or grievances
-Consumer or family satisfaction

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

GEORGIA
Georgia Better Health Care

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 14, 1993

Implementation Date:
October 01, 1993

Waiver Expiration Date:
July 01, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Home Health, Immunization, In-home Nursing, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Occupational and Physical Therapy, Outpatient Hospital, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Certain Specialists Who Provide Primary Care
-Psychologists
-Clinical Social Workers

Enrollment

GEORGIA
Georgia Better Health Care

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

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
Three Dollar Per Member Per Month Case Management Fee. The lock-in period for this program varies. State's definition of Special Needs Children is SSI Children without Medicare.

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

Performance Measures

GEORGIA
Georgia Better Health Care

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care

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

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

Consumer Self-Report Data
-State-developed Survey

GEORGIA
Mental Health/Mental Retardation Rehabilitation Services

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 1994

Implementation Date:
November 01, 1994

Waiver Expiration Date:
February 14, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Mental Health (MH) - Limited Benefits) - Capitation

Service Delivery

Included Services:
Mental Health and 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:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Women
-Reside in ICF/MR

GEORGIA
Mental Health/Mental Retardation Rehabilitation Services

-Enrolled in another managed care program
-QMB
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Special Needs Children

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Mental Health/Mental Retardation Rehabilitation Services

ADDITIONAL INFORMATION
One contractor provides services to this population statewide.

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

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

Collection: Standardized Forms
None

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

GEORGIA
Mental Health/Mental Retardation Rehabilitation Services

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

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

Consumer Self-Report Data
None

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-OASYS

EQRO Organization
-Peer Review Organization (PRO)

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

GEORGIA
Non-Emergency Transportation Broker Program

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 08, 1999

Implementation Date:
October 01, 1997

Waiver Expiration Date:
September 07, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Transportation - Limited Benefits) - Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-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

GEORGIA
Non-Emergency Transportation Broker Program

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
-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

NET Broker Program

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

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

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

Consumer Self-Report Data
None

Performance Improvement Projects

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

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

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

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Activities
-Not Applicable

HAWAII
Hawaii QUEST

CONTACT INFORMATION

State Medicaid Contact:
Aileen Hiramatsu
Hawaii Department of Human Services, Med-QUEST
(808) 692-8083

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
July 16, 1993

Implementation Date:
August 01, 1994

Waiver Expiration Date:
March 31, 2002

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

For All Areas Phased-In:
Yes

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

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

PHP (Dental - Limited Benefits) - Capitation

Service Delivery

HAWAII
Hawaii QUEST

Included Services:
Dental

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-General Assistance (GA) Program
-Others who meet Quest Eligibility Requirements

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
12 month lock-in

HAWAII
Hawaii QUEST

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:
-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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
12 month lock-in

HAWAII
Hawaii QUEST

PHP (Mental Health and Substance Abuse (MH/SA) - Limited Benefits) -

Service Delivery

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

Allowable PCPs:
-Psychiatrists
-Psychologists

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

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

Lock-In Provision:
No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aloha Care
Aloha Care-Dental
Denticare
HMSA-Behavioral Health for SMI
HMSA-Dental
HMSA-Medical
Kaiser Permanente
Kapiolani HealthHawaii
Queens Hawaii Care
Straub

ADDITIONAL INFORMATION

This program provides medical, dental, and behavioral health services through competitive managed care delivery system. Aged, Blind/Disabled populations have the option to enroll in either a fee-for-service or a managed care programs for mental health.

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. Children who satisfy the disability criteria under State law.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

HAWAII
Hawaii QUEST

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

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

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

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

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

Consumer Self-Report Data
-State-developed Survey

Standards/Accreditation

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

Accreditation Required for Participation
None

HAWAII
Hawaii QUEST

Accreditation for Deeming
None

EQRO Name
-Mountain-Pacific Quality Health Foundation

EQRO Organization
-Peer Review Organization (PRO)

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

IDAHO
Healthy Connections

CONTACT INFORMATION

State Medicaid Contact:
Patty Rustad
Medicaid Managed Care
(208) 364-1893

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
October 01, 1993

Implementation Date:
October 01, 1993

Waiver Expiration Date:
February 09, 2002

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

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

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

IDAHO
Healthy Connections

Enrollment

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

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

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Connections

ADDITIONAL INFORMATION

Case management fee per member per month; two mandatory counties; one region has a nursing home pilot project where nursing facility residents are eligible for the program.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Disenrollment Surveys

Use of Collected Data:
-Program Evaluation

IDAHO
Healthy Connections

-Enrollee Hotlines
-Enrollee Satisfaction Surveys
-Focused Studies
-Focuses Clinical Studies
-Greivance and Complaints Information
-Ombudsman
-Received Board Certification of Providers

ILLINOIS
Voluntary Managed Care

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
November 01, 1974

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Blood and Blood Components, Chiropractic Services, Clinic Services, Durable Medical Equipment, Emergency Medical Services, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Medical Appliances, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physical Therapies and Related Services for Enrollees Aged 21 and Over, Physician, Podiatric Services, 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) Adults and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

ILLINOIS
Voluntary Managed Care

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

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

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

Lock-In Provision:

No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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

ADDITIONAL INFORMATION

Nursing facility services are provided up to 90 days annually.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

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

ILLINOIS
Voluntary Managed Care

Collection: Standardized Forms
-IDPA Approved Electronic Flat File Format for Transmitting Pharmacy Encounters
-NSF - (National Standard Format) - the HCFA approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA 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-apropriate diagnosis/procedure
-Gender-apropriate 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

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate

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

ILLINOIS
Voluntary Managed Care

for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

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

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 Care

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

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-CIMRO

EQRO Organization
-PRO-like Entity

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

INDIANA
Hoosier Healthwise

CONTACT INFORMATION

State Medicaid Contact:
Ginger Brophy
Indiana Family and Social Services Administration
(317)232-4345

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
September 13, 1993

Implementation Date:
July 01, 1994

Waiver Expiration Date:
January 24, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, 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
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)

Enrollment

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

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

INDIANA
Hoosier Healthwise

Populations Mandatory Enrolled with a Sole Source Provider:

None

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:

6 month lock-in

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:

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

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

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

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

Lock-In Provision:

6 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-Public Health Agency

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Managed Health Services (MHS)
Maxicare (MaxiHealth)
PCCM (PrimeStep)

ADDITIONAL INFORMATION

Inpatient psychiatric hospital and outpatient pyschiatric services are generally carved-out. However, where these services are provided by an acute care hospital or a PCP, they are included. The same coverage condition applies to inpatient and out patient substance abuse services.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

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

Validation: Methods

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

INDIANA
Hoosier Healthwise

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

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Adolescent immunization rate
-Cervical cancer screening rate
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Studies are conducted on a rotating schedule.
-Well-child care visit rates

Health Status/Outcomes Quality
None

Access/Availability of Care
-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 PCP visits per beneficiary

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

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

Consumer Self-Report Data
-State-developed Survey

Performance Improvement Projects

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

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Low birth-weight baby
-Pre-natal care
-Well Child Care/EPSDT

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

INDIANA
Hoosier Healthwise

Standards/Accreditation

MCO/PHP Standards
-NCQA recommended, not required.

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Health Care Excel-Until August 2000

EQRO Organization
-Peer Review Organization (PRO)

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

-Performance Measures (see below for details)

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

Performance Measures

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

Health Status/Outcomes Quality
-Patient satisfaction with care

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

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

Provider Characteristics
None

Beneficiary Characteristics
None

Consumer Self-Report Data
-State-developed Survey

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment
-Childhood Immunization

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

INDIANA
Hoosier Healthwise

-Low birth-weight baby
-Provider Data
-Pre-natal care
-Well Child Care/EPSDT

IOWA
Iowa Medicaid Managed Health Care

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 01, 1986

Implementation Date:
December 01, 1986

Waiver Expiration Date:
May 09, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, 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)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Clinical Social Workers
-Psychiatrists
-Pediatricians

IOWA
Iowa Medicaid Managed Health Care

Enrollment

Populations Voluntarily Enrolled:
None

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
9 month lock-in

PCCM Provider - Fee-for-Service

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
None

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
6 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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Iowa Medicaid Managed Health Care

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

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

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

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

ADDITIONAL INFORMATION

Based upon the number of managed care entities in an individual county, managed care assignment may be voluntary or involuntary. 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

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

-Monitor Quality Improvement

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

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

Collection: Standardized Forms

None

Validation: Methods

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

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Iowa Medicaid Managed Health Care

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

Process Quality
-abortions
-Adolescent immunization rate
-hysterectomy
-Immunizations for two year olds
-Influenza vaccines for high risk enrollees
-sterilization
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Inpatient 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

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

Health Plan/ Provider Characteristics
-Board Certification
-Provider turnover

Beneficiary Characteristics
-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

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

Consumer Self-Report Data
None

Performance Improvement Projects

IOWA
Iowa Medicaid Managed Health Care

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
-HCFA'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
-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
-Conduct of 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:
-Focused Studies
-Performance Improvements Projects (see below for details)

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

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care

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

Use of Services/Utilization
-Inpatient 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
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to PCCM
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

Consumer Self-Report Data
None

IOWA
Iowa Medicaid Managed Health Care
Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Performance Measures (see below for details)
-Childhood Immunization
-Hysterectomy
-Well Child Care/EPSDT

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

IOWA
Iowa Plan For Behavioral Health

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
Statewide

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:
December 31, 2000

Enrollment Broker:
Yes

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

PHP (Mental Health and Substance Abuse (MH/SA) - Limited Benefits) -

Service Delivery

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

Allowable PCPs:
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Addictionologists

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

IOWA
Iowa Plan For Behavioral Health

Populations Mandatory Enrolled with a Sole Capitation

-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
-Dual Eligibles-Medicaid and Medicare

-Foster Care Children

Lock-In Provision:

No lock-in

Subpopulations Excluded from Otherwise Source Provider: Included Populations:

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

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

This program has a permanent lock-in.

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

-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

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

IOWA
Iowa Plan For Behavioral Health

Collection: Standardized Forms
None

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

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Depression management
-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
-Drug Utilization
-Inpatient admission for MH/SA conditions/1,000 beneficiaries

Health Plan Stability/ Financial/Cost of
None

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

Beneficiary Characteristics
-Information of beneficiary ethnicity/race

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

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups

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
None

IOWA
Iowa Plan For Behavioral Health

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

Standards/Accreditation

MCO/PHP Standards
None

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

Accreditation for Deeming
None

EQRO Name
-Iowa Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

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

KANSAS
KMMC: HealthConnect

CONTACT INFORMATION

State Medicaid Contact:
Bobbie Graff-Hendrixson
Health Care Policy/Medical Policy
(785)296-7010

State Website Address:
http://www.ink.org/public/srs/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months continous eligibility for children

Initial Waiver Approval Date:
January 01, 1984

Implementation Date:
January 01, 1984

Waiver Expiration Date:
October 04, 2002

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Nursing Facility, Obstetrical, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Personal Care, Pharmacy, Physician, Therapies, Transportation, Vision, X-Ray

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

KANSAS
KMMC: HealthConnect

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-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
-Receive Other Insurance
-Medically Needy-eligible
-Foster Care Children
-Receive Adoption Support
-Spenddown 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:
-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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HealthConnect

ADDITIONAL INFORMATION

None

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

Performance Measures

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

Health Status/Outcomes Quality
-Patient satisfaction with care

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

Use of Services/Utilization
-Drug Utilization

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

Beneficiary Characteristics
None

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Consumer/eneficiary Focus Groups

KANSAS
KMMC: PrimeCare Kansas

CONTACT INFORMATION

State Medicaid Contact:
Bobbie Graff-Hendrixson
Health Care Policy/Medical Policy
(785)296-7010

State Website Address:
http://www.ink.org/public/srs/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months continous eligibility for children

Initial Waiver Approval Date:
December 28, 1994

Implementation Date:
December 01, 1995

Waiver Expiration Date:
October 04, 2002

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
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
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Indian Health Service (IHS) Providers
-Nurse Practitioners
-Nurse Midwives
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)

Enrollment

KANSAS
KMMC: PrimeCare Kansas

Populations Voluntarily Enrolled:
None

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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
-Receive Services through Helath Insurance Premium Payment System (HIPPS)
-Reside in State Hospitals

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 information from the 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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

FirstGuard Health Plan Kansas

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

Encounter Data

KANSAS
KMMC: PrimeCare Kansas

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-HCFA 1500 - the HCFA 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 HCFA approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-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
None

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)

KANSAS
KMMC: PrimeCare Kansas

Beneficiary Characteristics
None

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

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

Care

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
-Kansas Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

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

KENTUCKY
Human Service Transportation

CONTACT INFORMATION

State Medicaid Contact:
Neville Wise
KY Department for Medicaid Services
(502) 564-5472

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
February 01, 1996

Implementation Date:
June 01, 1998

Waiver Expiration Date:
October 30, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Transportation - Limited Benefits) - Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

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

-Aged and Related Populations
-Foster Care Children
-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:

-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
-Substance Abuse Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Human Service Transportation

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
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman

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

Encounter Data

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

Collections: Submission Specifications
None

Collection: Standardized Forms
None

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

within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Comparsion to plan claims payment data
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) 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 on specified assessments
Yes

Standards/Accreditation

MCO/PHP Standards
-N/A for Transportation

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-N/A

EQRO Organization
-N/A for Transportation Waiver

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

KENTUCKY
Kentucky Health Care Partnership Program

CONTACT INFORMATION

State Medicaid Contact:
Dennis Boyd
Kentucky Department for Medicaid Services
(502) 564-4321

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

PROGRAM DATA

Program Service Area:
Substate

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
October 06, 1995

Implementation Date:
November 01, 1997

Waiver Expiration Date:
November 01, 2002

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

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

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

KENTUCKY
Kentucky Health Care Partnership Program

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatory Enrolled with a Sole Source Provider:

X-Ray
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Most Medicaid Eligibles
-Dual Eligibles for Medicaid Services only

Lock-In Provision:

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

Populations Voluntarily Enrolled:

None

Subpopulations Excluded from Otherwise Source Provider:

-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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Uses Claims Data To Identify Members of These Groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-KY Commission for Children with Special Health Care Needs
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Social Services Agency
-Tranportaion Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Kentucky Health Select

Passport Health Plan

ADDITIONAL INFORMATION

There are 2 regions (Region 3 and Region 5) operating as of 06/30/00. Only Region 3 of this program will remain in effect after June 2000. This program provides Inpatient Substance Abuse Services but only for acute services.

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

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement

KENTUCKY
Kentucky Health Care Partnership Program

-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
-Plan Reimbursement
-Program Evaluation
-Track Health Service provision

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing

Collection: Standardized Forms
None

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

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

State conducts general data completeness assessments
Yes

Performance Measures

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

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

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

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

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

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

Consumer Self-Report Data
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
-HCFA'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
-Plan required to obtain MCO accreditation by NCQA or other accrediting body

Accreditation for Deeming
None

EQRO Name
-Health Care Review Corporation

KENTUCKY
Kentucky Health Care Partnership Program

EQRO Organization
-Federally Designated PRO-like Entity

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

KENTUCKY
Kentucky Patient Access and Care (KENPAC) Program

CONTACT INFORMATION

State Medicaid Contact:
Philip Kremer
KY Department for Medicaid Services
(502) 564-5969

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
1 month guaranteed eligibility

Initial Waiver Approval Date:
July 05, 1985

Implementation Date:
March 01, 1986

Waiver Expiration Date:
June 30, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, 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

Enrollment

Populations Voluntarily Enrolled:
None

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

KENTUCKY
Kentucky Patient Access and Care (KENPAC) Program

-TITLE XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:

None

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
-Spenddown

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

-TITLE XXI SCHIP

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency
-Commission for Children with Special Health Care Needs
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Kentucky Patient Access and Care (KenPAC)

ADDITIONAL INFORMATION

Beginning in April 2000 the KenPAC Program was implemented under a state plan ammendment in all counties in Kentucky excluding region 3. For the following Included services- EPDST, Dental, Pharmacy, Transportation, Vision, and Hearing services , be neficiary may go to any participating provider for these services without a referral.

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

LOUISIANA
Community Care

CONTACT INFORMATION

State Medicaid Contact:
Madeline Darcey
Department of Health and Hospitals
225 342-0327

State Website Address:
http://www.dhh.state.la.us

PROGRAM DATA

Program Service Area:
Parish

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
June 01, 1992

Implementation Date:
June 01, 1992

Waiver Expiration Date:
December 25, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
None

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

LOUISIANA
Community Care

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period Less Than 3 Months
-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

Coordinates the Operation of the Program:
-TITLE XXI SCHIP

Agencies with which Medicaid
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care Program

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

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

MAINE
Maine PrimeCare

CONTACT INFORMATION

State Medicaid Contact:
Brenda McCormick
Bureau of Medical Services
(207) 287-1774

State Website Address:
HTTP://www.state.me.us/bms/bmshome.htm

PROGRAM DATA

Program Service Area:
Statewide

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

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 19, 1998

Implementation Date:
May 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Ambulatory Surgical Center Services, Certain Family Planning Services, Chiropractic Services, Clinic Services (FQHC & RHC), Developmental & Behavioral Evaluation Clinic Services, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Physical Therapy Services, Physician, Podiatric Services, Speech/Language Pathology Services, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

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

MAINE
Maine PrimeCare

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

Populations Mandatory Enrolled with a Sole Source Provider:

None

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
-Special Needs Children
-American Indian/Alaskan Native
-Individuals on Medicaid recipient restriction program
-Individuals eligible for SSI
-Individuals under 19 with special health care needs
-Katie Beckett Eligibles

Lock-In Provision:

12 months lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

-Uses eligibility data to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Maine PrimeCare

ADDITIONAL INFORMATION

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)
-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

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care

Health Status/Outcomes Quality

-Patient satisfaction with care

MAINE
Maine PrimeCare

-Breast Cancer screening rate
-Provider Data
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Diabetes management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care
-Lead screening rate
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

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

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

Provider Characteristics
-Languages spoken (other than English)

Beneficiary Characteristics
-Beneficiary need for interpreter
-Disenrollment rate
-Percentage of beneficiaries who are auto-assigned to PCCM
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

Consumer Self-Report Data
-Disenrollment Survey
-State-developed Survey

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-Lead toxicity
-Medical prblems of the frail elderly
-Otitis Media management
-Pharmacy management
-Pre-natal care
-Presciption drug abuse
-Prevention of Influenza
-Smoking prevention and cessation
-Well Child Care/EPSDT

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

MAINE
Medicaid Managed Care Initiative

CONTACT INFORMATION

State Medicaid Contact:
Marianne Ringel
Bureau of Medical Services
(207) 624-5518

State Website Address:
http://www.state.me.us/bms/bmshome.htm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 24, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

Enrollment

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

Populations Mandatorily Enrolled:
None

MAINE
Medicaid Managed Care Initiative

Populations Mandatory Enrolled with a Sole Source Provider:

None

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
-Residing in jail or State mental institutions

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:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

NylCare Health Plans of Maine

ADDITIONAL INFORMATION

AETNA US HealthCare purchased NylCare Health Plans of Maine, INC.as of 4/1/2000

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Focused Studies
-MCO/PHP Standards (see below for details)
-Ombudsman
-On-Site Reviews
-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

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

Collections: Submission Specifications

None

MAINE
Medicaid Managed Care Initiative

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

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
-Revenue Codes

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

Use of Services/Utilization
-Frequency of selected procedures
-General hospital/Acute care inpatient utilization
-General outpatient utilization
-Non-acute inpatient utilization
-Number of discharges and average length of stay for females in maternity care
-Number of live births and average length of stay
-Number of PCP visits per beneficiary

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net worth
-Total revenue

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

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

Consumer Self-Report Data
None

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-IPRO, INC., LAKE SUCCESS, NY

MAINE
Medicaid Managed Care Initiative

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct of 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 measures

MARYLAND
HealthChoice

CONTACT INFORMATION

State Medicaid Contact:
Shelby Boggs
Department of Health and Mental Hygiene
(410) 767-5204

State Website Address:
http://www.dhmh.state.md.us/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
October 30, 1996

Implementation Date:
June 02, 1997

Waiver Expiration Date:
June 01, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(E)
-1902(a)(23) Freedom of Choice
-1902(a)(4)(A)
-1902(a)(47)
-1902(a)(5)

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

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

MARYLAND
HealthChoice

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled and Related Populations
-Foster Care Children
-Children and Pregnant Woment with Income at or Below 200% FPL

Populations Mandatory Enrolled with a Sole Source Provider:
None

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
-Is enrolled in Model Waiver for Fragile Children
-Is determined Medically Needy Under a Spend Down
-Eligibility for 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:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMERICAID Community Care
Helix Family Choice
Maryland Physicians Care
Priority Partner MCO
Freestate Health Plan
JAI Medical System
PrimeHealth Corporation
United Health Care

ADDITIONAL INFORMATION

The Program was approved to begin on October 15, 1996, however, the Program officially began enrolling eligible individuals on June 2, 1997 and services delivery began on July 1, 1997. On July 1,1998, those eligible for the new Childrens Health Program were enrolled in HealthChoice.

The included services listed are the services that are part of the MCOs capitation rates and are provided by the MCOs. There are other Medicaid covered services provided to HealthChoice enrollees on the fee-for- service basis. These services are:
. Health related services and targeted case management services provided to children when the services are specified in the childs

Individualized Education plan (IEP) or Individualized Family Service Plan (IFSP);
. Occupational therapy, physical therapy, speech therapy and audiology services for children;
. Specialty mental health services;
. Rare and expensive case management program services;
. Personal care services;
. Medical day care services for adults or children;
. Long-term care services (after the first 30 days of care);
. Healthy Start case management services:
. Viral load testing services for treatment of HIV/A

Hearing is provided to enrollees under 21.

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
-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
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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, definitons, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA 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 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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

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

State conducts general data completeness assessments
Yes

MARYLAND
HealthChoice

-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Diabetes management
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Inpatient admissions/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit

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

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

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

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

Performance Improvement Projects

MARYLAND
HealthChoice

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
-Childhood Immunization
-Coordination of primary and behavioral health care
-Diabetes management
-Lead toxicity
-Prevention of Influenza
-Primary and behavioral health care coordination
-Well Child Care/EPSDT

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

Standards/Accreditation

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

Accreditation Required for
None

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

EQRO Name
-Delmarva Foundation for Medical Care, Inc.

EQRO Organization
-Peer Review Organization (PRO)

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

MARYLAND
Voluntary HMO Program

CONTACT INFORMATION

State Medicaid Contact:
Katherine Tvaronas
Department of Health and Mental Hygiene
410-767-1478

State Website Address:
None

PROGRAM DATA

Program Service Area:
City
County

Initial Waiver Approval Date:
Not Applicable

Operating Authority:
Voluntary - No Authority

Implementation Date:
July 01, 1973

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, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Substance Abuse, Laboratory, Most Medicaid Services, Outpatient Hospital, Outpatient Substance Abuse, Pharmacy, Physician, Vision, X-Ray

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

Enrollment

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

Populations Mandatorily Enrolled:
None

MARYLAND
Voluntary HMO Program

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Special Needs Children

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-Uses eligibility data to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

FreeState Health Plan

PrimeHealth Corporation

ADDITIONAL INFORMATION

Since 1973, Maryland has contracted with HMOs to provide Medicaid services.

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
-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
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

MARYLAND
Voluntary HMO Program

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, definitons, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA 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 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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

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

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
-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
-Smoking prevention and cessation
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Inpatient admissions/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit

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

Health Plan/ Provider Characteristics
None

MARYLAND
Voluntary HMO Program

Beneficiary Characteristics
None

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

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

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
-Childhood Immunization
-Coordination of primary and behavioral health care
-Diabetes management
-Lead toxicity
-Prevention of Influenza
-Primary and behavioral health care coordination
-Well Child Care/EPSDT

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

Standards/Accreditation

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

Accreditation Required for Participation
None

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

EQRO Name
-Delmarva Foundation for Medical Care, Inc.

EQRO Organization
-Peer Review Organization (PRO)

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

MASSACHUSETTS
Mass Health

CONTACT INFORMATION

State Medicaid Contact:
Phyllis Peters
Division of Medical Assistance
(617) 210-5720

State Website Address:
http://www.state.ma.us/dma/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

Initial Waiver Approval Date:
April 15, 1995

Implementation Date:
July 01, 1997

Waiver Expiration Date:
June 30, 2001

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)(18)
-1902(a)(23) Freedom of Choice
-1902(a)(30)(A)
-1902(a)(32)
-1902(a)(34)
-1902(a)(4)

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(A)(vi) Eligibility Expansion, IMD, Insurance Reimbursement

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, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, 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

MASSACHUSETTS
Mass 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
-TITLE XXI SCHIP
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

PHP (Mental Health and Substance Abuse (MH/SA) - Limited Benefits) -

Service Delivery

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

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Federally Qualified Health Centers (FQHCs)
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Addictionologists

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
None

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

MASSACHUSETTS
Mass Health

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray

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

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
-Foster Care Children

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Boston Medical Center HealthNet Plan
MA Behavioral Health Partnership
Network Health
Fallon Community Health Plan
Neighborhood Health Plan
Primary Care Clinician Plan

MASSACHUSETTS
Mass Health

ADDITIONAL INFORMATION

MassHealth has a behavioral carve-out for PCCM enrollees and for enrollees over the age of 18 and under the age of 65 who qualify under the Divisions eligibility criteria of the long-term unemployed.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

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

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

-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA 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 Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments

Yes

Performance Measures

MASSACHUSETTS
Mass Health

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

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

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

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

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

Beneficiary Characteristics
None

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

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

Performance Improvement Projects

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

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Coordination of primary and behavioral health care
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Primary and behavioral health care coordination
-Well Child Care/EPSDT

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

MASSACHUSETTS
Mass Health

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-MassPro

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct of 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:
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Track Health Service provision

Performance Measures

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

Health Status/Outcomes Quality
-Patient satisfaction with care

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

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

Provider Characteristics
None

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

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

Performance Improvement Projects

MASSACHUSETTS
Mass Health

Clinical Topics

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Performance Measures (see below for details)
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-Inpatient maternity care and discharge planning
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Primary and behavioral health care coordination
-Well Child Care/EPSDT

Non-Clinical Topics

None

MICHIGAN
Children's Special Health Care Services

CONTACT INFORMATION

State Medicaid Contact:
Jane Finn
Michigan Department of Community Health
(517) 241-7186

State Website Address:
http://www.mdch.state.mi.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

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

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Additional Continuity of Care Requirement, Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Individualized Care Planning, Inpatient Hospital, Laboratory, Maternal and Infant Support Services, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians

Enrollment

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

Populations Mandatorily Enrolled:
None

MICHIGAN
Children's Special Health Care Services

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Other Insurance
-Participate in HCBS Waiver
-Special Needs Children
-Medicare Dual Eligibles excluded as of 10/1/2000

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

Children's Choice of Michigan

Kids Care of Michigan

ADDITIONAL INFORMATION

The Childrens Special Health Care Services Program serves children who have qualifying conditions under CSHCS within a managed care plan. 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.

State defined Special Needs Children: These arrangements are based on the special health needs of the population. Primary care services are not covered by Childrens Special Health Care Services (CSHCS). If the beneficiary has CSHCS and is a SHP, they get care for speciality care only (and a bonus of immunizations and well-child visits). If they have CSHCS and Medicaid they get all treatment as needed but the primary focus is on the speciality needs not regulary primary care.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

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

Use of Collected Data

-Collected data will be used for assurance of appropriate care and to identify trends

MICHIGAN
Children's Special Health Care Services

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

Performance Measures

Process Quality
-other

Health Status/Outcomes Quality
None

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

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-State minimum reserve requirements

Health Plan/ Provider Characteristics
-Board Certification
-Experience with pediatric care of special needs population
-Languages Spoken (other than English)

Beneficiary Characteristics
None

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

Consumer Self-Report Data
-CAHPS
add-on sruvey for special needs
-Consumer/Beneficiary Focus Groups
-Satisfaction survey for SHP enrollees
-Survey for new enrollees and follow-up at 6 months
-Survey for people who have lost coverage

Performance Improvement Projects

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

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

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

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Michigan Peer Review Organization

EQRO Organization
-Planning underway with MPRO
CP population

EQRO Activities
-Planning for MPRO to review general population, asthma, and

MICHIGAN
Comprehensive Health Plan

CONTACT INFORMATION

State Medicaid Contact:
William Keller
Michigan Department of Community Health
(517) 335-5113

State Website Address:
http://www.mdch.state.mi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 30, 1997

Implementation Date:
July 01, 1997

Waiver Expiration Date:
March 27, 2002

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Maternal and Infant Support Services, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

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

Enrollment

MICHIGAN
Comprehensive Health Plan

Populations Voluntarily Enrolled:
None

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Other Insurance
-Participate in HCBS Waiver
-Special Needs Children
-Medicare Dual Eligibles excluded as of 10/1/2000
-Enrolled in Another Managed Care Program
-Spenddown
-Court Wards
-Kosovo Refugees
-Residents of Correctional Facilities- cannot be medicaid eligible

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-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
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

American Family Care
Blue Care Network
Botsford Health Plan
Cape Health Plan
Care Choices
Community Care Plan
Community Choice
Good Health Plan
Great Lakes Health Plan
Health Alliance Plan
Health Plan of Michigan
HealthPlus of Michigan
M-Care
McLaren Health Plan
Midwest Health Plan
Oakwood St. John's Health Plan
Omnicare Health Plan
Physicians Health Plan of Mid-Michigan
Physicians Health Plan of South Michigan
Physicians Health Plan of Southwest Michigan
Priority Health
Pro-Care Health Plan
SelectCare HMO
Total Health Care
Ultimed HMO of Michigan
Upper Penninsula Health Plan
Wellness Plan

MICHIGAN
Comprehensive 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 2700 different qualifying physical diagnoses, if the condition has the necessary level of severity and chronicity to qualify.

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
-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)
-Provider Data

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

Encounter Data

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

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

Collection: Standardized Forms
None

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

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-apropriate diagnosis/procedure
-Gender-apropriate diagnosis/procedure
-county
-zip code

State conducts general data completeness assessments
Yes

Performance Improvement Projects

MICHIGAN
Comprehensive Health Plan

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

Standards/Accreditation

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

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

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

EQRO Name
-Market Facts - (conducts consumer surveys)
-Michigan Peer Review Organization

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-MarketFacts (conduct comsumer surveys)
-Medstat (collects and validates 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:
Patrick Barrie
MDCH, Bureau of Managed Care and Community
(517) 373-6440

State Website Address:
http://www.mdch.state.mi.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
June 26, 1998

Implementation Date:
October 01, 1998

Waiver Expiration Date:
December 31, 2000

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Developmentally Disabled, Mental Health and Substance Abuse - Limited Benefits) - Capitation

Service Delivery

Included Services:
Crisis, Durable Medical Equipment, Emergency Specialty DD, MH and SA Services, Home Health, Inpatient Mental Health, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, MH Clinic Services, Outpatient Mental Health (Partial Hospitalization), Outpatient Substance Abuse, Personal Care, Residential Substance Abuse Rehabilitation, Specialty Services and Supports for persons with DD, Targetted Case Management,

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

Contractor Types:
-County Community Mental Health Services

Enrollment

MICHIGAN

Specialty Community Mental Health Services Programs

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
- 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
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Housing Agency
-Social Services Agency
-Specialty Employment Agency (Supported Employment)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Allegan County CMH
AuSable Valley CMH
Bay Arenac CMH
Central Michigan CMH
CMH Services of Muskegon County
Copper Country CMH
Genesee County CMH
Gratiot County CMH
Hiawatha Behavioral Health
Ionia County CMH
Kent County CMH
Lenawee CMH Authority
Livingston County CMH
Manistee-Benzie CMH
Monroe County CMH Authority
Newaygo County CMH
Northeast Michigan CMH
Antrim Kalkaska CMH
Barry County CMH
Berrien County CMH Authority
Clinton-Eaton-Ingham CM
CMH Services of St. Joseph County
Detroit-Wayne CMH
Gogebic County CMH
Great Lakes CMH
Huron Behavioral Health
Kalamazoo County CMH
Lapeer County CMH
Lifeways
Macomb County CMH
Midland-Gladwin CMH
Montcalm Center
North Central CMH Authority
Northern Michigan CMH

MICHIGAN
Specialty Community Mental Health Services Programs

Northpointe Behavioral Healthcare Systems
Ottawa County CMH
Pines Behavioral Health Services
Sanilac County CMH
St. Clair County CMH
Tuscola Behavioral Health Systems
Washtenaw County CMH
Woodland Behavioral Health
Oakland County CMH
Pathways
Saginaw County CMH Authority
Shiawassee County CMH
Summit Pointe
Van Buren County CMH
West Michigan CMH System

ADDITIONAL INFORMATION

Michigan remains one of the very few, if not the only, state to have incorporated services to persons with Developmental Disabilities into a 1915(b) Freedom of Choice "managed care" waiver. Also, all persons adjudicated Medicaid eligible are deemed enrolled in this Specialty Community Mental Health Services and Supports managed care program.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

Use of Collected Data
-Actuarial analysis
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

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

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

Collection: Standardized Forms
None

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

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

State conducts general data completeness assessments
Yes

MICHIGAN
Specialty Community Mental Health Services Programs

Performance Measures

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

Health Status/Outcomes Quality
-Adults living in homes of their own
-Adults working in supported employment
-Children living with family
-Patient satisfaction with care
-Rates of rights complaints
-Rates of sentinel events/1000 served
-Rates of suicide/1000 served

Access/Availability of Care
-Average wait time for an appointment with PCP
-Penetration rates for special populations
-Percent of denials of service
-Percent of persons in NH's who met OBRA criteria, served

Use of Services/Utilization
-Cost per case by population
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

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

Consumer Self-Report Data
-MHSIP Consumer Survey

Standards/Accreditation

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

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

Accreditation for Deeming
None

EQRO Name
-Michigan Peer Review Organization

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Clinical Record Review
-Validation of performance measures

MINNESOTA
Consolidated Chemical Dependency Treatment Fund (CCDTF)

CONTACT INFORMATION

State Medicaid Contact:
Mary Kennedy
Minnesota Department of Human Services
(651)282-9921

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1988

Implementation Date:
January 01, 1988

Waiver Expiration Date:
March 23, 2001

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(30) Utilization Review

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

County Case Manager - Fee-for-Service

Service Delivery

Included Services:
Case Management, EPSDT, Extended Rehabilitation (Consolidated Care), Inpatient Hospital Services, Inpatient Substance Abuse Services, Outpatient Hospital Services, Outpatient Substance Abuse Services, Residential Substance Abuse Treatment Programs, Transitional Rehabilitation (Halfway House)

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

MINNESOTA
Consolidated Chemical Dependency Treatment Fund (CCDTF)

Populations Mandatory Enrolled with a Sole Source Provider:

-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
-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:

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-Mental Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Consolidated Chemical Dependency Treatment Fund (CCDTF)

ADDITIONAL INFORMATION

The CCDTF program is only for chemical dependency services and does not designate types of primary care providers. Providers are reimbursed on a Fee-For-Service basis. County Chemical Dependency Assessors assess the level of care and make appropriate placements or necessary referrals based on statewide placement criteria. Recipients are locked in for the period of the chemical dependency placement which can vary in length.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

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

Use of Collected Data:

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

MINNESOTA
Consolidated Chemical Dependency Treatment Fund (CCDTF)

Performance Measures

Process Quality
-HIV/AIDS care
-Track # of placements by beneficiary characteristics
-Track # of placements by type of service

Health Status/Outcomes Quality
-Drug/alcohol use at admision and 6-months after
-Treatment completion rates

Access/Availability of Care
-Average wait time before admission to treatment

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

Provider Characteristics
-Licensing for provider/entity and its staff

Beneficiary Characteristics
-Age
-County of residence
-Disenrollment rate
-Household size
-Housing status
-Information of beneficiary ethnicity/race
-Marital status
-Percentage of beneficiaries who are auto-assigned to PCCM

Consumer Self-Report Data
-State-developed Survey

Performance Improvement Projects

Clinical Topics
-Adolescent Well Care/EPSDT
-Coordination of primary and behavioral health care
-HIV Status/Screening
-HIV/AIDS Prevention and/or Management
-Post-natal Care
-Pre-natal care
-Presciption drug abuse
-Primary and behavioral health care coordination
-Tuberculosis screening and treatment
-Well Child Care/EPSDT

Non-Clinical Topics
-Case management
-Special population projects for cultural/ethnic minorities

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

CONTACT INFORMATION

State Medicaid Contact:
Mary Kennedy
Minnesota Department of Human Services
(651)282-9921

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 01, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Medicare Services Under Parts A & B, Case Management, Dental, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Nursing Facility Services Are Covered For 180 Days For Enrollees Who Are In The Community When They, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Services Available Under The Home And Community-Based Waiver (Elderly Waiver), Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Age 65 Or Older And Dually Eligible For Medicare And Medicaid

Populations Mandatorily Enrolled:
None

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Non-institutionalized recipients who are eligible for Medicaid on spenddown basis at time of enrollment

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

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:

-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

Encounter Data

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA 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 HCFA approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Cervical cancer screening rate
-Cholesterol screening and management
-Depression management
-Diabetes management
-Influenza Vaccination Rate

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of home health visits per benificiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Medical loss ratio

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

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

-Net income
-State minimum reserve requirements
-Total revenue

-Provider turnover

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate

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

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

Performance Improvement Projects

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

Clinical Topics
-Diabetes management
-Prevention of Influenza

Non-Clinical Topics
None

Standards/Accreditation

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

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-FMAS (PRO-Like)
-MetaStar (PRO)
-NCQA (Accreditation)
-PRS (PRO)
-Stratis Health (PRO)

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

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

MINNESOTA
Minnesota Care Program For Families And Children

CONTACT INFORMATION

State Medicaid Contact:
Mary Kennedy
Minnesota Department of Human Services
(651)282-9921

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility

Initial Waiver Approval Date:
April 27, 1995

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30) Utilization Review
-1902(a)(4) Contract-Specific Upper Payment

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Eligibility Expansion, Eligibility Simplification, Medical Education Trust Fund

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All other MA Benefits Covered Except NF, ICF/MR and Home And Community Based Waiver Services, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable

Enrollment

MINNESOTA
Minnesota Care 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 Or Relative Caretakers Whose Household Income Is At Or Below 1

Populations Mandatory Enrolled with a Sole Source Provider:

None

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
-Children 0 To 21 With Family Income Between 150 and 275 Percent Of FPG With 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:

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Altru
First Plan
Health Partners
Medica
UCARE
Blue Plus
Group Health, Inc.
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

Use of Collected Data

-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

MINNESOTA
Minnesota Care Program For Families And Children

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA 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 HCFA approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

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

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Cervical cancer screening rate
-Cholesterol screening and management
-Depression management
-Diabetes management
-Immunizations for two year olds
-Influenza vaccination rate
-Lead screening rate
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

MINNESOTA
Minnesota Care Program For Families And Children

Access/Availability of Care
-Average distance to PCP

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Medical loss ratio
-Net income
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate

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

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

Performance Improvement Projects

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

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Childhood Immunization
-Prevention of Influenza
-Well Child Care/EPSDT

Non-Clinical Topics
None

Standards/Accreditation

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

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-FMAS (PRO-Like)
-MetaStar (PRO)
-NCQA (Accreditation)
-PRS (PRO)
-Stratis Health (PRO)

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

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

MINNESOTA
Prepaid Medical Assistance Program

CONTACT INFORMATION

State Medicaid Contact:
Mary Kennedy
Minnesota Department of Human Services
(651)282-9921

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
July 01, 1985

Implementation Date:
July 01, 1985

Waiver Expiration Date:
June 30, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30) Utilization Review
-1902(a)(4) Contract-Specific Upper Payment

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Medical Education Trust Fund, Eligibility Simplification

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

MINNESOTA
Prepaid Medical Assistance Program

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
-Aged and Related Populations
-TITLE XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Those With Private Coverage With An HMO Not Participating In Medicaid
-Children Eligible Through Subsidized Adoption
-Refugee Assistance Program Recipients
-Recipients Residing in State Institutions
-Enrolled in Another Managed Care Program
-Blind/Disabled under age 65
-American Indians living on reservation
-Children with severe emotional disturbance
-Children in need of protection whose provider is not enrolled in PMAP

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Altru
First Plan
Health Partners
Medica
UCARE
Blue Plus
Group Health, Inc.
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; 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.

MINNESOTA
Prepaid Medical Assistance 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
-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
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA 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 HCFA approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

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

State conducts general data completeness assessments
Yes

MINNESOTA
Prepaid Medical Assistance Program

Performance Measures

Process Quality
-Adolescent immunization rate
-Cervical cancer screening rate
-Cholesterol screening and management
-Depression management
-Diabetes management
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years

Health Plan Stability/ Financial/Cost of
-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

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

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

Performance Improvement Projects

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

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Childhood Immunization
-Prevention of Influenza
-Well Child Care/EPSDT

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-HCFA's Quality Improvement System for Managed Care

(QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
None

MINNESOTA
Prepaid Medical Assistance Program

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

MISSISSIPPI
HealthMACS

CONTACT INFORMATION

State Medicaid Contact:
Melzana Fuller
Division of Medicaid
601-359-6133

State Website Address:
None

PROGRAM DATA

Program Service Area:
Statewide

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

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
August 18, 1993

Implementation Date:
June 28, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

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

MISSISSIPPI
HealthMACS

-Section 1931 (AFDC/TANF) Adults and Related Populations
-Certain Title XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

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

Lock-In Provision:

1 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HealthMACS

ADDITIONAL INFORMATION

No longer have capitated managed care programs with HMO plans as they have been taken over by the Department of Insurance -Certain Title XXI SCHIP for financial reasons. Certain XXI SCHIP is listed as an Included Population. This refers to those children in CHIP Phase 1 who are up to age 19 are enrolled in regular Medicaid and are included in HEALTHMACS program.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Enrollee Hotlines
-Focused Studies
-On-Site Reviews

Use of Collected Data:

-Contract Standard Compliance
-Program Evaluation
-Program Modification, Expansion, or Renewal

MISSOURI
MC+ Managed Care/1115

CONTACT INFORMATION

State Medicaid Contact:

Pam Victor
Department of Social Services, Division of Medical
(573)751-6926

State Website Address:

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

PROGRAM DATA

Program Service Area:
City
County

Initial Waiver Approval Date:
April 29, 1998

Operating Authority:
1115 - Demonstration Waiver Program

Implementation Date:
September 01, 1998

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

Waiver Expiration Date:
December 03, 2003

Enrollment Broker:
Yes

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1916(a)(1)
-1916(a)(2)(A)
-1916(a)(3)
-1916(c)(3)
-1916(e)

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(u) Eligibility Expansion

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, 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, Pharmacy, Physician, Prenatal Case Management, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-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

MISSOURI
MC+ Managed Care/1115

Enrollment

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

Populations Mandatorily Enrolled:
-TITLE XXI SCHIP
-MC+ for Kids (ME 71 - 75)
-Uninsured Parents (ME 76 - 80)
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children

Populations Mandatory Enrolled with a Sole

None

Subpopulations Excluded from Otherwise

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Aid to the Blind and Blind Pension individuals
-General Relief Program participants
-AIDS Waiver program participants
-Permanently and Totally Disabled Individuals
-Presumptive Eligibility Program pregnant women eligibles
-Children enrolled in Developmental Disabilities Program
-Mentally Retarded Developmental Disabled (MRDD) Waiver
-American Indian/Alaskan Native

Lock-In Provision:
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:

-Health Risk Assessment
-MCO Helpline
-MCOs Use Drug Usage
-MCOs Use ER Encounters
-MCOs Use Hospital Admissions
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Social Service Agency (SSI)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Care Partners
FirstGuard
Missouri Care
Family Health Partners
HealthNet

ADDITIONAL INFORMATION

MISSOURI
MC+ Managed Care/1115

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.

Included Services: Inpatient Substance Abuse, Outpatient Substance Abuse, Inpatient Mental Health, Outpatient Mental Health services are 30 inpatient/20 outpatient with no wrap around services.

Transportation: 1115 Adults and Children receive emergency transportation only except for 1115 Parents Fairshare recipients.

EPDST: Uninsured Parents Age 19 and above do not receive EPDST services.

OB/GYNs: HealthPlans can choose to designate OB/GYNs are PCPs.

Populations Excluded: Mentally Developmentally Disabled (MRDD) Waiver in the following counties: Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Franklin, Gasconade, Howard, Jefferson, Miller, Maniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Randolph, Saline, St. Charles, St. Louis and St. Louis City

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

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

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 initial encounter data submission
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-HCFA 1500 - the HCFA 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 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

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

MISSOURI
MC+ Managed Care/1115

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

care facilities

Process Quality
-Adolescent immunization rate
-Asthma care
-C-Section Rates
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-Dental services
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Mental Health Utilization
-Outcomes of Pregnancy
-Percentage of beneficiaries 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 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
-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
-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

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

MISSOURI
MC+ Managed Care/1115

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

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

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Missouri Patient Care Review Foundation

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct of 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:
Marineda "Jackie" Jung
Department of Social Services, Division of Medical
(573)751-5178

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

PROGRAM DATA

Program Service Area:
City
County

Initial Waiver Approval Date:
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, 2002

Enrollment Broker:
Yes

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 Health, Case Management, Comprehensive Day Rehabilitation, Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Substance Abuse, Personal Care, Pharmacy, Physician, Prenatal Case Management, Transportation, Vision, X-Ray

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

Enrollment

MISSOURI
MC+ Managed Care/1915b

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

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-MC+ for Pregnant Women
-Children in the Legal Custody of Department of Social Services
-Mentally Retarded Developmentally Disabled (MRDD) Waiver participants
-TITLE XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-General Relief Participants
-AIDS Waiver program participants
-Permanently and Totally Disabled Individuals
-Presumptive Eligibility Program Pregnant Women Eligibles
-Aid to the Blind and Blind Pension Individuals
-Special Needs Children
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Children with Developmental Disabilities Program
-Mentally Retarded Developmentally Disabled (MRDD) 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:
-Health Risk Assessment
-MCO Helpline
-MCOs use Drug Usage
-MCOs use ER Encounters
-MCOs use Hospital Admissions
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Social Services Agency (SSI)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Care Partners
FirstGuard
Missouri Care
Family Health Partners
HealthNet

ADDITIONAL INFORMATION

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. MC+ is mandatory for specific counties. For other counties, MC+ is under the expansion on a FFS basis.

MISSOURI
MC+ Managed Care/1915b

Title XXI SCHIP populations is included as a Medicaid expansion population and are mandatory to enroll in the MC+ program for specific counties. For the counties that do not have managed care, they are on a FFS basis.

Included Services: Inpatient Mental Health, Outpatient Mental Health, Inpatient Substance Abuse, Outpatient Substance Abuse program provides 30 inpatient/20 outpatient with wrap around services in the following counties: Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Franklin, Gasconade, Howard, Jefferson, Miller, Montieau, Monroe Montgomery, Morgan, Osage, Pettis, Randolph, Saline, St. Charles, St. Louis and St.Louis City.

Populations Excluded: Mentally Retarded Developmentally Disabled (MRDD) Waiver in the above counties.

Participate in HCBS Waiver: These participants are "included" except for waivered services. Special Needs Children enrollment is mandatory but individuals may request to opt out.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

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

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 initial encounter data submission
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-HCFA 1500 - the HCFA 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 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

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

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

State conducts general data completeness assessments
Yes

MISSOURI
MC+ Managed Care/1915b

-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Medicaid Eligibility
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-C-Section Rates
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-Dental services
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Mental Health Utilization
-Outcomes of pregnancy
-Percentage of beneficiaries 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 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
-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
-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

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

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

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

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Missouri Patient Care Review Foundation

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct of 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 Serv
(406)444-4146

State Website Address:
http://www.dphhs.state.mt.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
August 31, 1993

Implementation Date:
January 01, 1993

Waiver Expiration Date:
October 26, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility,

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

Enrollment

MONTANA
Passport To Health

Populations Voluntarily Enrolled:
None

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

Transportation, X-Ray

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period Less Than 3 Months
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligible

Lock-In Provision:
3 month lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
EPSDT, Home Health, Inpatient Hospital, Outpatient Hospital, Physician

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Indian Health Service (IHS) Providers
-Physician Assistants
-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
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

MONTANA
Passport To Health

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
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross Blue Shield
Yellow Stone

Passport to Health

ADDITIONAL INFORMATION

Program includes a $3.00 case management fee. The beneficiaries in Cascade and Yellowstone counties have the option to enroll in the PCCM program or HMOs.

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 Measures (see below for details)

Use of Collected Data

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

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

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

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

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills

MONTANA
Passport To Health

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

care facilities

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical 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
None

Access/Availability of Care
-Ratio of PCPs to beneficiaries

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

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
-Board Certification

Beneficiary Characteristics
None

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

-The State generates from encounter data ALL of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PHPs to follow NCQA specifications

Consumer Self-Report Data
-Disenrollment Survey

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Mountain Specific Foundation

EQRO Organization
-Peer Review Organization (PRO)

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

MONTANA
Passport To Health

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
-Track Health Service provision

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Diabetes management
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates

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

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

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics
-Board Certification

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

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

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Diabetes management
-Emergency Room service utilization
-Lead toxicity
-Low birth-weight baby
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Native American

NEBRASKA
Nebraska Health Connection - Medical/Surgical Component

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months continous eligibility for children

Initial Waiver Approval Date:
June 06, 1995

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2001

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
None

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

NEBRASKA
Nebraska Health Connection - Medical/Surgical Component

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

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Participate in HCBS Waiver
-Children Participating in the Katie Beckett Program
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Clients Eligible During the Period of Presumptive Eligibility
-Transplant Recipients
-Clients Who Have Received a Disenrollment/Waiver of Enrollment
-Clients Residing Outside the Desinated Coverage Area
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program

Lock-In Provision:

1 month lock-in

NEBRASKA
Nebraska Health Connection - Medical/Surgical Component

PCCM Provider - Fee-for-Service

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
None

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Children Participating in the Katie Beckett Program
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Clients Eligible During the Period of Presumptive Eligilbility
-Transplant Recipients
-Clients Who Have Received a Disenrollment/Waiver of Enrollment
-Clients Residing Outside the Designated Coverage Area

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 groups

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

NEBRASKA

Nebraska Health Connection - Medical/Surgical Component

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Primary Care Plus
Share Advantage
The Wellness Option

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

Use of Collected Data

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

Encounter Data

Collection: Requirements

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

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

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

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

Validation: Methods

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

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

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

State conducts general data completeness assessments

No

NEBRASKA

Nebraska Health Connection - Medical/Surgical Component

Performance Measures

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-HIV/AIDS care
-Initiation of prenatal care
-Lead screening rate
-Pregnancy Prevention
-Well-child care visit rates

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

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

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

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

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

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-State-developed Survey

Performance Improvement Projects

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

Clinical Topics
-Diabetes management

Non-Clinical Topics
-None

NEBRASKA
Nebraska Health Connection - Medical/Surgical Component

Standards/Accreditation

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

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

Accreditation for Deeming
None

EQRO Name
-Iowa Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

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

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

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

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

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

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

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

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

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-State-developed Survey

NEBRASKA
Nebraska Health Connection - Mental Health/Substance Abuse

CONTACT INFORMATION

State Medicaid Contact:
Kerri Bestul
Nebraska Medicaid
(402)471-9337

State Website Address:
http://www.hhs.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 17, 1995

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

Waiver Expiration Date:
August 01, 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:
None

SERVICE DELIVERY

PHP (Mental Health and Substance Abuse (MH/SA) - Limited Benefits) -

Service Delivery

Included Services:
Crisis, EPDST, IMD Services, Inpatient Hospital, Inpatient Mental Health Services, Inpatient Substance Abuse Services, Laboratory, Mental Health Outpatient, Mental Health Residential, Mental Health Support, Opiate Treatment Programs, Outpatient Hospital, Outpatient Substance Abuse Services, Pharmacy, Physician Services, Residential Substance Abuse Treatment Programs, Transportation, X-Ray

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

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

NEBRASKA

Nebraska Health Connection - Mental Health/Substance Abuse

Populations Mandatory Enrolled with a Sole Capitation

-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

Subpopulations Excluded from Otherwise Source Provider: Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program

Lock-In Provision:

1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ValueOptions

ADDITIONAL INFORMATION

Due to the nature of the waiver which is a limited carve-out for a segment of Substance Abuse/Mental Health Services, the program does not designate a primary care provider. Individuals choose their own providers or rely on the contractor for referr al. 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)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data

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

Encounter Data

NEBRASKA

Nebraska Health Connection - Mental Health/Substance Abuse

Collection: Requirements

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

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

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

-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA 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)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

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

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

State conducts general data completeness assessments

No

Performance Measures

Process Quality

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

Health Status/Outcomes Quality

None

Access/Availability of Care

-Average distance to PCP
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization

None

Health Plan Stability/ Financial/Cost of

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

Health Plan/ Provider Characteristics

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

Beneficiary Characteristics

None

Use of HEDIS

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

NEBRASKA

Nebraska Health Connection - Mental Health/Substance Abuse

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

Performance Improvement Projects

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

Clinical Topics
-Attention Deficit/Hyperactivity Disorder

Non-Clinical Topics
-None

Standards/Accreditation

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

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

Accreditation for Deeming
None

EQRO Name
-Iowa Foundation for Medical Care

EQRO Organization
-Peer Review Organization (PRO)

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

NEVADA
Mandatory Health Maintenance Program

CONTACT INFORMATION

State Medicaid Contact:
Laurie England
Division of Health Care Financing and Policy
(775) 687-6664

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

PROGRAM DATA

Program Service Area:
County

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

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 23, 1998

Implementation Date:
December 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Ambulatory Surgery Center, Case Management, Certified Registered Nurse Practioner, Chiropactor, Disposable Medical Supplies, Durable Medical Equipment, Emergency Transportation, End Stage Renal Disease Facilities, EPSDT, Family Planning, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Intravenous Therapy, Laboratory, Medical Rehabilitation Center, Mental Health Rehabilitative Services, Noninvasive Diagnostic Centers, Nurse Anesthetist, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Physician Assistants, Podiatrist, Prosthetics, Pyschologist, Respiratory Therapy, Rural Health Clinics, Skilled Nursing Facility, Special Clinics, Speech Therapy, Transitional Rehabilitative Center, Vision, X-Ray

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

Enrollment

NEVADA
Mandatory Health Maintenance Program

Populations Voluntarily Enrolled:
-Severely Emotionally Disabled Children
-Seriously Mentally Ill Adults
-Children with Special Health Care Needs
-American Indian

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Children - Inpatients at Residential Treatment Facility
-Medicare Dual Eligible
-Other Insurance

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Plan of Nevada
United Healthcare 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)
-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

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

NEVADA
Mandatory Health Maintenance Program

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

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

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

NEVADA
Mandatory Health Maintenance Program

Standards/Accreditation

MCO/PHP Standards
-HCFA'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
-Private Accreditation Organization

EQRO Activities
-Administration or validation of consumer or provider surveys
-Conduct of 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

NEVADA
Voluntary Health Maintenance Program

CONTACT INFORMATION

State Medicaid Contact:
Mary Pennington
Division of Health Care Financing & Policy
(702)687-4176

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

PROGRAM DATA

Program Service Area:
County

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

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Ambulatory Surgery Center, Case Management, Certified Registered Nurse Practioner, Chiropractor, Disposable Medical Supplies, Durable Medical Equipment, Emergency Transportation, End Stage Renal Disease Facilities, EPSDT, Family Planning, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Intravenous Therapy, Laboratory, Medical Rehabilitation Center, Mental Health Rehabilitative Service, Noninvasive Diagnostic Center, Nurse Anesthetist, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Physician Assistant, Podiatrist, Prosthetics, Psychologist, Respiratory Therapy, Rural Health Clinic, Skilled Nursing Facility, Special Clinics, Speech Therapy, Transitional Rehabilitative Center, Vision, X-Ray

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

Enrollment

NEVADA
Voluntary Health Maintenance Program

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

-Severely Emotionally Disturbed Children
-Seriously Mentally Ill Adults
-Children with Special Health Care Needs

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Inpatients in Residential Treatment Facilities
-Residents in Nursing Facilities beyond 45 Days

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Nevadacare DBA Nevada Health Solutions

ADDITIONAL INFORMATION

This program only includes beneficiaries in Washoe county.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Accreditation for Deeming (see below for details)
-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)
-Provider Data

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

NEVADA
Voluntary Health Maintenance Program

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

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

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

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

State conducts general data completeness assessments
Yes

Performance 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

NEVADA
Voluntary Health Maintenance Program

MCO/PHP Standards
-HCFA'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
-Private Accreditation Organization

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

NEW HAMPSHIRE
New Hampshire Voluntary Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:
Brenda Lovely
State of New Hampshire Medicaid Agency
603-271-4350

State Website Address:
http://www.dhhs.state.nh.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 02, 1983

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Organ Transplant, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Skilled Nursing Facility, Vision, X-Ray

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

Enrollment

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

Populations Mandatorily Enrolled:
None

NEW HAMPSHIRE

New Hampshire Voluntary Managed Care Program

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

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

-TITLE XXI SCHIP
-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
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Employment Agency
-Housing Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem Blue Cross/Blue Shield

ADDITIONAL INFORMATION

The SCHIP children aged 0-1 are enrolled voluntary.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

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

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

None

NEW HAMPSHIRE

New Hampshire Voluntary Managed Care Program

Access/Availability of Care
None

Use of Services/Utilization
-# readmissions,same patients,same diagnosis within 7 days
-after-hours visits
-Emergency room visits/1,000 beneficiary
-Hospital Days/ 1000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Use of HEDIS
-State modifies/requires MCOs/PHPs to modify some or all

Consumer Self-Report Data
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 of performance improvement projects
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services

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

CONTACT INFORMATION

State Medicaid Contact:
Susan Welsh
Office of Quality Assurance
(609)588-7379

State Website Address:
http://www.state.nj.us/humanservices

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

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

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 18, 2000

Implementation Date:
October 01, 2000

Waiver Expiration Date:
September 30, 2002

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Chiropractor, Dental, Durable Medical Equipment, Emergency Services, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Optical Appliances, Organ Transplants, Outpatient Hospital, Outpatient Rehabilitative Services, Pharmacy, Physician, Podiatrist Services, Preventive Health Care and Counseling and Promotion, Prosthetics and Orthotics, Transportation Services, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

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

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program Without Department of Human Services Contract
-Participate in HCBS Waiver (except DDD/CCW non-duals)

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna US Healthcare
AMERIGROUP New Jersey, Inc.
Physicians Health Services of New Jersey, Inc.
AmeriChoice of New Jersey, Inc.
Horizon Mercy
University Health Plans, Inc.

ADDITIONAL INFORMATION

1915(b) Waiver program was approved in April 2000, however, the program was not effective until 10/01/2000. Please note benefits listed are those that were in effect prior to 10/01/2000.

For Included Population: Non-dual , Aged, Blind, Disa bled and Division of Developmental Disabilities Community Care Waiver (DDD/CCW) children from birth through 18 years old.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

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

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

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

Encounter Data

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

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-Electronic format is a modified Fee-For-Service MMIS based on HCFA 1500, UB 92 and Home Grown Forms.

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

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-apropriate diagnosis/procedure
-Gender-apropriate diagnosis/procedure
-Comparison of reported changes to reasonable and customary fees.

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes management
-Frequency of on-going prenatal care
-HIV/AIDS care
-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

-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

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

Use of Services/Utilization
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
None

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

Use of HEDIS
-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continous enrollment
-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

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management
-Lead toxicity
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-The Peer Review Organization of New Jersey, Inc.

NEW JERSEY
New Jersey Care 2000+ (1915 {b})

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-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
-Medical Record review
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of performance improvement projects
-Validation of performance measures

NEW JERSEY
New Jersey Care 2000+ (1932)

CONTACT INFORMATION

State Medicaid Contact:
Susan Welsh
Office of Quality Assurance
(609)588-7379

State Website Address:
http://www.state.nj.us/humanservices

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
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
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-Family Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Medicare Dual Eligible

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Non Dually Eligible Aged, Blind and Disabled Adults and

NEW JERSEY
New Jersey Care 2000+ (1932)

-Related populations
-Non dual DDD/CCW

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program Without Department of Human Services Contract
-Special Needs Children and all Aged, Blind and Disabled were excluded from mandatory enrollment
-American Indian/Alaskan Native
-Participate in HCBS Waiver except DDD/CCW non-duals

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna US Healthcare
AMERIGROUP New Jersey, Inc.
Physicians Health Services of New Jersey, Inc.
AmeriChoice of New Jersey, Inc.
Horizon Mercy
University Health Plans, Inc.

ADDITIONAL INFORMATION

Initially a 1915(b) converted to a SPA effective 1/1/1999. Effective 4/1/00, 1932(a) program was amended to include SSI, Aged, Blind, Disabled, and Division of Developmental Disabilities Community Care Waiver (DDD/CCW) population. Contract to provide services to newly mandated population was not effective until 10/1/00. Phased-in Enrollment for the Aged, Blind, Disabled and DDD/CCW Population effective 10/01/2000. Lock-in Period: 12-month lock in is for AFDC/TANF and Title XXI population. There is no lock-in for SSI, Aged, Blind, Disabled and DDD and DFYS populations. Children with special Health Care Needs and those children who have or are at increased risk for chronic physical, developmental, or emotional conditions and who also require health

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies

Use of Collected Data

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement

NEW JERSEY
New Jersey Care 2000+ (1932)

-Monitoring of MCO/PHP Standards
  -On-Site Reviews
  -Performance Improvements Projects (see below for details)
  -Performance Measures (see below for details)
  -Provider Data
-Program Evaluation
  -Program Modification, Expansion, or Renewal
  -Regulatory Compliance/Federal Reporting
  -Track Health Service provision

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-Electronic format is a modified Fee-For-Service MMIS based on HCFA 1500, UB 92 and Home Grown Forms.

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-apropriate diagnosis/procedure
-Gender-apropriate diagnosis/procedure
-Comparison of reported changes to reasonable and customary fees.

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

-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

Access/Availability of Care
-Well-child care visit rates
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

Use of HEDIS
-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continous enrollment
-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

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management
-Lead toxicity
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

NEW JERSEY
New Jersey Care 2000+ (1932)

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 of 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:
Rita A. Duran
HSD-Medical Assistance Division
(505) 827-6239

State Website Address:
Not Applicable

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
May 13, 1997

Implementation Date:
July 01, 1997

Waiver Expiration Date:
July 01, 2000

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related

NEW MEXICO
SALUD!

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
-Home and Community Based Waiver

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Poverty Level Pregnant Woman
-Native Americans

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses fee for service claims data
-Uses history of prior authorization of special services

Agencies with which Medicaid Coordinates the Operation of the Program:

-Department of Health
-Mental Health Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Cimarron
Lovelace
Presbyterian Salud

ADDITIONAL INFORMATION

HMOs designate PCPS.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Track Health Service provision

NEW MEXICO
SALUD!

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA 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 HCFA approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-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

NEW MEXICO
SALUD!

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Use of HEDIS
-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continous enrollment
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
-State-developed Survey

Performance Improvement Projects

Care

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for
-NCQA (National Committee for Quality Assurance)

Accreditation for Deeming
-NCQA (National Committee for Quality Assurance)

EQRO Name
-IPRO

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

NEW YORK
New York State Mandatory Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:
Elizabeth McFarlane
Office of Managed Care, New York State Department
(518)473-0122

State Website Address:
http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
July 15, 1997

Implementation Date:
October 01, 1997

Waiver Expiration Date:
March 31, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(C)
-1902(a)(23) Freedom of Choice
-1902(a)(25)
-1902(a)(30)
-1902(a)(34)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Eligibility Expansion, Guaranteed Eligibility, Family Planning, IMD
-1903(u) Special Program (Community Health Care Conversion Demonstration Program)

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental (MCO Option), Durable Medical Equipment, EPSDT, Family Planning (MCO Option), Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Skilled Nursing Facility, Transportation (Optional), Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis

NEW YORK
New York State Mandatory Managed Care Program

Enrollment

Populations Voluntarily Enrolled:

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-NYS Home Relief Adults

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Reside in State Operated Psychiatric Facility
-Reside in residential treatment facility for children and youth
-Infants weighing less than 1200 grams or other infants who meet criteria for SSI
-Enrolled in the Restricted Recipient Program
-Admitted to hospice at the time of enrollment
-Foster children in direct care
-Eligible only for TB related services
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Other Insurance
-Participants in LTC Demonstration Program

Lock-In Provision:

12 month lock-in

NEW YORK
New York State Mandatory Managed Care Program

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, 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

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF)Adults and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Spend downs
-Eligibility Period Less than 6 months
-Reside in State Operated Psychiatric Facility
-Reside in residential treatment facility for children and youth
-Infants weighing less than 1200 grams or other infants who meet criteria for SSI
-Enrolled in the Restricted Recipient Program
-Admitted to hospice at the time of enrollment
-Foster children in direct care
-Eligible only for TB related services
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Other Insurance
-Participants in LTC Demonstration Program

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Social Services Agency

NEW YORK

New York State Mandatory Managed Care Program

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Americhoice
Buffalo Community Health
Catholic Services Health Plan/Fidelis
Excellus
Health Now
Independent Health/Hudson Valley&WNY
Metroplus Health Plan
Preferred Care
United Healthcare of Upstate
Broome County MC
Capital District Physicians Health Plan
Community Choice Health Plan
Genesis Health Plan
Hum Healthcare Systems
LMC/Health Care Plus
Physician Case Management Program
Syracuse PHSP/Total Care
Wellcare

ADDITIONAL INFORMATION

This program has an enrollment broker in NYC and may also come on board in Long Island.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

None

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

NEW YORK
New York State Mandatory Managed Care Program

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-apropriate diagnosis/procedure
-Gender-apropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Alcohol and Substance abuse use screening
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Depression management
-Diabetes management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead Screening
-Lead screening rate
-Smoking prevention and cessation
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

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

NEW YORK
New York State Mandatory Managed Care Program

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

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

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
Care -Island Peer Review Organization

EQRO Organization
-Peer Review Organization (PRO)

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
-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
HEDIS measures listed for Medicaid in the future
-State use/requires MCOs/PHPs to follow NCQA specifications

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Focused Studies
-On-Site Reviews
-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

Performance Measures

NEW YORK

New York State Mandatory Managed Care Program

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Immunizations for two year olds
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics
-Board Certification
-Languages spoken (other than English)

Beneficiary Characteristics
-Disenrollment rate
-Percentage of beneficiaries who are auto-assigned to PCCM

Consumer Dself-Report Data
-Provider developed survey

NEW YORK
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:
Tim Perry-Coon
Office of Medicaid Management, NY State Dept
(518)474-9266

State Website Address:
http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 16, 1996

Implementation Date:
July 01, 1996

Waiver Expiration Date:
December 20, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Transportation - Limited Benefits) - Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

NEW YORK
Non-Emergency Transportation

-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-All Medicaid 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:
-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

None

ADDITIONAL INFORMATION

The reimbursement arrangement waiver is described as: Selective contracting for non-emergency transportation.

NEW YORK
Office of Mental Health/Partial Capitation Program

CONTACT INFORMATION

State Medicaid Contact:
Mike Kohler
New York State Office of Mental Health
(518)474-7720

State Website Address:
http://www.omh.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Mental Health (MH) - Limited Benefits) - Capitation

Service Delivery

Included Services:
Case Management, Day 61 State operated facility, IMD Services, Inpatient Psychatric Day 1-Day 60, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support

Allowable PCPs:
-Mental Health PHP
-Personal Services Coordinator

Contractor Types:
-New York State Office of Mental Health Hospital

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Age 18-21/22 or 65 and over residing in a State-operated

Populations Mandatorily Enrolled:
None

psychiatric center
-Receiving inpatient, outpatient (Clinic, Continuing Day Treatment, and
-Aged 18 or over admitted to an outpatient psychiatric center program

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 6 Months
-Participants in State-authorized mental health programs
-Participation in HCBS Waiver
-Special Needs Children

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-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 PCPs or hospitals 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 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

NEW YORK
Office of Mental Health/Partial Capitation Program

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care

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

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

Consumer Self-Report Data
None

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
-Not Applicable
-Private Accreditation Organization

EQRO Activities
-Not Applicable

NEW YORK
The New York State Voluntary Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:
Elizabeth McFarlane
New York State Department of Health
(518)473-0122

State Website Address:
http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1987

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental (MCO Option), Durable Medical Equipment, EPSDT, Family Planning (MCO Option), Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Transportation (Optional), Vision, X-Ray

Allowable PCPs:
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
None

NEW YORK
The New York State Voluntary Managed Care Program

-Foster Care Children
-Aged and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Medicare Dual Eligible
-Eligibility Period Less than 6 months
-Other Insurance
-Spend downs
-Reside in State Operated Psychiatric Facility
-Reside in residential treatment facility for children and youth
-Infants weighing less than 1200 grams or other infants who meet criteria for SSI
-Enrolled in the Restricted Recipient Program
-Admitted to hospice at the time of enrollment
-Foster children in direct care
-Eligibility only for TB related services

Lock-In Provision:

12 month lock-in

NEW YORK
The New York State Voluntary Managed Care Program

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less than 6 months
-Spend downs
-Reside in State Operated Psychiatric facility
-Reside in residential treatment facility for children and youth
-Infants weighing less than 1200 grams or other infants who meet criteria for SSI
-Enrolled in the Restricted Recipient Program
-Admitted to hospice at the time of enrollment
-Foster children in direct care
-Eligible only for TB related services
-Enrolled in Another Managed Care Program

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses 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

NEW YORK

The New York State Voluntary Managed Care Program

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ABC Health Plan
Bronx Health Plan
CarePlus Health Plan
Community Blue
Community Premier Plus
Family Health Service/Priority Care
Health Choice
HIP Combined
LMC/Health Care Plus
Manhattan PHSP (Centercare)
Neighborhood Health Providers
Preferred Care
St. Barnabas/Partners in Health
Twin Tier/ Southern Tier Priority
Vytra
Westchester PHSP
Blue Choice HMO Options
Capital District Physicians Health Plan
Catholic Services Health Plan/Fidelis
Community Choice Health Plan
Compre-Care
Genesis Health Plan
Health First
HUM Healthcare Systems
Managed Healthcare Systems
Metroplus Health Plan
NY Hospital Community PHSP
Southern Tier Pediatrics
Suffolk Health Plan
United Healthcare of NY
Wellcare

ADDITIONAL INFORMATION

The enrollment of foster care children is a county option.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

None

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Revenue Codes

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Alcohol and substance abuse screening
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Depression management
-Diabetes management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Smoking prevention and cessation
-Well-child care visit rates

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care

-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of

-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income

Health Plan/ Provider Characteristics

-Board Certification
-Languages Spoken (other than English)
-Provider turnover

-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

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

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

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 of performance improvement projects
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Focused Studies
-On-Site Reviews
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation

NEW YORK
The New York State Voluntary Managed Care Program

-Provider Data

-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Performance Measures

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Immunizations for two year olds
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics
-Board Certification
-Languages spoken (other than English)

Beneficiary Characteristics
-Disenrollment rate
-Percentage of beneficiaries who are auto-assigned to PCCM

Consumer Self-Report Data
-Provider developed survey

NEW YORK
The Westchester County Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:
Linda Reese
Office of Managed Care, NY State Dept.
(518)473-4175

State Website Address:
http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
October 01, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
March 31, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, 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:
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

NEW YORK
The Westchester County Managed Care Program

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Period Less than 6 Months
-Eligible only for TB related services
-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Spend downs
-Reside in State Operated Psychiatric facility
-Reside in residential treatment facility for children and youth
-Enrolled in the Restricted Recipient Program
-In hospice at the time of enrollment
-Foster children in direct care
-Infants weighing less than 1200 grams or infants who meet SSI criteria

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

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Choice Health Plan
Genesis Health Plan
Health First
HIP Combined
Westchester PHSP

ADDITIONAL INFORMATION

Westchester County TANF enrollees have been subsumed in the 1115 waiver program. In 1997 SDOH and Westchester requested that the 1915(b) be expanded to include SSI enrollees. The 1915(b) covers the SSI population only. There is authority to auto-assign the SSI population, but it has not been implemented. This program will be subsumed by the 1115 waiver 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)
-Focused Studies
-MCO/PHP Standards (see below for details)

Use of Collected Data

-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation

NEW YORK
The Westchester County Managed Care Program

-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
None

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-apropriate diagnosis/procedure
-Gender-apropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Alcohol and substance abuse screening
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Depression management
-Diabetes management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Smoking prevention and cessation
-Well-child care visit rates

Access/Availability of Care
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of
-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

-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

-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

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

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

NEW YORK
The Westchester County Managed Care Program

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 of performance improvement projects
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

NORTH CAROLINA
Access II 1915b

CONTACT INFORMATION

State Medicaid Contact:
Deborah Bowen
Division of Medical Assistance
(919)857-4226

State Website Address:
http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 01, 1998

Implementation Date:
July 01, 1998

Waiver Expiration Date:
November 08, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractor, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Outpatient Hospital, Physician

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants
-Health Departments

Enrollment

NORTH CAROLINA
Access II 1915b

Populations Voluntarily Enrolled:
-Adoption Subsidy Children
-Foster Care Children
-Medicaid Pregnant Women
-Medicare Dual Eligibles
-American Indians

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibillity Period that is only Retroactive

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access II

ADDITIONAL INFORMATION

An Administrative Entity is paid an additional case management fee of $2.50 per recipient participating in Access II to monitor care and implement disease management initiation and targeting preventive services.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Care Management
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan & Provide Education
-Program Evaluation

NORTH CAROLINA
Access II 1915b

)

-Performance Measures (see below for details)
-Provider Data

-Program Modification, Expansion, or Renewal
-Provider Profiling
-Quality Improvement Activities
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Average wait time for an appointment with primary care case manager
-Compliant Monitoring
-Ratio of primary care case managers to beneficiaries
-Satisfaction Survey

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per benificiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics
-Languages spoken (other than English)
-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

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
Adult Medicaid SSI Questionnaire
Adult with Special Needs Questionnaire
Child Medicaid AFDC Questionnaire
Child Medicaid SSI Questionnaire
Child with Special Needs Questionnaire

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Diabetes management
-Emergency Room service utilization
-Gastroenteritis
-Lead toxicity
-Otitis Media management
-Pre-natal care
-Pregnancy Prevention
-Prevention of Influenza
-Smoking prevention and cessation
-Tuberculosis screening and treatment
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners
-Community Communication and Collaboration with High-Risk Clients
-Utilization of Rap-Around Services

NORTH CAROLINA
Access II 1932(a)

CONTACT INFORMATION

State Medicaid Contact:
Deborah Bowen
Division of Medical Assistance
(919)857-4226

State Website Address:
http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Outpatient Hospital, Physician

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants
-Health Departments
-Hospital Outpatient Clinics
-Community Health Centers

Enrollment

NORTH CAROLINA
Access II 1932(a)

Populations Voluntarily Enrolled:
-Pregnant Women
-Aged and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligible
-Eligibillity Period that is only Retroactive
-Refugees
-QMB

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access II

ADDITIONAL INFORMATION

An Administrative Entity is paid an additional case management fee of $2.50 per recipient participating in Access II to monitor care and implement disease management initiatives and targeting preventive studies.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Care Management
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan and Provide Education
-Program Evaluation
-Program Modification, Expansion, or Renewal

NORTH CAROLINA
Access II 1932(a)

-Performance Measures (see below for details)
-Provider Data
-Provider Profiling
-Quality Improvement Activities
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Average wait time for an appointment with primary care case manager
-Complaint Monitering
-Ratio of primary care case managers to beneficiaries
-Satisfaction Survey

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per benificiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics
-Languages spoken (other than English)
-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

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
Adult Medicaid SSI Questionnaire
Adult with Special Needs Questionnaire
Child Medicaid AFDC Questionnaire
Child Medicaid SSI Questionnaire
Child with Special Needs Questionnaire

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Diabetes management
-Emergency Room service utilization
-Gastroenteritis
-Lead toxicity
-Otitis Media management
-Pre-natal care
-Pregnancy Prevention
-Prevention of Influenza
-Smoking prevention and cessation
-Tuberculosis screening and treatment
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners
-Community Communication and Collaboration with High-Risk Clients
-Utilization of Rap-around Services

NORTH CAROLINA
Carolina ACCESS 1915 (b)

CONTACT INFORMATION

State Medicaid Contact:
Deborah Bowen
Division of Medical Assistance
(919)857-4226

State Website Address:
http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 1991

Implementation Date:
April 01, 1991

Waiver Expiration Date:
November 08, 2000

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Ambulance and Coordination of Non-Emergency Transportation, Case Management (Excludes HIV Case Management And At-Risk Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Hearing And Hearing Aids, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Indian Health Service Providers

Enrollment

NORTH CAROLINA
Carolina ACCESS 1915 (b)

Populations Voluntarily Enrolled:
-Foster Care Children
-Adoption Subsidy Child
-Pregnant Women
-Medicare Dual Eligibles
-American Indians

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/disabled Children and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-American Indian/Alaskan Native
-Eligibility Period that is only Retroactive
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Internists
-Family Practitioners
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Public Health Departments

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Medicaid Pregnant Women
-Medicare Dual Eligibles
-American Indians who have Indian Health Services Identification

Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Supplemental Security Income and SSI-related
-Section 1931 (AFDC/TANF) Children and Related

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period that is Retroactive
-Native Americans choosing to be exempt
-Terminally Ill
-Non MPW pregnant women

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

NORTH CAROLINA
Carolina ACCESS 1915 (b)

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
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carolina Access
Wellness Plan of North Carolina
United HealthCare

ADDITIONAL INFORMATION

Beneficiaries in 13 counties have an option to either enroll in an MCO or PCCM.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

NORTH CAROLINA
Carolina ACCESS 1915 (b)

Collection: Standardized Forms
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA 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-apropriate diagnosis/procedure
-Gender-apropriate diagnosis/procedure
-Units of Service

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 distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Consumer Self-Report Data
-CAHPS
Child with Special Needs Questionnaire

Performance Improvement Projects

NORTH CAROLINA
Carolina ACCESS 1915 (b)

Project Requirements
-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Asthma management
-Childhood Immunization
-Diabetes management
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
None

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
-Medical Review of North Carolina
-Myers and Stauffer

EQRO Organization
-Peer Review Organization (PRO)
-PRO-like Entity

EQRO Activities
-Conduct of performance improvement projects
-Conduct of 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)
-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

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per benificiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

NORTH CAROLINA
Carolina ACCESS 1915 (b)

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

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
Adult Medicaid SSI Questionnaire
Adult with Special Needs Questionnaire
Child Medicaid AFDC Questionnaire
Child Medicaid SSI Questionnaire
Child with Special Needs Questionnaire

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Diabetes management
-Emergency Room service utilization
-Lead toxicity
-Pre-natal care
-Pregnancy Prevention
-Prevention of Influenza
-Tuberculosis screening and treatment
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

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:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Ambulance And Coordination of Non-ER Transportation, Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Health Department, Hearing And Hearing Aids, Home Health, Hospice, ICF/MR, Immunization, Inpatient Hospital, Laboratory, Nursing Home, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

NORTH CAROLINA
Carolina ACCESS 1932

-Aged and Related Populations
-Medicaid Pregnant Women

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-American Indian/Alaskan Native
-Medicare Dual Eligible
-Participate in HCBS Waiver
-Eligibility Period that is only Retroactive
-Terminally Ill Who Sees Multiple Specialists
-A Recipient Who Has Chronic, Complex Medical Problems And Sees Multiple Specialists Who Do not Participate in the Program

Lock-In Provision:
No lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Public Health Departments

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles
-Medicaid for Pregnant Women
-American Indians who have an Indian Health Services Identification

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Supplemental Security Income and SSI Related

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Period that is Retroactive
-Native Americans Choosing to be Exempt
-Terminally Ill
-Private Insurance and PCP not willing to participate
-Non-MPW Pregnant Women
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

NORTH CAROLINA
Carolina ACCESS 1932

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carolina Access
Wellness Plan of North Carolina
United HealthCare

ADDITIONAL INFORMATION

The recipient must choose and enroll with or be assigned to a primary case provider who is paid a monthly case management fee of $3.00 for each enrollee in addition to regular fee for service payments. For PCCM, the program does not have a Phased- in Enrollment nor an Enrollment Broker.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

NORTH CAROLINA
Carolina ACCESS 1932

Collection: Standardized Forms
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA 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
None

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
None

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Consumer Self-Report Data
-CAHPS
Child with Special Needs Questionnaire

Performance Improvement Projects

NORTH CAROLINA
Carolina ACCESS 1932

Project Requirements
-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Asthma management
-Childhood Immunization
-Diabetes management
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Medical Review of North Carolina
-Myers and Stauffer

EQRO Organization
-Peer Review Organization (PRO)
-PRO-like Entity

EQRO Activities
-Conduct of performance improvement projects
-Conduct of 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:
-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

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per benificiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

NORTH CAROLINA
Carolina ACCESS 1932

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

Consumer Self-Report Data
-CAHPS
- Adult Medicaid AFDC Questionnaire
- Adult Medicaid SSI Questionnaire
- Adult with Special Needs Questionnaire
- Child Medicaid AFDC Questionnaire
- Child Medicaid SSI Questionnaire
- Child with Special Needs Questionnaire

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

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 1991

Implementation Date:
July 01, 1996

Waiver Expiration Date:
November 08, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Ambulance And Coordination of Non-ER Transportation, Case Management (Excludes HIV Case Management And At-Risk Case Management), Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Hearing And Hearing Aids, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Preventive Therapies, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants
-Pediatricians

Enrollment

NORTH CAROLINA
Health Care Connection (1915)b

Populations Voluntarily Enrolled:
-Foster Care Children
-Adoption Subsidy Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations
-Pregnant Women

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-American Indian/Alaskan Native
-Medicare Dual Eligible
-Participate in HCBS Waiver
-Eligibility Period That Is Only Retro-active
-Terminally Ill Who Sees Multiple Specialists
-A Recipient Who Has Chronic, Complex Medical Problems And Sees Multiple Specialists Who Do Not Participate in the same HMO

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

IPA of North Carolina DBA Southcare
United Healthcare
Metrolina (FQHC)
Wellness Plan of North Carolina

ADDITIONAL INFORMATION

Although Health Care Connection is capitated, the Metrolina (FQHC) plan reimburses on a FFS basis.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies

Use of Collected Data
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Modification, Expansion, or Renewal

NORTH CAROLINA
Health Care Connection (1915)b

-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
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA 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-apropriate diagnosis/procedure
-Gender-apropriate diagnosis/procedure
-Units of Service

State conducts general data completeness assessments
No

Performance Measures

Process Quality
None

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
None

NORTH CAROLINA
Health Care Connection (1915)b

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

None

-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

Consumer Self-Report Data
-CAHPS
Child with Special Needs Questionnaire

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Asthma management
-Childhood Immunization
-Diabetes management
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-QARI (Quality Assurance Reform Initiative)
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Medical Review of North Carolina
-Myers and Stauffers

EQRO Organization
-Peer Review Organization (PRO)
-PRO-like Entity

EQRO Activities
-Conduct of performance improvement projects
-Conduct of 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:
Sujata Joshi
Division of Medical Assistance
(919)857-4242

State Website Address:
http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 1991

Implementation Date:
July 01, 1996

Waiver Expiration Date:
June 30, 2001

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Ambulance And Co-ordination Of Non-ER Transportation, Case Management (Excludes HIV Case Management And At-Risk Case Management), Chiropractic, Durable Medical Equipment, EPSDT, Hearing and Hearing Aids, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations

Populations Mandatorily Enrolled:
-Pregnant Women
-Section 1931 (AFDC/TANF) Adults and Related Populations

NORTH CAROLINA
Health Care Connection (1932)a

-Blind/Disabled Adults and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Age 65 or older, Family Planning Waiver Recipients
-American Indian/Alaskan Native

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-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
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

IPA of North Carolina DBA Southcare
United Healthcare
Metrolina (FQHC)
Wellness Plan of North Carolina

ADDITIONAL INFORMATION

Although Health Care Connection is capitated, the Metrolina (FQHC) plan reimburses on a FFS basis.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)

Use of Collected Data

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

NORTH CAROLINA
Health Care Connection (1932)a

-Performance Measures (see below for details)
-Provider Data

Encounter Data

Collection: Requirements
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA 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-apropriate diagnosis/procedure
-Gender-apropriate diagnosis/procedure
-Units of Service

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 distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

NORTH CAROLINA
Health Care Connection (1932)a

Beneficiary Characteristics
None

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Consumer Self-Report Data
-CAHPS
Chile with Special Needs Questionnaire

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Asthma management
-Childhood Immunization
-Diabetes management
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-QARI (quality Assurance Reform Initiative)
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Medical Review of North Carolina
-Myers and Stauffers

EQRO Organization
-Peer Review Organization (PRO)
-PRO-like Entity

EQRO Activities
-Conduct of performance improvement projects
-Conduct of 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
North Dakota Department of Human Services, Medical
(701)328-1884

State Website Address:
http://www.state.nd.us/hms/dhs.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
June 23, 1993

Implementation Date:
January 01, 1994

Waiver Expiration Date:
May 05, 2001

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, 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

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
-Poverty Level

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medically Needy
-Foster Care
-Refugee Assistance
-Adoption Assistance
-Eligibility Period that is only Retroactive

Lock-In Provision:
6 month lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Durable Medical Equipment, Emergency Services, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Mid-level Practitioner, Non-Emergency Transportation, Nutritional, Occupational, Physical, and Speech Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Podiatry, Private Duty Nursing, Public Health Unit, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Optional Categorically Needy
-Medically Needy

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Foster Care
-Refugee Assistance
-Adoption Assistance
-Eligiblity Period that is only Retroactive

Lock-In Provision:
6 month lock-in

NORTH DAKOTA
North Dakota Access and Care Program

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Altru Health Plan

North Dakota Access and Care Program

ADDITIONAL INFORMATION

Altru Health Plan is only offered in Grand Forks county.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO/PHP Standards (see below for details)
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data

-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements

None

State conducts general data completeness assessments

No

Performance Measures

Process Quality

-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Well-child care visit rates

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

NORTH DAKOTA
North Dakota Access and Care Program

Access/Availability of Care
-Average wait time for an appointment with PCP
-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.)

Health Plan/ Provider Characteristics
-Number and Type of Services Provided

Beneficiary Characteristics
-MCO/PCP-specific disenrollment rate

Use of HEDIS
-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continous enrollment
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Consumer Self-Report Data
-Health Plan Developed Survey with State Approval

Performance Improvement Projects

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing
-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-Lead toxicity
-Low birth-weight baby
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-North Dakota Health Care Review

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Yet To Be Determined

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Performance Measures (see below for details)

Use of Collected Data:
-Does Not Use the Data Collected

NORTH DAKOTA
North Dakota Access and Care Program

-Provider Data

Performance Measures

Process Quality
-Breast Cancer screening rate
-Cervical cancer screening rate
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
None

Provider Characteristics
None

Beneficiary Characteristics
None

Consumer Self-Report Data
-State-developed Survey

OHIO
Ohio 1115 (TANF & TANF-Related)

CONTACT INFORMATION

State Medicaid Contact:
Cynthia Burnell
Bureau of Managed Health Care
(614) 466-4693

State Website Address:
http://www.state.oh.us/odjfs/index.stm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 17, 1995

Implementation Date:
July 01, 1996

Waiver Expiration Date:
June 30, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(A)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(a)
-1902(a)(17)(D)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(34)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Eligibility Expansion, IMD
-1903(m)(I)(A)

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All other Ohio Medicaid services, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Other Specialists Approved on a Case-by-Case Basis

OHIO
Ohio 1115 (TANF & TANF-Related)

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-All except TANF and TANF-Related Medicaid eligibles

Lock-In Provision:
6 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Public Health Agency
-Education Agency
-Mental Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Dayton Area Health Plan
Family Health Plan
HMO Health Ohio
Qualchoice Health Plan
Supermed HMO
Emerald HMO
Genesis
Paramount Health Care
Summacare
Total Health Care Plan

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.

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
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement

-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
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA 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 HCFA approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Manual analysis of encounter data submision to help determine data completeness
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-apropriate diagnosis/procedure
-Gender-apropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Asthma care
-Check-ups after delivery
-Dental services
-Depression management
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

OHIO
Ohio 1115 (TANF & TANF-Related)

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Administrative Loss Ratio
-Assets to Liabilities
-Current Ratio
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Equity Ratio
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth

Health Plan/ Provider Characteristics
-Provider turnover

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

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

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Asthma management
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-Low birth-weight baby
-Otitis Media management
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

OHIO
Ohio 1115 (TANF & TANF-Related)

Accreditation for Deeming
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Peer Review Systems

EQRO Organization
-Peer Review Organization (PRO)
-PRO-like Entity

EQRO Activities
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance measures

OKLAHOMA
SoonerCare

CONTACT INFORMATION

State Medicaid Contact:
Rebecca Pasternik-Ikard
Oklahoma Health Care Authority
(405)522-7300

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:
Yes

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) Guranteed 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)

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

OKLAHOMA
SoonerCare

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Children in permanent custody
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
1 month lock-in

PCCM Provider - Partial Capitation

Service Delivery

Included Services:
Case Management, EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:
None

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
-Children In State Custody

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

OKLAHOMA
SoonerCare

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Bluelincs
Heartland
SoonerCare PCCM
CommunityCare
Prime Advantage

ADDITIONAL INFORMATION

Beneficiaries are auto assigned to either PCCM or MCO models depending on where they live.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Reimbursement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-ADA - American Dental Association dental claim form
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to

between trading partners, such as physicians and suppliers

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms,
-Revenue Codes 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

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-apropriate diagnosis/procedure
-Gender-apropriate diagnosis/procedure

State conducts general data completeness assessments

No

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care
-Dental services
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care

-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization

-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics

None

Use of HEDIS

-The State uses ALL of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs/PHPs to follow NCQA specifications

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

Performance Improvement Projects

Project Requirements
-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Emergency Room service utilization
-Newborn screening for heritable diseases
-Pre-natal care
-Presciption drug abuse
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards
-HCFA's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards

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 of 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

OREGON
Oregon Health Plan

CONTACT INFORMATION

State Medicaid Contact:
Joan Kapowich
Office of Medical Assistance Programs
(503) 945-6500

State Website Address:
http://www.omap.hr.state.or.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
March 19, 1993

Implementation Date:
February 01, 1994

Waiver Expiration Date:
January 31, 2002

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(A)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(C)
-1902(a)(13)(e)
-1902(a)(17)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(43)(A)

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, Guaranteed Eligibility, IMD
-1905(a)(13)

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

PHP (Dental - Limited Benefits) - Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-DOES NOT APPLY

OREGON
Oregon Health Plan

Enrollment

Populations Voluntarily Enrolled:
None

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

Lock-In Provision:
No lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Physician Assistants
-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
-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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

PHP (Mental Health and Substance Abuse (MH/SA) - Limited Benefits) -

Service Delivery

Included Services:
Crisis, IMD Services, Inpatient Mental Health Services, 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)
-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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

PCCM Provider - Fee-for-Service

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:
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
-TITLE XXI SCHIP
-Pregnant Women and Optional Children
-Medicare Dual Eligible
-American Indian/alaskan Native

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

PHP (Transportation - Limited Benefits) - Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-DOES NOT APPLY

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 and Optional Children
-Medicare Dual Eligible
-American Indian/Alaskan Native

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

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
-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
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Housing Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Accountable Behavioral Health
Care Oregon
Capitol Dental Care Inc.
Cascade Comprehensive Care

OREGON
Oregon Health Plan

Central Oregon Independent Health Services
Deschutes County CDO
Douglas County IPA
Family Care (Mental Health)
Hayden Family Dentistry
Jefferson Behavioral Health
Lane Care MHO
Managed Dental Care of Oregon
Mid-Rogue Independent Practice Assoc.
Multnomah CaapCare
ODS Dental Plan
ODS Health Plan (Mental Health)
Oregon Health Management Service
Providence Behavioral
Regence HMO
Tillamook Counseling Incl.
Tuality Health Care
Clackamas County Mental Health
Doctors of the Oregon Coast South
Family Care
Greater Oregon Behavioral Health, Inc.
Inter-Community Health Network
Kaiser Permanente
Lane Individual Practice Association
Mid Valley Behavioral Care Network
Multicare Dental
Northwest Dental Services
ODS Health Plan
Oregon Dental Service
PCCM
Providence Health Plan
Regence HMO (Mental Health)
Tuality Health Alliance (Mental Health)
Willamette Dental

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)
-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

Encounter Data

Collection: Requirements

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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

-NSF - (National Standard Format) - the HCFA 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)

OREGON
Oregon Health Plan

-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-apropriate diagnosis/procedure
-Gender-apropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Depression management
-Diabetes management
-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
-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
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Percentage of beneficiaries with at least one dental visit

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

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)

OREGON
Oregon Health Plan

-Net worth
-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

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Consumer Self-Report Data
-CAHPS
"Core" Adult/Child Survey w/selected Medicaid and Special Needs Questions

-Ratio of PCPs to beneficiaries

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
-Deprssion management
-Primary and behavioral health care coordination
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Permedion

EQRO Organization
-PRO-like Entity Permedion

EQRO Activities
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Ombudsman

Use of Collected Data:
-Health Services Research
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

OREGON
Tri-County Metro. Transportation District

CONTACT INFORMATION

State Medicaid Contact:
Larry Daimler
Office of Medical Assistance Programs
(503) 945-6493

State Website Address:
http://www.omap.hr.state.or.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 01, 1994

Implementation Date:
September 01, 1994

Waiver Expiration Date:
July 25, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Transportation - Limited Benefits) - Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-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

OREGON
Tri-County Metro. Transportation District

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Medicare Dual Eligible
-American Indian/Alaskan Native
-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 eligibility data to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Other Brokers from other States
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Not Applicable

ADDITIONAL INFORMATION

The enrollment broker contracts with providers to provide non-emergency transportation services. The program was approved retroactively. The State contracts with a broker and pays a per-ride fee based on bills submitted by the broker. The broker subcontracts for services and pays contracted rates on a per ride basis. Annual auditing.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Provider Data

Use of Collected Data:

-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting

PENNSYLVANIA
Family Care Network

CONTACT INFORMATION

State Medicaid Contact:
Sherry Gritman
Pennsylvania Department of Welfare
(717) 772-6112

State Website Address:
www.dpw.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 14, 1993

Implementation Date:
February 01, 1994

Waiver Expiration Date:
October 26, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Psychiatrists
-Other Specialists Approved on a Case-by-Case Basis
-Specialist Who Meets Special Needs of Client

Enrollment

PENNSYLVANIA
Family Care Network

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:
None

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
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Housing Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Family Care Network

ADDITIONAL INFORMATION

Enrollment focuses on Medicaid recipients under age 21. This is a monthly patient fee of $3.00.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-On-Site Reviews
-Performance Improvements Projects (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Performance Measures

PENNSYLVANIA
Family Care Network

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Performance Measures (see below for details)
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Average distance to primary care case managerNone

Provider Characteristics
None

Beneficiary Characteristics
None

-State-developed Survey

Performance Improvement Projects

Clinical Topics
None

Non-Clinical Topics
-Availability of language interpretation services

PENNSYLVANIA
HealthChoices

CONTACT INFORMATION

State Medicaid Contact:
Mike Jacobs
Pennsylvania Department of Welfare
(717) 772-6300

State Website Address:
http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 31, 1996

Implementation Date:
February 01, 1997

Waiver Expiration Date:
December 18, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30) Upper Payment Limit

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Emergency Ambulance Transportation, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility for First 30 Days, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

PENNSYLVANIA
HealthChoices

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-State Only Categorically and Medically Needy

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-State Blind Pension Recipients
-Monthly Spend Downs

Lock-In Provision:
No lock-in

PHP (Mental Health (MH) - Limited Benefits) - Capitation

Service Delivery

Included Services:
Case Management, EPSDT, Inpatient Mental Health Services, Inpatient Substance Abuse, Laboratory, Mental Health Outpatient, Outpatient Substance Abuse, Physician

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-State Blind Pension Recipients
-Monthly Spend Downs

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

PENNSYLVANIA
HealthChoices

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
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Housing Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

City of Philadelphia - Community Behavioral Health,Inc. - HCSE
County of Allegheny - Community Care Behavioral Health - HCSW
County of Armstrong - Value Behavioral Health of PA - HCSW
County of Beaver - Value Behavioral Health of PA -
County of Bucks - Magellan Behavioral Health
County of Butler - Value Behavioral Health of PA
County of Chester - Magellan Behavioral Health
County of Delaware - Magellan Behavioral Health
County of Fayette - Value Behavioral Health of PA
County of Indiana - Value Behavioral Health of PA
County of Lawrence - Value Behavioral Health of PA
County of Montgomery - Magellan Choice Behavioral
County of Washington - Value Behavioral Health of PA
County of Westmoreland - Value Behavioral Health of PA
Gateway Health Plan, Inc.
Health Partners of Philadelphia
Healthcare Management Alternatives, Inc.
Keystone Mercy Health Plan
OakTree Health Plan (HRM)
Three Rivers Health Plans, Inc. / MedPLUS
UPMC Health Plan / Best Health Care Plan
Value Behavioral Health of PA (Greene Co.)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of

PENNSYLVANIA
HealthChoices

-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
acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
None

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

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 measure
-Drug Utilization
-Emergency room visits/1,000 beneficiary

PENNSYLVANIA
HealthChoices

-Number of days in ICF or SNF per beneficiary over 64 years
-Number of home health visits per benificiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

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

Consumer Self-Report Data

-CAHPS
2.0H adult and children
-State-developed Survey

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
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Hypertension management
-Low birth-weight baby
-Post-natal Care
-Pre-natal care

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-HCFA's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-IPRO
-KeyPro

PENNSYLVANIA
HealthChoices

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct of performance improvement projects
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

PENNSYLVANIA
Lancaster Community Health Plan

CONTACT INFORMATION

State Medicaid Contact:
Sherry Gritman
Pennsylvania Department of Welfare
(717)772-6112

State Website Address:
http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 10, 1994

Implementation Date:
May 01, 1995

Waiver Expiration Date:
January 18, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Other Specialists Approved on a Case-by-Case Basis
-Outpatient Hospital Clinics

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related

PENNSYLVANIA
Lancaster Community Health Plan

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
-State Only Categorically and Medically Needy

Populations Mandatory Enrolled with a Sole Source Provider:

None

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:

-Aged and Related Populations
-State Only Categorically and Medically Needy
-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Housing Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Lancaster Community Health Plan

ADDITIONAL INFORMATION

PCCM program sponsors by consortium of hospitals and State Medical Society.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)

Use of Collected Data:

-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Performance Measures

PENNSYLVANIA
Lancaster Community Health Plan

Process Quality
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management
-Frequency of on-going prenatal care
-Performance Measures (see below for details) -Initiation of prenatal care
-Pregnancy Prevention

Health Status/Outcomes Quality
None

Access/Availability of Care
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Number of primary care case manager visits per beneficiary

Provider Characteristics
None

Beneficiary Characteristics
None

Consumer Self-Report Data
-State-developed Survey

Performance Improvement Projects

Clinical Topics
None

Non-Clinical Topics
-Availability of language interpretation services
-Children and adults access to dental care

PENNSYLVANIA
Voluntary HMO Contracts

CONTACT INFORMATION

State Medicaid Contact:
Harry Mirach
Pennsylvania Department of Welfare
(717) 772-6293

State Website Address:
http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1972

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Emergency Ambulance Transportation, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility for First 30 Days, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Populations Mandatorily Enrolled:
None

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-State Only Categorically Needy
-State Only Medically Needy

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-State Blind Pension Recipients
-Monthly spend Downs
-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:

-Aged and Related Populations
-State Only Categorically Needy
-State Only Medically Needy
-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
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Housing Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriHealth HMO, Inc./AmeriHealth Mercy - Magellan - VOL

PhilCare Health Systems/ PA Healthmate - VOL

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

PENNSYLVANIA
Voluntary HMO Contracts
Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-All use of services - Hedis measure
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per benificiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs
-Weeks of pregnancy at time of enrollment in MCO/PHP, for women giving birth during the reporting period

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

Consumer Self-Report Data
-CAHPS
  2.0H Adult and Children
-State-developed Survey

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
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Hypertension management
-Low birth-weight baby
-Post-natal Care

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-HCFA's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-IPRO
-KeyPro

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Conduct of performance improvement projects
-Conduct of 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:
Guillermo Silva-Janer
Puerto Rico Health Insurance Administration
(787)725-9427

State Website Address:
None

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
February 01, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

-Foster Care Children
-TITLE XXI SCHIP
-Individual/families up to 200% of the Puerto Rico poverty line. Police

Populations Mandatory Enrolled with a Sole Source Provider:
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

Humana Health Plans of Puerto Rico, Inc.
Triple-S, Inc.
La Cruz Azul de Puerto Rico

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 Se ptember 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 s ervices. It does not include vision or hearing equipment.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-On-Site Reviews

Use of Collected Data
-Program Evaluation

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, definitons, 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
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-QIPRO

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Validation of client level data, such as claims and encounters

RHODE ISLAND
Rite Care

CONTACT INFORMATION

State Medicaid Contact:
Sharon Penkala
Center for Child & Family Health
(401) 462-2187

State Website Address:
http://www.state.ri.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
November 01, 1993

Implementation Date:
August 01, 1994

Waiver Expiration Date:
July 31, 2002

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(A)(ii)(I)(II)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(E)
-1902(a)(14)
-1902(a)(17)(b)
-1902(a)(23) Freedom of Choice
-1902(a)(34)

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(1)(A)
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Eligibility Expansion, Family Planning, IMD

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Nurse Practitioners
-Physician Assistants

RHODE ISLAND
Rite Care

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Participate in HCBS Waiver
-Medicare Dual Eligible
-American Indian/Alaskan Native

Lock-In Provision:
12 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coordinated Health Partners
Neighborhood Health Plan of RI
United HealthCare of NE

ADDITIONAL INFORMATION

Effective May 1, 1997, eligibility was expanded to include children in families with income up to 250% federal poverty level to age 18. Program has a one month open enrollment period every 12 months. Enrollees are "locked in" from the date of enroll ment. 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.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
None

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service

State conducts general data completeness assessments

Performance Measures

Process Quality
-Cervical cancer screening rate
-Check-ups after delivery
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Complaint Resolution Statistics
-Patient/Member Satisfaction with Access to Care
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SA

RHODE ISLAND
Rite Care

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information on primary languages spoken by beneficiaries
-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

Use of HEDIS
-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continous enrollment
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Consumer Self-Report Data
-Consumer Advisory Committee
-Consumer/Beneficiary Focus Groups
-State-developed Survey

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
-Birch & Davis Health Management Corp.

EQRO Organization
-PRO-like Entity

EQRO Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of 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:
Leslie Martin
Division of Family Services
(803) 898-2565

State Website Address:
http://www.dhhs.state.sc.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
December 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, X-Ray

Allowable PCPs:
-Rural Health Centers (RHCs)
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related

Populations Mandatorily Enrolled:
None

SOUTH CAROLINA
Health Maintenance Organization (HMO)

Populations Mandatory Enrolled with a Sole Source Provider:

None

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
-Blind/Disabled Children and Related Populations

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)
-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

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

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

SOUTH CAROLINA
Health Maintenance Organization (HMO)

Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-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
-Recipient Not on File
-Submitting Provider Not on File

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Frequency of on-going prenatal care
-Initiation of prenatal care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-State minimum reserve requirements

Health Plan/ Provider Characteristics
-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

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

SOUTH CAROLINA
Health Maintenance Organization (HMO)

Consumer Self-Report Data
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
Care
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 of performance improvement projects
-Review of MCO compliance with structural and operational standards established by the State
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

SOUTH CAROLINA
High Risk Channeling Project (HRCP)

CONTACT INFORMATION

State Medicaid Contact:
Leslie Martins, RN
Department of Health and Human Services
803-898-2565

State Website Address:
http://www.dhhs.state.sc.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 1986

Implementation Date:
April 01, 1986

Waiver Expiration Date:
February 11, 2001

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medicaid Fee-For-Service Program - Fee-for-Service

Service Delivery

Included Services:
Ancillary Services based on Individual Circumstances, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Hospice, IE Social Work, Immunization, Inpatient Hospital, Laboratory, Nutrition, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

SOUTH CAROLINA
High Risk Channeling Project (HRCP)

-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-All high-risk pregnant women

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Pregnancy/Newborn Risk Assessment

Agencies with which Medicaid Coordinates the Operation of the Program:
-Department of Health and Environmental Control

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

High Risk Channeling Project (HCRP)

ADDITIONAL INFORMATION

None

SOUTH CAROLINA
Physicians Enhanced Program (PEP)

CONTACT INFORMATION

State Medicaid Contact:
Jonathan Tapley
Department of Physician Services
(803)898-2660

State Website Address:
http://www.dhhs.state.sc.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Alternative Reimbursement Methodology - Partial Capitation

Service Delivery

Included Services:
EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Children and Related

Populations Mandatorily Enrolled:
None

SOUTH CAROLINA
Physicians Enhanced Program (PEP)

Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Physicians Enhanced Program (PEP)

ADDITIONAL INFORMATION

Only physician services are partially capitated for this program. All other services are fee-for-service.

SOUTH DAKOTA
Dental Program

CONTACT INFORMATION

State Medicaid Contact:
Scott Beshara
Office of Medical Services
(605) 773-3495

State Website Address:
http://www.state.sd.us/social/medicaid

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Dental - Limited Benefits) - Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-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

SOUTH DAKOTA
Dental Program

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)
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data
-Contract Standard Compliance
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Encounter Data

Collection: Requirements
-State established standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
None

Collection: Standardized Forms
None

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care

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

SOUTH DAKOTA
Dental Program

Beneficiary Characteristics
None

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Consumer Self-Report Data
None

Care

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

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
June 30, 1993

Implementation Date:
September 01, 1993

Waiver Expiration Date:
September 28, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Laboratory, opthalmology, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Residential Treatment Centers, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

SOUTH DAKOTA
PRIME

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-TITLE XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:

None

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

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

Use of Services/Utilization
None

Providre Characteristics
None

Beneficiary Characteristics
None

Consumer Self-Report Data
-State-developed Survey

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Low birth-weight baby
-Well Child Care/EPSDT

Non-Clinical Topics
None

TENNESSEE
TennCare

CONTACT INFORMATION

State Medicaid Contact:
Mark Reynolds
TennCare
(615)741-0213

State Website Address:
http://www.state.tn.us/tenncare

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
November 18, 1993

Implementation Date:
January 01, 1994

Waiver Expiration Date:
December 31, 2001

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(A)
-1902(a)(13)(C)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(34)
-1902(a)(54)

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(1)(A)
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Eligibility Expansion, IMD

Guaranteed Eligibility:
12 months guaranteed eligibility for children

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Title XIX Medicaid services are covered except Long Term Care and Medicare crossovers., Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists or Gynecologists
-Rural Health Centers (RHCs)
-Public Health Departments and Clinics
-Internists
-Federally Qualified Health Centers (FQHCs)
-Nurse Midwives
-Indian Health Service (IHS) Providers

TENNESSEE
TennCare

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Medically Needy
-Uninsured
-Unisurable

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

PHP (Mental Health and Substance Abuse (MH/SA) - Limited Benefits) -

Service Delivery

Included Services:
Crisis, Detoxification, Inpatient Mental Health Services, Inpatient Substance Abuse Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Abuse Services, Residential Substance Abuse Treatment Programs

Allowable PCPs:
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Indian Health Service (IHS) Providers

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

TENNESSEE
TennCare

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

John Deere/Heritage National Health Plan
Omnicare Health Plan
Premier Behavioral Systems of TN
TN Managed Care Network (ACCESS MED PLUS)
VUMC Care (VHP Community Care)
Memphis Managed Care Corp. (TLC)
Preferred Health Partnership/PHP
Tennessee Behavioral Health, Inc.
Volunteer State Health Plan (Bluecare)
Xantus Health Care

ADDITIONAL INFORMATION

All medically necessary services are provided through the managed care organizations. All mental health and substance abuse services are provided through behavioral health organizations. The State has carved out pharmacy services from the capitation rate from these individuals who are both TennCare enrollees and eligible for Medicare.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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

Collection: Standardized Forms
-HCFA 1500 - the HCFA 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 HCFA approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-apropriate diagnosis/procedure
-Gender-apropriate 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
-Dental services
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Pregnancy Prevention
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Average distance to PCP
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Annual Financial Statements

Health Plan/ Provider Characteristics
-Provider turnover

-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

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

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

Consumer Self-Report Data
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
-Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Coordination of primary and behavioral health care
-Coronary artery disease prevention
-Diabetes management
-Emergency Room service utilization
-Hospital Discharge Planning
-Lead toxicity
-Low birth-weight baby
-Newborn screening for heritable diseases
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Presciption drug abuse
-Sickle cell anemia management
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PHP Standards
-NCQA/National Committee for Quality Assurance Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-First Health

TENNESSEE
TennCare

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys
-Conduct of 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 Department of Health
(512)794-5167

State Website Address:

http://www.tdh.texas.gov/hcf/medicaid.htm

PROGRAM DATA

Program Service Area:
Metropolitan Statistical Areas

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Initial Waiver Approval Date:
September 01, 1994

Implementation Date:
September 01, 1994

Waiver Expiration Date:
September 03, 2000

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

The reimbursement arrangement waiver is described as: LoneSTAR Select I is the program that enables the State of Texas to selectively contract with general acute care hospitals including childrens hospitals for inpatient services. Under selective contracting arrangements, providers must bid a discount from their Medicaid reimbursement rates. Then, the State of Texas accepts or negotiates those bids so that qualified providers may serve the Medicaid population for a period of three years.

TEXAS
Lonestar Select II

CONTACT INFORMATION

State Medicaid Contact:

Doug Odle
Texas Department of Health
(512) 794-5167

State Website Address:

http://www.tdh.state.tx.us/hcf/medicaid.htm

PROGRAM DATA

Program Service Area:
Metropolitan Statistical Areas

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
March 10, 1995

Implementation Date:
March 10, 1995

Waiver Expiration Date:
March 18, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

ADDITIONAL INFORMATION

The reimbursement arrangement waiver is described as: Lonestar Select II is a program that enables the State of Texas to selectively contract with freestanding psychiatric facilities for inpatients services to children. Under Lonestar Select II, providers must bid all inclusive per diem rates for Medicaid reimbursement. The State of Texas then either accepts or negotiates those rates so that providers may serve the under 21 Medicaid population for a period of three years.

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CONTACT INFORMATION

State Medicaid Contact:
Linda Wertz
Health and Human Services Commision
(512) 424-6500

State Website Address:
http://www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
November 01, 1999

Implementation Date:
November 01, 1999

Waiver Expiration Date:
October 31, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Mental Health and Substance Abuse (MH/SA) - Limited Benefits) -

Service Delivery

Included Services:
Assertive Community Treatment Team Services, Crisis, Detoxification, Dual Diagnosis Services, Inpatient Mental Health Services, Inpatient Substance Abuse Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Abuse Services, Residential Substance Abuse Treatment Programs, Targeted Case

Allowable PCPs:
-Not applicable, contractors not required to identify PCP

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

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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 Related populations

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Children in Protective Foster Care
-Individuals Residing Outside of the Service Region
-Individuals Eligible as Medically Needy
-Individuals Receiving Inpatient Medicaid IMD Services
-Qualified Medicare Beneficiaries
-Other Insurance

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Protective and Regulatory Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Magellan Behavioral Health, Inc.

ValueOptions

ADDITIONAL INFORMATION

NorthSTAR originally contracted with both ValueOptions and Magellan Behavioral Health Inc. to provide services to NorthSTAR enrollees. Magellan withdrew from the program as of 9/30/00.

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)

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

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-Performance Measures (see below for details)
-Provider Data

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
None

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Number and types of providers

Use of Services/Utilization
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-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.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
-Behavioral Health Specialty Network
-Languages Spoken (other than English)
-Provider turnover

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Beneficiary Characteristics
None

Use of HEDIS
-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continous enrollment
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Consumer Self-Report Data
-MHSIP survey

Care

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
-Attention Deficit Hyperactivity Disorder
-Coordination of primary and behavioral health care
-Substance Abuse and Pregnancy

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-HCFA's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Texas Health Quality Alliance

EQRO Organization
-PRO-like Entity

EQRO Activities
-Administration or validation of consumer or provider surveys
-Conduct of 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

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STAR

CONTACT INFORMATION

State Medicaid Contact:
Alison Smith
Texas Department of Health
(512)794-6859

State Website Address:
http://www.tdh.texas.gov/hcf/medicaid.htm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
August 01, 1993

Implementation Date:
August 01, 1993

Waiver Expiration Date:
August 31, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Vision, X-Ray

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists

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STAR

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medicare Dual Eligible

Lock-In Provision:
No lock-in

PHP (Medical-only - Limited Benefits) - Capitation

Service Delivery

Included Services:
EPSDT, Family Planning, Hearing, Immunization, Laboratory, 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
-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:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:
None

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

Lock-In Provision:
No lock-in

TEXAS
STAR

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ACCESS - STAR
AmeriHealth
El Paso First (PHP)
HMO Blue - STAR
Methodist Care
Americaid - STAR
Community Health Choice
First Care
JPS STAR Plan
Parkland Community Health Plan

TEXAS
STAR

PCA
Superior Health Plan
Seton Health Plan
Texas Health Network - Birch & Davis (STAR)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-MCO to submit encounter data to the External Quality Review Organization.
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA 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 HCFA approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility

State conducts general data completeness assessments

No

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-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Age-apropriate diagnosis/procedure
-Gender-apropriate diagnosis/procedure

Performance Measures

Process Quality
-Adolescent immunization rate
-Check-ups after delivery
-Depression management
-Diabetes management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SA providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per benificiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of
-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
-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

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire
-Consumer/Beneficiary Focus Groups
-State-developed Survey

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Performance Improvement Projects

Project Requirements
-All MCOs/PHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs/PHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Childhood Immunization
-Coordination of primary and behavioral health care
-Deprssion management
-Diabetes management
-Emergency Room service utilization
-Pre-natal care
-Primary and behavioral health care coordination
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services
-Ratio of PCPs to beneficiaries

Standards/Accreditation

MCO/PHP Standards
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
Care -Texas Health Quality Alliance

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
-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)
-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

Performance Measures

Process Quality
-Check-ups after delivery
-Depression management

Health Status/Outcomes Quality
-Patient satisfaction with care

-Diabetes management
-Provider Data
-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

Access/Availability of Care

-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of mental health providers to number of beneficiaries
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization

-Average number of visits to MH/SA providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SA conditions/1,000 beneficiaries
-Number of home health visits per benificiary
-Number of OB/GYN visits per adult female beneficiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary
-Re-admission rates of MH/SA

Provider Characteristics

-Board Certification
-Languages spoken (other than English)
-Provider turnover

Beneficiary Characteristics

-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM

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 Improvement Projects

Clinical Topics

-Adolescent Immunization
-Childhood Immunization
-Diabetes management
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics

-Availability of language interpretation services
-Children@s access to primary care practitioners

TEXAS
STAR Plus

CONTACT INFORMATION

State Medicaid Contact:
Pam Coleman
Texas Department of Human Services
(512)438-5067

State Website Address:
http://www.hhsc.state.tx.us/starplus/starplus.htm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 01, 1998

Implementation Date:
January 01, 1998

Waiver Expiration Date:
August 31, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Internists
-Physician Assistants
-Nurse Practitioners
-Nurse Midwives

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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

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Substance Abuse, Physician, X-Ray

Allowable PCPs:
-Nurse Midwives
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Poverty Level Pregnant Woman

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Mental Health Agency
-Public Health Agency

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STAR Plus

-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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ACCESS
HMO Blue
Americaid
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

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

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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

-HCFA 1500 - the HCFA 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 HCFA approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

TEXAS
STAR Plus

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Payment
-Provider ID
-Type of Service

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for
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 of 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

UTAH
Choice Of Health Care Delivery

CONTACT INFORMATION

State Medicaid Contact:
Ed Furia
Utah State Health Department
(801)538-6505

State Website Address:
http://www.state.ut.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 23, 1982

Implementation Date:
July 01, 1982

Waiver Expiration Date:
February 16, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Diabetes self-management education, Durable Medical Equipment, Emergency, Emergency Transportation, Enhanced Services to Pregnant Women, EPSDT, ESRD, Family Planning, Hearing, HIV prevention, Home Health, Hospice, Immunization, Inpatient detoxification, Inpatient Hospital, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Private Duty Nursing, Speech Therapy, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

UTAH
Choice Of Health Care Delivery

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-All Other Medicaid Eligibles
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Medically Needy Children and Adults

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)
-Eligibility Period Less Than 3 Months
-Eligibility Period Only Retroactive
-Approved as Exempt

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:
-Maternal and Child Health Agency
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Altius
Healthy U
MedChoice (UnitedHealthcare)
American Family Care
IHC Health Plans Inc.

ADDITIONAL INFORMATION

Mandatory HMO enrollment only in 4 urban counties, unless client requests an exemption and it is approved. Exemptions are only approved if there is reasonable expectation that the client's health will suffer if the client was unable to obtain an exemption. Exemption policy developed to ensure that individuals with special health care needs have access to appropriate care.

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

Use of Collected Data
-Contract Standard Compliance
-Plan Reimbursement

UTAH
Choice Of Health Care Delivery

-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

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to aggregate data submitted by plans
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)

UTAH
Choice Of Health Care Delivery

Beneficiary Characteristics
None

Use of HEDIS
-The State uses ALL of the HEDIS measures listed for Medicaid

-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs/PHPs to follow NCQA specifications

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
Adult Medicaid SSI Questionnaire
Child Medicaid AFDC Questionnaire
Child Medicaid SSI Questionnaire

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
-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 of performance improvement projects
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services

UTAH
Prepaid Mental Health Program

CONTACT INFORMATION

State Medicaid Contact:
Karen Ford
Utah State Health Department
(801)538-6637

State Website Address:
http://www.health.state.ut.us/Medicaid

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
July 01, 1991

Implementation Date:
July 01, 1991

Waiver Expiration Date:
September 28, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Mental Health (MH) - Limited Benefits) - Capitation

Service Delivery

Included Services:
Crisis, Inpatient Mental Health Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Transportation

Contractor Types:
-CMHC Operated Entity (Public)
-County Operated Entity (Public)
-CMHC - some private, some governmental

Allowable PCPs:
-Not Applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care (inpatient services only)
-Medically Needy Children and Adults

UTAH
Prepaid Mental Health Program

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Resident of the Utah State Hospital (IMD) and 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:

-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

Bear River Mental Health
Central Utah Mental Health
Four Corners Mental Health
Valley Mental Health
Weber Mental Health
Central Utah Mental
Davis 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 11 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

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing

UTAH
Prepaid Mental Health Program

Data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Validation: Methods
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Medicaid Eligibility
-Plan enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Continuity of care
-Symptom reduction

Health Status/Outcomes Quality
-Patient satisfaction with care
-Recidivism
-Symptom reduction

Access/Availability of Care
-Average wait time for intake

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net worth
-State minimum reserve requirements

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on age and gender
-Information on primary languages spoken by beneficiaries

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

Consumer Self-Report Data
-State-developed Survey

Performance Improvement Projects

UTAH
Prepaid Mental Health Program

Project Requirements
-MCOs/PHPs are required to conduct a project(s) of their own choosing

Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-State of Utah

EQRO Organization
-In-house

EQRO Activities
-Administration or validation of consumer or provider surveys
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of performance improvement projects
-Validation of performance measures

VERMONT
Vermont Health Access

CONTACT INFORMATION

State Medicaid Contact:
Ann E. Rugg
Vermont Health Access Plan
(802)241-2766

State Website Address:
http://www.dsw.state.vt.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

Initial Waiver Approval Date:
July 28, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2000

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(A)
-1902(a)(13)(C)
-1902(a)(13)(E)
-1902(a)(14)
-1902(a)(23) Freedom of Choice
-1902(a)(30)(A)
-1902(a)(34)

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Eligibility Expansion, Guaranteed Eligibility, IMD

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Indian Health Service (IHS) Providers
-Obstetricians/Gynecologists or Gynecologists
-General Practitioners
-Family Practitioners
-Internists

VERMONT
Vermont Health Access

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Spenddown
-Children who participate in Vermont High Tech Home Care Program
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

PC PLUS

ADDITIONAL INFORMATION

Allowable PCP Specialists: OB/GYNs or GYNs may be approved to be PCPs on a case-by-case basis.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Ombudsman

Use of Collected Data:
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting

VERMONT
Vermont Health Access

-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Performance Measures

Process Quality
-Asthma care
-Depression management
-Diabetes management
-Immunizations for two year olds

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
None

Provider Characteristics
None

Beneficiary Characteristics
None

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire

Performance Improvement Projects

Clinical Topics
-Coordination of primary and behavioral health care
-Deprssion management
-Pharmacy management

Non-Clinical Topics
None

VIRGINIA
Medallion

CONTACT INFORMATION

State Medicaid Contact:
Cheryl Roberts
Department of Medical Assistance Services
(804)786-6147

State Website Address:
http://www.dmas.state.va.us

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 23, 1991

Implementation Date:
March 01, 1992

Waiver Expiration Date:
March 21, 2002

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-Family Practitioners
-General Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Other Specialists Approvd on a Case-by-Case Basis

Enrollment

VIRGINIA
Medallion

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Refugees
-Other Insurance
-Spenddown
-Hospice

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Initial interview with new enrollees
-Reviews claims activity of all new enrollees for special indicators.

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medallion

ADDITIONAL INFORMATION

Medallion PCPs are paid $3 per member per month plus fee-for-service claims reimbursement..

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-On-Site Reviews
-Provider Data

Use of Collected Data:
-Fraud and Abuse
-Health Services Research

VIRGINIA
Medallion II

CONTACT INFORMATION

State Medicaid Contact:
Mary Mitchell
Department of Medical Assistance Services
(804)786-3594

State Website Address:
http://www.dmas.state.va.us

PROGRAM DATA

Program Service Area:
City
County

Initial Waiver Approval Date:
December 18, 1995

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
January 01, 1996

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Waiver Expiration Date:
September 27, 2000

Enrollment Broker:
Yes

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

VIRGINIA
Medallion II

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Poverty Level Pregnant Women
-Hospice

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Initial interview with new enrollees
-Review claims activity of all new enrolless for special indicators.

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Chartered Health Plan
Healthkeepers Plus - Inc.
Healthkeepers Plus - Peninsula
Healthkeepers Plus - Priority
Sentara Family Care
Southern Health Services

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Focused Studies
-On-Site Reviews

Use of Collected Data
-Fraud and Abuse
-Monitor Quality Improvement
-Track Health Service provision

Encounter Data

VIRGINIA
Medallion II

Collection: Requirements
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-HCFA 1500 - the HCFA 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 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-KePro

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Validation of client level data, such as claims and encounters

WASHINGTON
Healthy Options

CONTACT INFORMATION

State Medicaid Contact:
Michael Paulson
Division of Program Support
(360) 725-1641

State Website Address:
http://www.dshs.wa.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 01, 1993

Implementation Date:
October 01, 1993

Waiver Expiration Date:
February 24, 2001

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
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
-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
-Physician Assistants

Enrollment

WASHINGTON
Healthy Options

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

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
-Retroactive Eilgibility

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, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, X-Ray

Allowable PCPs:
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations\
-Pregnant Women and Optional Children

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Retroactive Eligibility

Lock-In Provision:
No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna US Healthcare Of Washington

BHP Plus

WASHINGTON
Healthy Options

Clark United Providers
Group Health
Kaiser
Premera Blue Cross
Community Health Plans of Washington
Healthy Options/PCCM
Northwest Washington Medical Bureau
Qual-Med

ADDITIONAL INFORMATION

Native Americans have the option to enroll in PCCM, MCOs or fee-for service. All Health Options populations must enroll in

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data
-Beneficiary Plan Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

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
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA 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 (HCFA 1450) - (Uniform Billing) - the HCFA 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)

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

WASHINGTON
Healthy Options

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of
care facilities
None
ER, pharmacy, lab, x-ray, dental, vision, etc.)

Health Plan/ Provider Characteristics
-Expenditures by medical category of service (I.e., inpatient,

Beneficiary Characteristics
None

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Consumer Self-Report Data
-CAHPS
  Adult Medicaid SSI Questionnaire
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire
  Chile with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups

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
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Breast cancer treatment
-Childhood Immunization
-Well Child Care/EPSDT

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
-OMPRO and PROWest

WASHINGTON
Healthy Options

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-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

WASHINGTON
Hospital Selective Contracting

CONTACT INFORMATION

State Medicaid Contact:
Dee Hahn
Washington State Medical Assistance Administration
(360) 725-1832

State Website Address:
wws2.wa.gov/dshs/maa

PROGRAM DATA

Program Service Area:
Selective Hospitals

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
March 10, 1988

Implementation Date:
April 01, 1988

Waiver Expiration Date:
December 31, 2000

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Hospital Selective Contracting - Fee-for-Service

Service Delivery

Included Services:
Inpatient Hospital, Outpatient Hospital

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

WASHINGTON
Hospital Selective Contracting

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Pregnant Women and Optional Children

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

ADDITIONAL INFORMATION

All enrollees are auto-assigned exclusively to selected hospitals.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews

Use of Collected Data:
-Program Evaluation

WASHINGTON
Mental Health Services

CONTACT INFORMATION

State Medicaid Contact:
Judy Gosney
Mental Health Divison
(360) 902-0827

State Website Address:
http://www.mhdsql.mhd.dshs.wa.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
April 27, 1993

Implementation Date:
July 01, 1993

Waiver Expiration Date:
November 07, 2001

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Mental Health (MH) - Limited Benefits) - Capitation

Service Delivery

Included Services:
Case Management, Crisis, EPSDT, Inpatient Mental Health Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Psychologists
-Clinical Social Workers
-Other Specialists Approved on a Case-by-Case Basis
-Indian Health Service Providers
-Physician Assistants
-Psychiatrists
-Nurse Practitioners

Contractor Types:
-Regional Authority Operated Entity (Public)

Enrollment

WASHINGTON
Mental Health Services

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Reside in Nursing Facility or ICR/MR
-Other Insurance

Subpopulations Excluded from Otherwise Included Populations:
-American Indians/Alaska Native can at their option disenroll
-Medicare Dual Eligible
-Residents of State-owned institutions
-Eligibles for Tribal Health services who elect not to

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Public Health Agency
-Substance Abuse Agency
-Employment Agency
-Housing Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Chelan/Douglas Regional Support Network
Clark County Regional Support Network
Grays Harbor Regional Support Network
Greater Columbia Regional Support Network
King County Regional Support Network
North Central Washington Regional Support Network
North Sound Regional Support Network
Northeast Washington Regional Support Network
Pierce County Regional Support Network
Southwest Regional Support Network
Spokane County Regional Support Network
The Peninsula Regional Support Network
Thurston/Mason Regional Support Network
Timberland Regional Support Network
Washington State

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 for referral. The contractor acts as the gatekeeper .

WASHINGTON
Mental Health Services
QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PHP Standards (see below for details)
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Measures (see below for details)
-Quality Review Team

Use of Collected Data
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

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
-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SA facility
-Re-admission rates of MH/SA

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
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

Consumer Self-Report Data
-Consumer/Beneficiary Focus Groups
-State-developed Survey

Standards/Accreditation

MCO/PHP Standards
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Does not Apply

EQRO Organization
-State Mental Health Authority

EQRO Activities
-Calculation of performance measures
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

WEST VIRGINIA
Mountain Health Trust

CONTACT INFORMATION

State Medicaid Contact:
Randy Myers
Office of Managed Care, Bureau for Medical Service
(304) 558-5974

State Website Address:
http://www.wvdhhr.org

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
Yes

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 29, 1996

Implementation Date:
September 01, 1996

Waiver Expiration Date:
December 22, 2001

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Obstetricians/Gynecologists or Gynecologists
-Family Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations

WEST VIRGINIA
Mountain Health Trust

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medically Needed

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carelink Health Plan

Health Plan of the Upper Ohio Valley

ADDITIONAL INFORMATION

Dental services include adults only. Transportation in emergencies only. West Virginia operates an Options program with their PCCM program. If the recipient does not voluntarily choose either a health plan or a PCCM provider, the enrollment broker will automatically default the recipient to the health plan.

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)
-Focused Studies
-MCO/PHP Standards (see below for details)
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-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

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized

-Standards to ensure complete, accurate, timely encounter data submission

forms (e.g. HCFA 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

-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers

-UB-92 (HCFA 1450) - (Uniform Billing) - the HCFA approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-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

Access/Availability of Care

-Average distance to PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Days/1000 & Ave Length of Stay for IP Adm, ER Visits, Amb Surgery, Maternity Care, Newborn Care
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per benificiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

WEST VIRGINIA
Mountain Health Trust

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

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

Consumer Self-Report Data
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
-Post-natal Care

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-HCFA'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
-State-Developed/Specified Standards

Accreditation Required for
-None

Accreditation for Deeming
None

EQRO Name
-Delmarva

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of 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

WEST VIRGINIA
Physician Assured Access System

CONTACT INFORMATION

State Medicaid Contact:
Ellen Cannon
Office of Managed Care, Bureau for Medical Service
(304) 558-1707

State Website Address:
http://www.wvdhhr.org

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
August 29, 1991

Implementation Date:
June 01, 1992

Waiver Expiration Date:
January 27, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Most West Virginia Medicaid Services, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-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
-General Surgeons

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

WEST VIRGINIA
Physician Assured Access System

-Foster Care Children

-Section 1931 (AFDC/TANF) Children and Related Populations

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Poverty Level Pregnant Woman
-Other Insurance
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver

Lock-In Provision:

1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Foster Care Children

-Section 1931 (AFDC/TANF) Adults and Related Populations

-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Physician Assured Access System

ADDITIONAL INFORMATION

PAAS program operates solely in counties not covered by Mountain Health Trust program and Options programs.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care
-Check-ups after delivery
-Diabetes management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Well-child care visit rates

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

WEST VIRGINIA
Physician Assured Access System

Access/Availability of Care
-Average distance to primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Claims data reviewed for 4 and 5, but not based on 1000

Provider Characteristics
None

Beneficiary Characteristics
None

Consumer Self-Report Data
-Consumer/Beneficiary Focus Groups
-Contractor developed survey

WISCONSIN
Children Come First (CCF)

CONTACT INFORMATION

State Medicaid Contact:
Angie Dombrowicki
Bureau of Managed Health Care Programs
(608)266-1935

State Website Address:
http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1993

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Mental Health (MH) - Limited Benefits) - Capitation

Service Delivery

Included Services:
Crisis, IMD Services, Inpatient Mental Health Services, Mental Health Outpatient, Mental Health Residential

Allowable PCPs:
-Not Applicable

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

WISCONSIN
Children Come First (CCF)

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:

-Mental Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Dane County Human Services

ADDITIONAL INFORMATION

Due to the nature of the program, which includes a limited segment of services, the program does not designate a primary care provider. Goal to keep recipients with severe emotional disturbances out of institutions; multi-agency approach; key components are clinical case management, crisis services, intensive day treatment, school based mental health.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-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
-Contract Standard Compliance
-Monitor Quality Improvement

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

WISCONSIN
Children Come First (CCF)

between trading partners, such as physicians and suppliers
UB-92(HCFA1450) -(uniform Billing) –the HCFA Approved electronic flat file format for transmitting Institutional billing data between trading partners, such As hospitals, long term care facilities

-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Asthma care
-Dental services
-Diabetes management
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality

-Patient satisfaction with care

Access/Availability of Care

-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization

-Drug Utilization
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

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

Consumer Self-Report Data

-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

WISCONSIN
Children Come First (CCF)

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Medastar

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Calculation of performance measures
-Validation of performance improvement projects
-Validation of performance measures

WISCONSIN
Independent Care (I-Care)

CONTACT INFORMATION

State Medicaid Contact:
Angie Dombrowicki
Bureau of Managed Health Care Programs
(608)266-1935

State Website Address:
http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Other WI Medicaid Services, Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Non-Medicaid Social, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Recreation, Skilled Nursing Facility, Transportation, Vision, Wellness, 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 (I-Care)

Populations Mandatory Enrolled with a Sole Source Provider:

None

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:

-Asks advocacy groups to identify members of these groups
-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:

-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Humana/Wisconsin Health Organization (Voluntary)

ADDITIONAL INFORMATION

Goal to integrate medical and social services; care coordinator in addition to PCP; evaluation by outside firm using interviews, claims data encounter forms.

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
-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

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing

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
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Dental services
-Diabetes management
-Follow-up after hospitalization for mental illness
-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

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics
-Information on primary languages spoken by beneficiaries

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for

WISCONSIN
Independent Care (I-Care)

some or all of the measures
-State Modifies/requires MCOs/PHP to modify some or all NCQA specifications in ways other than continuous enrollment

Consumer Self-Report Data
-State-developed Survey

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)
-Coordination of care for persons with physical disabilities
-Coordination of primary and behavioral health care
-Diabetes management
-Emergency Room service utilization
-Hypertension management
-Primary and behavioral health care coordination
-Smoking prevention and cessation

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
-HCFA's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Medastar

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Calculation of performance measures
-Validation of performance improvement projects
-Validation of performance measures

WISCONSIN
Medicaid HMO Program

CONTACT INFORMATION

State Medicaid Contact:
David Deinham
Bureau of Managed Health Care Programs
(608)267-9555

State Website Address:
http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Yes

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
September 22, 1999

Implementation Date:
August 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Pediatricians
-Family Practitioners
-Internists
-Obstetricians/Gynecologists or Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

WISCONSIN
Medicaid HMO Program

Populations Mandatory Enrolled with a Sole Source Provider:

None

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Residents residing in FFS counties
-Migrant workers

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-TITLE XXI SCHIP
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Atrium Health Plan
Family Health Plan
Group Health Cooperative Of Eau Claire
Humana/Wisconsin Health Organization (Mandatory)
Mercy Care Health Plan
Physicians Plus
Touchpoint Health Plan
Unity Health Plan
Dean Health Plan
Greater Lacrosse Health Plan
Group Health Cooperative Of SC WI
Managed Health Services
Network Health Plan
Security Health Plan
United Health Care
Valley Health Plan

ADDITIONAL INFORMATION

This program was converted from a 1915(b) to a 1932(a).

Enrollment Brokers Vary By County; Summary And Detailed Claim Data Required; HMOs Required To Coordinate With WIC, County Non-MA Programs, Etc.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)

Use of Collected Data

-Contract Standard Compliance
-Monitor Quality Improvement

WISCONSIN
Medicaid HMO Program

-Focused Studies
-Monitoring of MCO/PHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 1500, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCOs/PHPs

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Asthma care
-Dental services
-Diabetes management
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality
-Patient satisfaction with care

WISCONSIN
Medicaid HMO Program

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Drug Utilization
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs/PHPs

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures
-State modifies/requires MCOs/PHPs to modify some or all NCQA specifications in ways other than continous enrollment

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

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)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Coordination of primary and behavioral health care
-Diabetes management
-Emergency Room service utilization
-Hypertension management
-Lead toxicity
-Low birth-weight baby
-Primary and behavioral health care coordination
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics
None

Standards/Accreditation

MCO/PHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Medastar

WISCONSIN
Medicaid HMO Program

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Calculation of performance measures
-Validation of performance improvement projects
-Validation of performance measures

WISCONSIN
WI Partnership 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:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
January 01, 1999

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2002

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(17)
-1902(a)(23) Freedom of Choice
-1902(a)(34)
-1916(a)
-1931(b)

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 Other WI Medicaid Services, Case Management, Durable Medical Equipment, Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Abuse, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Abuse, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Internists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

WISCONSIN
WI Partnership Program

Populations Voluntarily Enrolled:
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these 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
Community Health Partnership
Elder Care Of Dane County - Partnership

ADDITIONAL INFORMATION

Same goals as PACE; nurse practitioners play a key role in linking services; recipients can bring own provider as PCP; external committee evaluation data techniques.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-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

Encounter Data

Collection: Requirements
-HCFA established requirements

Collections: Submission Specifications
None

Collection: Standardized Forms
None

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

WISCONSIN
WI Partnership Program

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

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

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

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

WISCONSIN
WI Partnership Program

MCO/PHP Standards
None

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Medastar

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Calculation of performance measures
-Validation of performance improvement projects
-Validation of performance measures

WISCONSIN
WrapAround Milwaukee (WAM)

CONTACT INFORMATION

State Medicaid Contact:
Angie Dombrowicki
Bureau of Managed Health Care Programs
(608)266-1935

State Website Address:
http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 01, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PHP (Mental Health (MH) - Limited Benefits) - Capitation

Service Delivery

Included Services:
Crisis, IMD Services, Inpatient Mental Health Services, Mental Health Outpatient, Mental Health Residential

Allowable PCPs:
-Not Applicable

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

Populations Mandatory Enrolled with a Sole Source Provider:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program

WISCONSIN
WrapAround Milwaukee (WAM)

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:

-SED children

Agencies with which Medicaid Coordinates the Operation of the Program:

-Mental Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Milwaukee County Human Services

ADDITIONAL INFORMATION

Due to the nature of the program, which includes a limited segment of services, the program does not designate a primary care provider. Goal to keep recipients with severe emotional disturbances out of institutions; multi-agency approach; key compon ents are clinical care case management, crisis services, intensive DT, school based mental health.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-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
-Contract Standard Compliance
-Monitor Quality Improvement

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitons, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. HCFA 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
-HCFA 1500 - the HCFA approved electronic file format for transmitting non-institutional and supplier billing data

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

between trading partners, such as physicians and suppliers
-UB-92 (HCFA 1450) – (Uniform Billing_ - the HCFA approved electronic flat file format for transmitting institutional billing between trading partners, such as hospitals,long term care facilities

-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Asthma care
-Dental services
-Diabetes management
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates

Health Status/Outcomes Quality

-Patient satisfaction with care

Access/Availability of Care

-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization

-Drug Utilization
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

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

Consumer Self-Report Data

-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

Standards/Accreditation

WISCONSIN
WrapAround Milwaukee (WAM)

MCO/PHP Standards
-State-Developed/Specified Standards

Accreditation Required for
None

Accreditation for Deeming
None

EQRO Name
-Medastar

EQRO Organization
-Peer Review Organization (PRO)

EQRO Activities
-Calculation of performance measures
-Validation of performance improvement projects
-Validation of performance measures

WYOMING
Hospital Inpatient Selective Contracting

CONTACT INFORMATION

State Medicaid Contact:
Sharon Kuster
Office of Medicaid
(307) 777-7245

State Website Address:
None

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 01, 1994

Implementation Date:
July 01, 1994

Waiver Expiration Date:
May 31, 2001

Sections of Title XIX Waived:
-1902(a)(13)(A)
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

The reimbursement arrangement waiver is described as: This waiver provides a reimbursement mechanism through selective contracting for NICU Level III, transplants for children <21, and inpatient psychiatric services for children <21. The waiver addr esses EPSDT requirements.

National Summary of State Medicaid Managed Care Programs
Glossary as of June 30, 2000

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.

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.

MCO
Managed Care Organization is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare-Choice organization, a provider sponsored organization or any other private or public organization which meets the requirements of §1902 (w) to provide comprehensive services.

HIO
Health Insuring Organization is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

Section: Service Delivery--Reimbursement Arrangement Terms

Fee-For-Service
The plan or Primary Care Case Manager is paid for providing services to enrollees solely through fee-for-service payments, plus in most cases, a case management fee.

Full Capitation
The plan or Primary Care Case Manager is paid for providing services to enrollees solely through capitation.

Partial Capitation
The plan or Primary Care Case Manager is paid for providing services to enrollees through a combination of capitation and fee-for-service reimbursements.

Section: Quality Activity Terms

Accreditation for Deeming
Some States use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as "deemed compliance" with a standard.

Accreditation for Participation
State requirement that plans must be accredited to participate in the Medicaid managed care program.

Consumer Self-Report Data
Data collected through survey or focus group. Surveys may include Medicaid beneficiaries

currently or previously enrolled in a MCO or PHP. The survey may be conducted by the State or a contractor to the State.

Encounter Data
Detailed data about individual services provided to individual beneficiaries at the point of the beneficiary's interaction with a MCO or PHP institutional or practitioner provider. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims".

Enrollee Hotlines
Toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their MCO/PHP. The people who staff hotlines are knowledgeable about program policies and may play an "intake and triage" role or may assist in resolving the problem.

Focused Studies
State required studies that examine a specific aspect of health care (such as prenatal care) for a defined point in time. These projects are usually based on information extracted from medical records or MCO/PHP administrative data such as enrollment files and encounter /claims data. State staff, EQRO staff, MCO/PHP staff or more than one of these entities may perform such studies at the discretion of the State.

MCO/PHP Standards
These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each MCO/PHP must have in order to participate in the Medicaid program.

Monitoring of MCO/PHP Standards
Activities related to the monitoring of standards that have been set for plan structure, operations, and quality improvement/assurance to determine that standards have been established, implemented, adhered to, etc.

Ombudsman
An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PHP, and the provider (as appropriate) to resolve individual enrollee problems.

On-Site Reviews
Reviews performed on-site at the MCO/PHP health care delivery system sites to assess the physical resources and operational practices in place to deliver health care.

Performance Improvement Projects
Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MCO/PHPs choosing or prescribed by the State.

Performance Measures
Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PHP.

Provider Data
Data collected through a survey or focus group of providers who participate in the Medicaid program and have provided services to enrolled Medicaid beneficiaries. The State or a contractor of the State may conduct survey.

HEDIS Measures from Encounter Data
Health Plan Employer Data and Information Set (HEDIS) measures from encounter data as opposed to having the plans generate HEDIS measures. HEDIS is a collection of performance measures and their definitions produced by the National Committee for Quality Assurance (NCQA).

EQRO
Federal law and regulations require States to use an External Quality Review Organization (EQRO) to review the care provided by capitated managed care entities. EQROs may be Peer Review Organizations (PROs), another entity that meets PRO requirements, or a private accreditation body.