# 2010 NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS PROGRAM DESCRIPTIONS AS OF JULY 1, 2010

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The National Summary of State Medicaid Managed Care Programs is composed annually by the Data and Systems Group (DSG) of the Centers for Medicare & Medicaid Services (CMS). The report provides descriptions of the States' Medicaid managed care programs as of July 1, 2010. The data was collected from State Medicaid Agencies and CMS Regional offices, and submitted for final review to DSG, Family and Children's Health Program Group (FCHPG), and Disabled and Elderly Health Program Group (DEHPG) and CMS Regional offices. Special thanks to Carolyn Lawson and Loan Swisher of DSG for developing the publication and Joseph Del Pilar of DSG for designing the publication.

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## 1915(B) PROGRAMS

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**Additional Data**

# ALABAMA
## Maternity Care Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Nancy Headley
Alabama Medicaid Agency
(334) 242-5684

**State Website Address:**

http://www.medicaid.alabama.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
October 01, 2004

**Implementation Date:**
September 23, 2005

**Waiver Expiration Date:**
December 31, 2012

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### Medical-only PAHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Family Planning, Home Visits, Outpatient Hospital, Physician

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

#### Enrollment

# ALABAMA
## Maternity Care Program

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-American Indian/Alaska Native
-Poverty-Level Pregnant Women
-Refugees
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-SSI over 19 eligibles

**Subpopulations Excluded from Otherwise Included Populations:**
-Illegal aliens
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Department of Human Resources
-Developmental Disabilities Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Maternity Care Program

## ADDITIONAL INFORMATION

Maternity Care primary contractors are reimbursed by a contracted global fee.

## QUALITY ACTIVITIES FOR PAHP

# ALABAMA
## Maternity Care Program

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-On-Site Reviews
-Performance Improvement 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
-Track Health Service provision

**Consumer Self-Report Data:**
-State-developed Survey

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

## Encounter Data

**Collection: Requirements:**
-Must meet normal editing/auditing processes as other claims

**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)

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

**State conducts general data completeness assessments:**
No

## Performance Measures

**Process Quality:**
None

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

**Access/Availability of Care:**
-Access to subcontractors who are 50 miles/50 minutes of recipient

**Use of Services/Utilization:**
-Percentage of women who began prenatal care during first 13 weeks of pregnancy
-Percentage of women who enroll when already pregnant, who begin prenatal care within 6 weeks after enrolling
-Percentage of women with live births who had post-partum visit between 21-56 days after delivery
-Percentage who have recommended number of pre-natal visits per ACOG

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

# ALABAMA
# Maternity Care Program

## Performance Improvement Projects

### Project Requirements:

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

### Clinical Topics:

-Low birth-weight baby
-Pre-natal care
-Smoking prevention and cessation

### Non-Clinical Topics:

-Appeals, grievances and other complaints
-Availability, accessibility & cultural competency of services
-Interpersonal aspects of care

## Standards/Accreditation

### PAHP Standards:

None

### Accreditation Required for Participation:

None

### Non-Duplication Based on Accreditation:

None

# ALABAMA
## Patient 1st

## CONTACT INFORMATION

**State Medicaid Contact:**

Nancy Headley
Alabama Medicaid Agency
(334) 242-5684

**State Website Address:**

http://www.medicaid.alabama.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
12 months guaranteed eligibility for children

**Initial Waiver Approval Date:**
October 01, 2004

**Implementation Date:**
December 01, 2004

**Waiver Expiration Date:**
May 31, 2013

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

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

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Infants of SSI Mothers
-Refugees
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Foster Care Children
-Medicare Dual Eligibles
-Other Insurance
-Poverty Level Pregnant Woman
-Recipient is a lock-in
-Recipient is determined to be medically exempt
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

1 month lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

-Self Referrals
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Developmental Disabilities Agency
-Mental Health Agency
-Public Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Patient 1st

## ADDITIONAL INFORMATION

The 12 months guaranteed eligibility applies to children born to Medicaid eligible mothers and if child remains in mother's home.

# ALABAMA
## Patient 1st

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-Consumer Self-Report Data (see below for details)
-Independent assessment of program impact, access, quality & cost-effectiveness
-Performance Measures (see below for details)
-Provider Data

**Use of Collected Data:**
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
-State-developed Survey

### Performance Measures

**Process Quality:**
-Asthma Related ER Visits
-Covered and Non-covered Days Per 1000
-Emergency room visits
-EPSDT screening rate
-HBA1C test performance
-Office visits per unique enrollee
-Pharmacy utilization

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of patients with PMP vs. referral rate

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

**Use of Services/Utilization:**
-Drug Utilization
-Emergency room visits/1,000 beneficiaries

**Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

# ARKANSAS
## Non-Emergency Transportation

## CONTACT INFORMATION

**State Medicaid Contact:**

Gene Gessow
Medicaid Agency
(501) 682-8292

**State Website Address:**

http://medicaid.state.ar.us

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
December 04, 1997

**Implementation Date:**
March 01, 1998

**Waiver Expiration Date:**
September 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### Transportation PAHP - Risk-based 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:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Breast and Cervical Cancer Prevention and Treatment
-Foster Care Children
-Medically Needy
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women

-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-SOBRA children
-Tax Equity and Fiscal Responsibility Act-Like Demonstration

**Subpopulations Excluded from Otherwise Included Populations:**

-ARKids First-B
-Eligibility only Retroactive
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Special Low Income Beneficiaries
-Tuberculosis
-Women Health (FP)

**Lock-In Provision:**

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

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only
Persons with full Medicaid eligibility

**Medicare Dual Eligibles Excluded:**

QMBs for whom Medicaid pays only the Medicare premium and/or Medicare coinsurance and deductibles
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

-Special Needs individuals or their representatives identify themselves to providers.

**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

Special Needs Children (State defined) are children with special needs due to physical and/or mental illnesses and foster care children who are categorically eligible.

## QUALITY ACTIVITIES FOR PAHP

# ARKANSAS
## Non-Emergency Transportation

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

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

**Consumer Self-Report Data:**
-State-developed Survey

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

## Encounter Data

**Collection: Requirements:**
-Requirements for PAHPs to collect and maintain encounter data
-Standards to ensure complete, accurate, timely encounter 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 PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across PAHPs

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

**State conducts general data completeness assessments:**
Yes

## Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# CALIFORNIA
## Children Services/Sacramento Dental Geographic Managed Care

## CONTACT INFORMATION

**State Medicaid Contact:**

Tanya Homman
Medi-Cal Managed Care Division
(916) 449-5000

**State Website Address:**

http://www.dhcs.ca.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
Health Care Options/Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
August 13, 2003

**Implementation Date:**
August 13, 2003

**Waiver Expiration Date:**
September 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### Dental PAHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Dental

**Allowable PCPs:**
-Dentists

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care/Medically Indigent-Child
-Medicare Dual Eligibles
-Pregnant/Medically Indigent-Adult

**Populations Mandatorily Enrolled:**
-Public Assistance-Family
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Program/Percent/Children

# CALIFORNIA
## Children Services/Sacramento Dental Geographic Managed Care

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligibility Less Than 3 Months
-Long Term Care
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-California Childrens Services

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan-Sacramento
Community Dental Services/Sacramento
Health Net of CA-Dental-Sacramento
Liberty Dental Plan of CA/Sacramento
Western Dental Services-Sacramento

## ADDITIONAL INFORMATION

This waiver operates in conjunction with Section 1932(a) authority for the Two-Plan, San Diego GMC, and Sacramento GMC programs. The 1915(b) waiver provides the additional authority necessary for mandatory enrollment of those populations that would otherwise be excluded from mandatory enrollment in these three models under Section 1932(a). The waiver allows for mandatory enrollment of children receiving services through CCS (the States Title V program for children with special health care needs) and for mandatory enrollment into dental managed care under Sacramento GMC.

## QUALITY ACTIVITIES FOR PAHP

# CALIFORNIA
## Children Services/Sacramento Dental Geographic Managed Care

**State Quality Assessment and Improvement Activities:**
-Encounter Data (see below for details)
-PAHP Standards (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance
-Track Health Service provision

**Consumer Self-Report Data:**
None

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

## Encounter Data

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

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

**Collection: Standardized Forms:**
None

**Validation - Methods:**
-Verify Provider ID with States Provider Master File

**PAHP conducts data accuracy check(s) on specified data elements:**
None
-Provider ID

**State conducts general data completeness assessments:**
No

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
-Number of procedures provided and monthly and yearly unduplicated users

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# CALIFORNIA
# COHS Santa Barbara San Luis Obispo Regional Health Authority

## CONTACT INFORMATION

**State Medicaid Contact:**

Tanya Homman
Medi-Cal Managed Care Division
(916) 449-5000

**State Website Address:**

http://www.dhcs.ca.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
August 31, 1983

**Implementation Date:**
September 01, 1983

**Waiver Expiration Date:**
December 31, 2010

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### HIO - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, Family Planning, Health Education and Counseling, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Rural Health Clinic (RHC), Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

#### Enrollment

# CALIFORNIA
## COHS Santa Barbara San Luis Obispo Regional Health Authority

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Breast and Cervical Cancer Preventive Treatment
-Children with Accelerated Eligibility
-Foster Care Children
-Medi-Cal Eligibles with Share Cost
-Medically Needy
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP (non-State only Healthy Families)

**Subpopulations Excluded from Otherwise Included Populations:**
-CHIP Title XXI (State-only Healthy Families)
-Enrolled in another Medicaid Managed Care program
-Medicare Dual Eligibles

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

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

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Santa Barbara San luis Obispo Regional Health Authority

## ADDITIONAL INFORMATION

# CALIFORNIA
## COHS Santa Barbara San Luis Obispo Regional Health Authority

Operating authority under 1903(m). Authorizes a county operated managed health care program in Santa Barbara and San Luis Obispo Counties. Enrollment is mandatory for all covered aid codes.

## QUALITY ACTIVITIES FOR MCO/HIO

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

### Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Drug Rebate
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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

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

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID

### State conducts general data completeness assessments:
Yes

-Medicaid Eligibility
-Procedure Codes

## Performance Measures

### Process Quality:
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Avoidance of antibiotic treatment in adulats with acute Bronchitis
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Diabetes medication management
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Postpartum care
-Use of imaging studies for low back pain
-Weight assessment and counseling for nutrition and physical activity for children and adolescents
-Well-child care visit rates in 3,4,5, and 6 years of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
-Average distance to PCP

### Use of Services/Utilization:
-Ambulatory care - ambulatory surgery/procedures
-Ambulatory care - emergency department visits
-Ambulatory care - observation room stays
-Ambulatory care - outpatient visits
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Frequency of selected procedures
-Inpatient admissions/1,000 beneficiary

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

### Health Plan/ Provider Characteristics:
-Board Certification

### Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Emergency Room service utilization
-Weight assessment and counseling for nutrition and physical activity for children and adolescents

### Non-Clinical Topics:
None

# CALIFORNIA
# COHS Santa Barbara San Luis Obispo Regional Health Authority

## Standards/Accreditation

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

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Health Services Advisory Group

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# CALIFORNIA
## Health Insuring Organizations (HIO) of California

## CONTACT INFORMATION

**State Medicaid Contact:**

Tanya Homman
Medi-Cal Managed Care Division
(916) 449-5000

**State Website Address:**

http://www.dhcs.ca.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
July 01, 2003

**Implementation Date:**
July 01, 2003

**Waiver Expiration Date:**
June 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### HIO - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

#### Enrollment

# CALIFORNIA
## Health Insuring Organizations (HIO) of California

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Breast and Cervical Cancer Treatment Program
-Children with Accelerated Eligibility
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-CHIP Title XXI (State only Healthy Families)
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

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

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

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Enhanced Alternative Coverage

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Caloptima-Orange

# CALIFORNIA
## Health Insuring Organizations (HIO) of California

Central California Alliance For Health

Partnership Health Plan

## ADDITIONAL INFORMATION

Authorizes county operated managed health care programs in specific counties. This waiver includes California Orange Prevention and Treatment Integrated Medical Assistance (CalOPTIMA) (Orange County), Central California Alliance for Health (Santa Cruz, Merced & Monterey counties), and Patrnership Health Plan of California (Solano, Sonoma, Napa, & Yolo counties). Enrollment is mandatory for all covered aid codes. These entities have special waiver authority under OBRA 1990. In Yolo County, a small health plan, Sutter Senior Care, that serves a limited number of ZIP codes, coexists in a county with Partnership Health Plan. Not all services are available through the HIO in all counties.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

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

### Use of Collected Data:

-Contract Standard Compliance
-Data Mining
-Drug Rebate
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved

### Validation - Methods:

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

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

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Avoidance of antibiotic treatment in adults with acute Bronchitis
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Diabetes medication management
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Postpartum care
-Use of imaging studies for low back pain
-Weight assessment & counseling for nutrition & physical activity for children & adolescents
-Well-child care visit rates in 3,4,5, and 6 years of life

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

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

**Use of Services/Utilization:**
-Ambulatory Care - Ambulatory surgery/procedures
-Ambulatory care - emergency department visits
-Ambulatory care - Observation room stays
-Ambulatory care - outpatient visits
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Frequency of selected procedures
-Inpatient admissions/1,000 beneficiary

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

**Health Plan/ Provider Characteristics:**
-Board Certification

**Beneficiary Characteristics:**
-Information on primary languages spoken by beneficiaries

**Performance Measures - Others:**
None

## Performance Improvement Projects

# CALIFORNIA
## Health Insuring Organizations (HIO) of California

**Project Requirements:**

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

**Clinical Topics:**

-Appropriate treatment for children with Upper Respiratory Infection
-Emergency Room service utilization
-Improving care & reducing acute readmissions for peple with COPD
-Improving effectiveness of case management

**Non-Clinical Topics:**

None

## Standards/Accreditation

**MCO Standards:**

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

**Accreditation Required for Participation:**

None

**Non-Duplication Based on Accreditation:**

None

**EQRO Name:**

-Health Services Advisory Group

**EQRO Organization:**

-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**

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

**EQRO Optional Activities:**

-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

**Implementation of P4P:**

The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**

Not Applicable

**Population Categories Included:**

Not Applicable

**Rewards Model:**

Not Applicable

**Clinical Conditions:**

Not Applicable

**Measurement of Improved Performance:**

Not Applicable

**Initial Year of Reward:**

Not Applicable

**Evaluation Component:**

Not Applicable

**Member Incentives:**

Not Applicable

# CALIFORNIA
## Health Plan of San Mateo

## CONTACT INFORMATION

**State Medicaid Contact:**

Tanya Homman
Medi-Cal Managed Care Division
(916) 449-5000

**State Website Address:**

http://www.dhcs.ca.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
November 30, 1987

**Implementation Date:**
December 01, 1987

**Waiver Expiration Date:**
September 30, 2012

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

#### Enrollment

**Populations Voluntarily Enrolled:**
None

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

-Breast Cervical Cancer Preventive treatment
-Children with Accelerated Eligiblity
-Foster Care Children
-Medi-Cal Eligibles with Share Cost
-Medically Needy
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP (non-State only Healthy Families)

**Subpopulations Excluded from Otherwise Included Populations:**

-CHIP Title XXI Children (State only Healthy Families)
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

**Lock-In Provision:**

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

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

No

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Plan of San Mateo

# CALIFORNIA
## Health Plan of San Mateo

## ADDITIONAL INFORMATION

Health Plan of San Mateo has special waiver authority under COBRA 1985. MCO/COHS is a County Organized Health System. Waiver authorizes a county operated managed health care program in San Mateo County. Enrollment is mandatory for all covered aid codes.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

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

### Use of Collected Data:

-Contract Standard Compliance
-Data Mining
-Drug rebate
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:

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

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Avoidance of antibiotic treatment in adults with acute Bronchitis
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Diabetes medication management
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Postpartum care
-Use of imaging studies for low back pain
-Weight assessment and counseling for nutrition and physical activity for children and adolescents
-Well-child care visit rates in 3,4,5, and 6 years of life

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

**Access/Availability of Care:**
-Average distance to PCP

**Use of Services/Utilization:**
-Ambulatory care - Ambulatory surgery/procedures
-Ambulatory care - emergency department visits
-Ambulatory care - observation room stays
-Ambulatory care - outpatient visits
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Frequency of selected procedures
-Inpatient admissions/1,000 beneficiary

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

**Health Plan/ Provider Characteristics:**
-Board Certification

**Beneficiary Characteristics:**
-Information on primary languages spoken by beneficiaries

**Performance Measures - Others:**
None

## Performance Improvement Projects

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

**Clinical Topics:**
-Emergency Room service utilization
-Increasing timeliness of pre-natal care

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

**Non-Clinical Topics:**

None

## Standards/Accreditation

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

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Health Services Advisory Group

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# CALIFORNIA
## Medi-Cal Specialty Mental Health Services Consolidation

## CONTACT INFORMATION

**State Medicaid Contact:**

Dina Kokkos-Gonzales
Department of Health Care Services
(916) 552-9422

**State Website Address:**

http://www.dmh.ca.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:**
March 17, 1995

**Implementation Date:**
March 17, 1995

**Waiver Expiration Date:**
June 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1904(a)(4) Method of Administration

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

## SERVICE DELIVERY

### Mental Health Plans - Fee-for-Service

#### Service Delivery

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

**Contractor Types:**
None

**Allowable PCPs:**
-Not Applicable

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations

-Section 1931 Children and Related Populations
-State-Only Medi-Cal and Emergency Services only populations

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

**Lock-In Provision:**
No lock-in

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

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Medicaid eligibles who meet medical necessity criteria are automatically enrolled.

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

County Mental Health Plans

## ADDITIONAL INFORMATION

All Medicaid eligibles that meet medical necessity criteria 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.

# COLORADO
# Colorado Medicaid Community Mental Health Services Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Marceil Case
Department of Health Care and Financing
(303) 866-3054

**State Website Address:**

http://www.colorado.gov/hcpf

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
October 04, 1993

**Implementation Date:**
July 01, 1995

**Waiver Expiration Date:**
June 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### Mental Health (MH) PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Assertive Community Treatment, Clinic, Case Management, Home Based Services for Children and Adolescents, IMD, Inpatient Mental Health, Intensive Case Management, Medication Management, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Peer Support for Mental Health, Prevention Programs (MH), Psychiatrist, Psychosocial Rehabilitiation, Recovery, School Based

**Contractor Types:**
-Behavioral Health MCO (Private)

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

#### Enrollment

# COLORADO
## Colorado Medicaid Community Mental Health Services Program

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

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

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Department of Behavioral Health
-Developmental Disabilities Agency
-Mental Health Agency
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Behavioral Care
Behavioral Healthcare, Inc.
Colorado Health Partnerships
Foothills Behavioral Health Partners
Northeast Behavioral Health Partnership

## ADDITIONAL INFORMATION

None

# COLORADO
## Colorado Medicaid Community Mental Health Services Program

## QUALITY ACTIVITIES FOR PIHP

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

### Consumer Self-Report Data:
-Mental Health Statistics Improvement Program (MHSIP)
-Youth Services Survey for Families (YSSF)

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

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-HCPF also use the Flat File encounter specification

### Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across PIHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

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

### State conducts general data completeness assessments:
Yes

# COLORADO
# Colorado Medicaid Community Mental Health Services Program

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

**Access/Availability of Care:**
-Penetration Rates

**Use of Services/Utilization:**
-Average length of stay
-Average number of visits to MH/SUD providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Re-admission rates of MH/SUD

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**

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

**Clinical Topics:**

-Coordination of primary and behavioral health care
-Emergency Room service utilization

**Non-Clinical Topics:**

-Improving Use and Documentation of Clinical Guidelines

## Standards/Accreditation

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

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Health Services Advisory Group, Inc

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of PIHP compliance with structural and operational standards established by the State
-Review of PIHP compliance with the BBA (Balanced Budget Act)
-Technical Report
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities**
-Administration or validation of consumer or provider surveys
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of encounter data

# CONNECTICUT
# HUSKY

## CONTACT INFORMATION

**State Medicaid Contact:**

Richard Spencer
State of CT Department of Social Services
(860) 424-5913

**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)(2)
1915(b)(4)

**Enrollment Broker:**
Affiliated Computer Systems

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
July 20, 1995

**Implementation Date:**
July 01, 2009

**Waiver Expiration Date:**
December 31, 2011

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Intermediate Care Facilities, Laboratory, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

#### Enrollment

# CONNECTICUT
## HUSKY

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-American Indian/Alaska Native
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

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

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

## Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## Dental ASO - Fee-for-Service

### Service Delivery

**Included Services:**
Dental

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

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

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

**Lock-In Provision:**
No lock-in

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

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# Mental Health ASO - Fee-for-Service

## Service Delivery

**Included Services:**
Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Outpatient Mental Health, Outpatient Substance Use Disorders

**Allowable PCPs:**
-Not applicable

**Contractor Types:**
None

## Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-American Indian/Alaska Native
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

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

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

## Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## PCCM Provider - Fee-for-Service

### Service Delivery

**Included Services:**
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-American Indian/Alaska Native
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Title CHIP XXI

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

# CONNECTICUT
## HUSKY

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

-Receive client file indicated Title V from Public Health Department
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Developmental Disabilities Agency
-Public Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna Better Health
Benecare
HUSKY Primary Care
Americhoice by United HealthCare
Community Health Network of Connecticut
Value Options

## ADDITIONAL INFORMATION

Mental Health ASO and Dental ASO are strictly Fee-for-Service. Administrative fees are paid to the ASOs.

Children at elevated risk for (biologic or acquired) chronic physical, developmental, behavioral, or emotional conditions and who also require health and related (not educational or recreational) services of a type and amount not usually required by children of the same age.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**

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

**Use of Collected Data:**

-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

**Consumer Self-Report Data:**

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

**Use of HEDIS:**

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

### Encounter Data

**Collection: Requirements:**

-Definition(s) of an encounter (including definitions that may

**Collections: Submission Specifications:**

-Data submission requirements including documentation

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

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

### Collection: Standardized Forms:
None

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

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Child Developmental Screening
-Chlamydia screening rate
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

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

### Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-EPSDT Visit Rates

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

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

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**

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

**Clinical Topics:**

-Adolescent Well Care/EPSDT
-Breast cancer screening (Mammography)
-Diabetes management
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

**Non-Clinical Topics:**

None

## Standards/Accreditation

**MCO Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Mercer

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities:**
-Assessment of MCO information systems
-Calculation of performance measures
-Conduct of performance improvement projects
-On site operations review

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

# CONNECTICUT
## HUSKY

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

## QUALITY ACTIVITIES FOR PCCM

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

**Use of Collected Data:**
-Beneficiary Provider Selection
-Contract Standard Compliance
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
-Disenrollment Survey

### Performance Measures

**Process Quality:**
-Asthma care - medication use

**Health Status/Outcomes Quality:**
-Obesity Monitoring

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
-Emergency room visits/1,000 beneficiaries
-EPSDT Visits
-Inpatient admissions/1,000 beneficiaries

**Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## QUALITY ACTIVITIES FOR OTHER

**Quality Oversight Activities:**
-Other

**Use of Collected Data:**
-other

**Consumer Self-Report Data:**
None

# FLORIDA
## Florida Coordinated Non-Emergency Transportation

## CONTACT INFORMATION

**State Medicaid Contact:**

G. Douglas Harper
Florida Agency for Health Care Administration
(850) 412-4210

**State Website Address:**

http://ahca.myflorida.com

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
June 07, 2001

**Implementation Date:**
November 01, 2004

**Waiver Expiration Date:**
March 31, 2012

**Sections of Title XIX Waived:**
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### Transportation PAHP - Flat Rate Per Ride

#### Service Delivery

**Included Services:**
Non-Emergency Transportation

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

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medically Needy
-Presumptively Eligible Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Populations Mandatorily Enrolled:**
None

-SOBRA Children and Pregnant Women
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrollees in a Medicaid MCO that provides transportation
-Legal Aliens
-Medicaid Beneficiaries enrolled in Medicare-funded MCOs
-Medicaid Beneficiaries that are domiciled or residing in an institution or facility
-Medicaid Beneficiaries who are enrolled in Family Planning Waiver or PACE
-Medicare Dual Eligibles

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these 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:**

-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

The Commission for the Transportation of the Disadvantaged

## ADDITIONAL INFORMATION

The 1915(b) authority is used to selectively contract for non-emergency transportation services with the Commission for the Transportation Disadvantaged. The commission subcontracts with a single community transportation coordinator in each county. The reimbursement arrangement is given in a lump sum, twice a month for non-emergency transportation. This program does not meet the

definition of capitation because the fixed rate is not tied to the number of riders, but rather is a fixed rate over a period of time regardless of the number of riders. Foster Care Children receiving medical care are voluntarily enrolled. Special Needs Children (State defined) are children classified as SSI. Under included populations SOBRA Pregnant Women is different than Presumptively Eligible Pregnant Women (PEPW). SOBRA and PEPW are two different programs. SOBRA is a program for women who are not pregnant. PEPW is for women who may be pregnant, but who have not confirmed their pregnancy yet (ie waiting to see a doctor, etc).

## QUALITY ACTIVITIES FOR PAHP

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

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

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-Not Applicable

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

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

**Collection: Standardized Forms:**
None

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

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

**State conducts general data completeness assessments:**
Yes

### Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# FLORIDA
## Managed Health Care

## CONTACT INFORMATION

**State Medicaid Contact:**

Linda Macdonald
Florida Agency for Health Care Administration
(850) 412-4031

**State Website Address:**

http://ahca.myflorida.com

## 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:**
Automated Health Systems, Inc.

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
January 01, 1990

**Implementation Date:**
October 01, 1992

**Waiver Expiration Date:**
August 31, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### Mental Health (MH) PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Crisis, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Peer Support for Mental Health, Physician (MH), Targeted Case Management

**Contractor Types:**
-Partnership between private managed care and local community MH inc.
-PIHP Subcontracting with local community health providers and an Administrative service

**Allowable PCPs:**
-Not Applicable

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Children in Residential Treatment Facilities
-Eligibles in Residential Group Care
-HIV/AIDS Waiver Enrollees
-Hospice
-Medicaid Eligibles in Residential Commitment Facilities
-Medically Complex Children in CMS Program
-Medically Needy
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Prescribed Pediatric Extended Care Center Residents
-Reside in Nursing Facility or ICF/MR
-Residents in ADM Residential Treatment Facilities
-Share of Cost (Medically Needy Beneficiaries)
-State Hospital Services

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

## Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
No

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## Disease Management PAHP - Non-risk Capitation

### Service Delivery

**Included Services:**
Disease Management

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

### Enrollment

**Populations Voluntarily Enrolled:**
-Foster Care Children

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Children in Residential Treatment Facilities
-Eligibles in Residential Group Care
-Hospice
-Medicaid Eligiblies in Residential Commitment Facilities
-Medically Complex Children in CMS Program
-Medically Needy
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Prescribed Pediatric Extended Care Center Residents
-Reside in Nursing Facility or ICF/MR
-Residents in ADM Residential Treatment Facilities
-Share of Cost (Medically Needy Beneficiaries)
-State Hospital Services

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## PCCM Provider - Fee-for-Service

### Service Delivery

**Included Services:**

Adult Health Screenings, Advanced Registered Nurse Practioner, Ambulatory Surgical, Birth Center, Chiropractic, County Health Department, Durable Medical Equipment, EPSDT, Federally Qualified Health Center (FQHC), Home Health, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Midwive, Obstetrical, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Physician assistant, Podiatry, Respiratory Therapy, Speech Therapy, X-Ray

**Allowable PCPs:**

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

### Enrollment

**Populations Voluntarily Enrolled:**

-Foster Care Children

**Populations Mandatorily Enrolled:**

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-Medicare Dual Eligibles

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

No

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## MCO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

**Included Services:**
Case Management, Community Mental Health, Dental, Durable Medical Equipment, EPSDT, Family Planning, Free Standing Dialysis Centers, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mental Health Targeted Case Management, Occupational Therapy, Outpatient Hospital, Physical Therapy, Respiratory Therapy, Speech Therapy, X-Ray

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

### Enrollment

**Populations Voluntarily Enrolled:**
-Foster Care Children
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in HMO that provides full dental coverage in Miami-Dade county
-Medicaid Recipients Age 21 Years and Older
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (State defined)

**Lock-In Provision:**
12 month lock-in

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

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
No

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## Dental PAHP - Risk-based Capitation

### Service Delivery

**Included Services:**
Dental

**Allowable PCPs:**
-Not Applicable

### Enrollment

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Children in Residential Treatment Facility
-Eligibles in Residential Group Care
-Enrolled in Another Managed Care Program
-HIV/AIDS Waiver Enrollees
-Hospice
-Medicaid Eligibles in Residential Committment Facilities
-Medically Complex Children in CMS Program
-Medically Needy
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Prescribed Pediatric Extended Care Center Residents
-Reside in Nursing Facility or ICF/MR
-Residents in ADM Residential Treatment Facilities
-Retroactive Eligibility
-Share of Cost (Medically Needy Beneficiaries)
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-State Hospital Services

**Lock-In Provision:**
No lock-in

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

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## Shared Savings Model - FFS/Some Risk Capitation

### Service Delivery

**Included Services:**

Ambulatory Surgical Centers, Birth Centers, Child Health Check-up, Chiropratic, Community Mental Health, Crisis, Dental, Dialysis, Durable Medical Equipment, Emergency room, Family Planning, Hearing, Home Health, Immunization, Independent Lab, Inpatient Hospital, Licensed Midwive, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Primary Care Case Management, Speech Therapy, Targeted Case Management, Transplant (Organ and Bone Marrow), Vision, X-Ray

**Allowable PCPs:**

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

### Enrollment

**Populations Voluntarily Enrolled:**

-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-Children in Residential Treatment Facility
-Eligibility Less Than 3 Months
-Eligibles in Residential Group Care
-Enrolled in Another Managed Care Program
-HIV/AIDS Waiver Enrollees
-Hospice
-Medicaid Eligibles in Residential Committment Facilities
-Medically Complex Children in CMS Program
-Medically Needy
-Other Insurance
-Poverty Level Pregnant Woman
-Prescribed Pediatric Extended Care Center Residents
-Reside in Nursing Facility or ICF/MR
-Residents in ADM Residential Treatment Facilities
-Retroactive Eligibility
-Share of Cost (Medically Needy Beneficiaries)
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-State Hospital Services

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**

None

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## Medical-only PAHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

### Service Delivery

**Included Services:**
Adult Health Screenings, Advanced Registered Nurse Practitioner, Ambulatory Surgical, Birth Center, Case Management, Chiropractic, County Health Department, Durable Medical Equipment, EPSDT, Family Planning, FQHCs, Home Health, Immunization, Laboratory, Midwife, Obstetrical, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Physician Assistant, Podiatry, Respiratory Therapy, Speech Therapy, X-Ray

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

### Enrollment

**Populations Voluntarily Enrolled:**
-Foster Care Children

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

# FLORIDA
## 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
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Community-based care providers
-Department of Juvenile Justice
-Education Agency
-Family Safety Program
-Florida Department of Children and families
-Forensic/Corrections System
-Mental Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Health Solutions
Alternative Medicine Integration
Atlantic Dental, Inc.
Citrus Health Care, Inc.
Coventry Health Care of Florida, Inc. d/b/a Buena Vista
Florida Health Partners, Inc.
HealthEase of Florida, Inc.
Hemophilia of the Sunshine State (Lynnfield Drug, Inc.)
Integral Health Plan
Magellan Behavioral Health of Florida
Medica Health Plans of Florida, Inc.
Molina Healthcare of Florida, Inc.
Personal Health Plan
Prestige Health Choice
Public Health Trust of Miami-Dade County
South Florida Community Care Network
UnitedHealthcare of Florida, Inc.
Wellcare of Florida, Inc.
AIDS Healthcare Foundation, Inc.
Amerigroup of Florida, Inc.
Caremark
Community Based Care Partnership, Ltd.
Coventry Health Care of Florida, Inc. d/b/a Vista
Freedom Health Plan, Inc.
HealthierFlorida (Pfizer Health Solutions, Inc.)
Humana Medical Plan, Inc.
Lakeview Center, Inc.
Managed Care of North America
MediPass
North Florida Behavioral Health Partnership
Preferred Medical Plan, Inc.
Public Health Trust of Dade County
Simply Healthcare Plans, Inc.
Sunshine State Health Plan
Universal Health Care, Inc.

## ADDITIONAL INFORMATION

Under the Prestige Health Choice Plan Case Management and Community Mental Health Services are not applicable.

The Disease Management PAHP is specifically for persons with one or more of the following diseases: HIV/AIDS, Sickle Cell disease, Renal disease, Chronic Obstructive Pulmonary Disorder, Congestive Heart Failure, Diabetes, Asthma, and Hypertension. The Disease Management program reimbursement arrangement is per member per month.

PCCM enrollees receive mental health services through a capitated arrangement. Dental and Transportation services are provided at the option of the Plan and the Agency.

The Shared Savings Model is mostly Fee-for-Service but administrative costs and transportation services are risk captitation. Excluded Populations: Under 21 residing in a Nursing Facility or ICF/MR. Community mental health services are provided in area 6 only. Reimbursement is varied throughout the program. Some vendors are paid on a per member per month basis, others are paid on a nurse FTE basis, and some are paid based on contract deliverables.

All elligible children 18 to 20 years of age are mandatory for the prepaid dental health plans.

Quality Activities are not performed under the Medical-only PAHP section of this program.

## QUALITY ACTIVITIES FOR MCO/HIO

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

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

### Consumer Self-Report Data:
-CAHPS
Adult Medicaid AFDC Questionnaire
-Disenrollment Survey
-MCO Member Satisfaction Surveys

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

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent well-care visit rate

### Health Status/Outcomes Quality:
-Controlling High Blood Pressure (CBP)

-Adults Access to Preventive/Ambulatory Health Services (AAP)
-Ambulatory Care
-Annual Dental Visits
-Antidepressant Medication Management (AMM)
-BMI Assessment (ABA)
-Breast Cancer Screening (BCS)
-Cervical Cancer Screening Rate
-Childhood Immunization Status (CIS) - Combo 2 and 3
-Controlling High Blood Pressure (CBP)
-Diabetes management/care
-Follow-up After Hospitalization for Mental Illness
-Follow-up Care for Children Prescribed ADHD Medication (ADD)
-Frequency of HIV Disease Monitoring Lab Tests (CD4 and VL)
-Highly Active Antiretroviral Treatment (HAART)
-HIV-Related Medical Visits (HIVV)
-Immunizations for Adolescents (IMA)
-Lead Screening in Children (LSC)
-Lipid Profile Annually (LPA)
-Mental Health Readmission Rate (RER)
-Mental Health Utilization - Inpatient Intermediate and Ambulatory Services (MPT)
-Number of Enrollees Admitted to State Mental Hospital
-Percentage of Enrollees Participating in Disease Management Program
-Persistence of Beta-Blocker Treatment After Heart Attack (PBH)
-Prenatal and Postpartum Care
-Prenatal Care Frequency (PCF)
-Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blocker (ARB) Therapy (ACE)
-Use of Appropriate Medications for People with Asthma (ASM)
-Well-Child Care Visit Rates and 3, 4, 5, and 6-years of Life
-Well-Child Care Visit Rates in First 15 Months of Life
-Patient satisfaction with care

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Annual Dental Visits (ADV)

### Use of Services/Utilization:
-Adolescent well-care visit (AWC)
-Number of Enrollees admitted to state mental hospital
-Well-Child care visit rates in 3,4,5, and 6 yrs of life
-Well-Child care visit rates in first 15 months of life

### Health Plan Stability/ Financial/Cost of Care:
-Behavioral health Medical Loss Ratio (80/20) -HMO only

### 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

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Breast Cancer Screening
-Child Heath Checkups
-Clinical Health Care Disparities - Blood Lead Screening African American Children
-Follow-up After Discharge From Mental Health Acute Care Facility
-Improving Ambulatory Follow-up Appointments After Discharge from Inpatient Mental Health Treatment
-Improving Annual Dental Visits

-Seven and 30-day Follow-ups for Hospitalization for Mental Health
-Timeliness of Prenatal Care
-Well Child Visits in the First 15 Months of Life - Six or More Visits

### Non-Clinical Topics:

-Behavioral Health Discharge Planning
-ER Utilization
-First Call Resolution
-Improving Member Satisfaction with Customer Service
-Language and Culturally Appropriate Access to Preventive Health Care Services
-Member Balance-Billing
-Member Service Call Answer Timeliness and Call Abandonment Rate
-Quality Assessment and Performance Improvement (QAPI)
-Timeliness of Service

## Standards/Accreditation

### MCO Standards:

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

### Accreditation Required for Participation:

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

### Non-Duplication Based on Accreditation:

None

### EQRO Name:

-Health Services Advisory Group

### EQRO Organization:

-Health Services Advisory Group

### EQRO Mandatory Activities:

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

### EQRO Optional Activities:

-Evaluation of AHCA Quality Strategy
-Focused Studies
-Strategic HEDIS Analysis Reports
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

### Implementation of P4P:

The State HAS NOT implemented a Pay-for-Performance program with the MCO

### Program Payers:

Not Applicable

### Population Categories Included:

Not Applicable

### Rewards Model:

Not Applicable

### Clinical Conditions:

Not Applicable

### Measurement of Improved Performance:

Not Applicable

### Initial Year of Reward:

Not Applicable

### Evaluation Component:

Not Applicable

**Member Incentives:**
Not Applicable

## QUALITY ACTIVITIES FOR PIHP

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

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

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

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

### Encounter Data

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

**Collections: Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-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 PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation

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

**State conducts general data completeness assessments:**
Yes

# FLORIDA
# Managed Health Care

## Performance Measures

### Process Quality:
-Follow-up after hospitalization for mental illness
-Mental Health Readmission Rate
-Mental Health Utilization

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

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

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

### Health Plan Stability/ Financial/Cost of Care:
None

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

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Follow-up within Seven Days after Acute Care Discharge for a Mental Health Diagnosis

### Non-Clinical Topics:
-Decreasing the Time From Claims Receipt to Claims Payment
-FARS/CFARS Submission Rates
-Improvement of Documentation related to Coordination of Care between Mental Health Providers and PCPs within a Prepaid Mental Health Plan
-Improving Access to Care by Reducing Abandoned Call Rate

## Standards/Accreditation

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

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-None

### EQRO Organization:
-Not Applicable

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

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

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Monitoring of PAHP Standards
-PAHP Standards (see below for details)

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

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures

### Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# FLORIDA
## Statewide Inpatient Psychiatric Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Barbara Butler-Moore
Florida Agency for Health Care Administration
(850) 412-4239

**State Website Address:**

http://ahca.myflorida.com

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Solely Reimbursement Arrangement:**
Yes

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
March 23, 1998

**Implementation Date:**
April 01, 1999

**Waiver Expiration Date:**
December 31, 2011

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## ADDITIONAL INFORMATION

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

# INDIANA
## Care Select

## CONTACT INFORMATION

**State Medicaid Contact:**

Sarah Jagger
Office of Medicaid Policy & Planning
(317) 234-5545

**State Website Address:**

http://www.in.gov/fssa/2408.htm

## 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:**
Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
September 26, 2007

**Implementation Date:**
November 01, 2007

**Waiver Expiration Date:**
December 31, 2011

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Food Supplements, FQHC, Hearing, Home Health, Immunization, Infant Formulas, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nutritional Supplements, Occupational Therapy, Organ Transplants, Out-of-state Medical, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Respiratory Therapy, RHC, Smoking Cessation, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians

# INDIANA
## Care Select

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-HCBS Waiver

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Enrolled with Spend Down
-Hospice
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Developmental Disabilities Agency
-Eligibility Agency
-Health Plan
-Mental Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Advantage Health Solutions-Care Select

MDwise-Care Select

## ADDITIONAL INFORMATION

None

# INDIANA
## Care Select

## QUALITY ACTIVITIES FOR PCCM

### Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:
-State-developed Survey

## Performance Measures

### Process Quality:
-Adolescent well care visits, ages 12-21, one or more visits
-Annual dental visit for ages 21-64
-Annual dental visits for ages 3-20
-Asthma Medications, use of appropriate medications
-Breast Cancer Screening for ages 52-69
-Comprehensive diabetes care, LDL-C screening
-ER bounce back measure
-Follow-Up after mental health hospitalization, 7 days
-Inpatient bounce back measure
-Well child visits in the 3rd through 6th years of life, one or more visits

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
-Adult access to preventive/ambulatory health services

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

### Provider Characteristics:
-Languages spoken (other than English)
-Provider turnover

### Beneficiary Characteristics:
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to PCCM

### Performance Measures - Others:
None

## Performance Improvement Projects

### Clinical Topics:
-Adolescent Well Care Visits
-Annual dental visits, for ages 21-64
-Annual dental visits, for ages 3-20
-Asthma management
-Behavioral Health Seven Day Follow-Up
-Breast cancer screening, ages 21-64
-Diabetes: LDL-C Screening
-ER bounce back measure
-Inpatient bounce back measure
-Well child visits, ages 7 througjh 11, one or more vistis
-Well child visitss in the 3rd through 6th years of life, one or more visits

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

# INDIANA
## Hoosier Healthwise (1915(b))

## CONTACT INFORMATION

**State Medicaid Contact:**

Sarah Jagger
Office of Medicaid Policy & Planning
(317) 234-5545

**State Website Address:**

http://www.in.gov/fssa/2408.htm

## 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:**
Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
September 13, 1993

**Implementation Date:**
July 01, 1994

**Waiver Expiration Date:**
December 31, 2011

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Food Supplements, FQHC, Hearing, Home Health, Immunization, Infant Formulas, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nutritional Supplements, Occupational Therapy, Organ Transplants, Out-of-state Medical, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Respiratory Therapy, RHC, Smoking Cessation, Speech Therapy, Transportation, Vision, X-Ray

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

#### Enrollment

# INDIANA
## Hoosier Healthwise (1915(b))

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Presumptively Eligible Pregnant Women
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Hospice
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Uses Health Needs Assessment

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Eligibility Agency
-Enrollment Broker
-Health Plans
-PBM
-State Actuary

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem-Hoosier Healthwise
MDwise-Hoosier Healthwise
Managed Health Services (MHS)-Hoosier Healthwise

## ADDITIONAL INFORMATION

Hoosier Healthwise is authorized by both an 1115(a) Demonstration and a 1915(b) Waiver. The MCHIP and Presumptively Eligible Pregnant Women populations are the only populations still on the 1915(b). The 1115(a) demonstration was established for the Healthy Indiana Plan. The remainder of the Hoosier Healthwise population was placed onto that 1115(a) demonstration for budget neutrality purposes.

## QUALITY ACTIVITIES FOR MCO/HIO

# INDIANA
## Hoosier Healthwise (1915(b))

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

### Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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

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

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-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

# INDIANA
# Hoosier Healthwise (1915(b))

## Performance Measures

### Process Quality:
-Adolescent well-care visit rate
-Annual Monitoring for Persistant Medications
-Antidepressant medication management
-Appropriate Testing and Treatment for COPD
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Depression management/care
-Diabetes Management
-Follow-up after hospitalization for mental illness
-Follow-Up for Children Prescribed ADHD Medication
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Initiation of Prenatal Care
-Lead screening rate
-Use of Imaging Studies for Low Back Pain
-Utilization for Ambulatory, Inpatient, and Mental Health Treatment
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of 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/SUD facility
-Re-admission rates of MH/SUD

### Health Plan Stability/ Financial/Cost of Care:
-Administrative Cost Ratio
-Claims Payable per Member
-Cost per Member
-Days cash on hand
-Days in Claims Receivable
-Days in unpaid claims/claims outstanding
-Equity per member
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Ratio Assets to Liabilities
-Revenue per Member
-State minimum reserve requirements
-Total revenue

### Health Plan/ Provider Characteristics:
-Grievance and Appeal Timeliness
-Languages Spoken (other than English)
-Provider Complaints
-Provider turnover

# INDIANA
## Hoosier Healthwise (1915(b))

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-ADHD Medication Follow-Up: Initiation Phase
-Adolescent Well-Care Visits
-Behavioral Health Seven Day Follow-Up
-Cervical Cancer Screening
-Diabetes-LDL-C, HbA1c, and Eye Exam
-Frequency of ongoing prental care
-Generic dispensing rate
-Medication utlilization rate
-Post-natal Care
-Pre-natal care
-Well child visits in the 3rd through 6th years of life, one or more visits
-Well child visits in the first 15 months of life, six or more visits

### Non-Clinical Topics:
-Program Integrity
-Provider Network Services

## Standards/Accreditation

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

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Burns & Associates

### EQRO Organization:
-Independent Consultant

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

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

## Pay for Performance (P4P)

### Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

### Program Payers:
Medicaid is the only payer

# INDIANA
## Hoosier Healthwise (1915(b))

### Population Categories Included:
A subset of MCO members, defined by beneficiary age
A subset of MCO members, defined by disease and medical condition

### Rewards Model:
Payment incentives/differentials to reward MCOs
Public reporting to reward MCOs
Withholds as an incentive

### Clinical Conditions:
Annual dental visits ages 21-64 (state)
Annual dental visits ages 3-20 (state)
Appropriate use of asthma medications ages 5-56 (HEDIS)
Breast cancer screening (mammogram) for women ages 52-69 (HEDIS)
Comprehensive diabetes care - LDL-C screening
ER bounce back-percentage of ER visits that result in a second ER visit within 30 days (state)
Follow-up after hospitalization to mental health illness within 7 days
Inpatient bounce back-percentage of inpatient stays that result in a second stay within 30 days (state)
Well-Child Visits (3-6 years) - one or more visits
Well-Child Visits for children 7-11 years old (state)

### Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

### Initial Year of Reward:
2008

### Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

### Member Incentives:
Not Applicable

# IOWA
# Iowa Plan For Behavioral Health

## CONTACT INFORMATION

**State Medicaid Contact:**

Dennis Janssen
Department of Human Services
(515) 256-4643

**State Website Address:**

http://www.dhs.state.ia.us

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
December 09, 1998

**Implementation Date:**
January 01, 1999

**Waiver Expiration Date:**
June 30, 2016

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### MH/SUD PIHP - Risk-based Capitation

#### Service Delivery

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

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

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicaid eligibility for persons with disability (MEPD)
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligible for Limited Benefit Package
-Medically Needy with cash spenddown
-Medicare Dual Eligibles
-PACE Enrollees
-Presumptively Eligible
-Reside in State Hospital-School

**Lock-In Provision:**

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

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Public Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Iowa Plan For Behavioral Health

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PIHP

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

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

**Consumer Self-Report Data:**
None

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

## Encounter Data

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

**Collections: Submission Specifications:**
-Guidelines for frequency of 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.)

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

**State conducts general data completeness assessments:**
No

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
-Inpatient Facility Safety Survey
-Outpatient penetration rate

**Use of Services/Utilization:**
-Re-admission rates of MH/SUD

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**

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

**Clinical Topics:**

-Co-Occurring Disorders Services
-Intensive Care Management
-Substance Use Disorders treatment after detoxification service

**Non-Clinical Topics:**

-Cultural Differences in Access to Services

## Standards/Accreditation

**PIHP Standards:**
None

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Iowa Foundation for Medical Care

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

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

# MICHIGAN
## Comprehensive Health Plan

## CONTACT INFORMATION

**State Medicaid Contact:**

Cheryl Bupp
Michigan Department of Community Health
(517) 241-7933

**State Website Address:**

http://www.michigan.gov/mdch

## 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:**
Michigan Enrolls

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
May 30, 1997

**Implementation Date:**
July 01, 1997

**Waiver Expiration Date:**
September 30, 2011

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Health education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Intermittent or Short-term Restorative or Rehab Skilled Nursing Care, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Podiatry, Prosthetics and Orthotics, Speech Therapy, Transplant, Transportation, Vision, X-Ray

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

#### Enrollment

# MICHIGAN
## Comprehensive Health Plan

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Court Wards
-Enrolled in Another Managed Care Program
-Foster Care
-Kosovo Refugees
-Medicare Dual Eligibles
-Other insurance (HMO or PPO only)
-Participate in HCBS Waiver
-Persons enrolled in CSHCS
-Persons without full medicaid coverage, including those in the state medical program or pluscare
-Reside in Nursing Facility or ICF/MR
-Spenddown

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Children who age out of CSHCS are identified to health plans by staff monthly

**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

BlueCaid of Michigan
CareSource of Michigan
Great Lakes Health Plan
Health Plan of Michigan
HealthPlus Partners, Inc.
McLaren Health Plan

Midwest Health Plan
Omnicare Health Plan
Priority Health Government Programs, Inc.
Total Health Care
Molina Healthcare of Michigan
Physicians Health Plan of Mid-Michigan - Family Care
ProCare Health Plan
Upper Peninsula Health Plan

## ADDITIONAL INFORMATION

Outpatient Mental Health services are limited to twenty (20) visits per contract year.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Accreditation for participation, member or applied for membership
-Complaint and Grievance Monitoring
-Compliance Reviews
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-EQR and HEDIS
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Timely and Accurate Provider File Submissions
-Timely and Compliant Claims Reporting

### Use of Collected Data:

-Contract Standard Compliance
-Data Mining
-Health Services Research
-Monitor quality improvement efforts
-Program Evaluation
-Public Reporting/Incentives
-Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:

-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-837 Implementation Guidelines
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-NCPDP Manual
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

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

### Validation - Methods:

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

**MCO/HIO 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
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Bill Type
-National Drug Code
-Place of Service

**State conducts general data completeness assessments:**

Yes

## Performance Measures

**Process Quality:**

-Appropriate testing for children with pharyngitis
-Appropriate treatment for children with URI
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Childhood immunization rates
-Chlamydia screening rates
-Controlling high blood pressure
-Diabetes disease management
-Lead screening rate
-Prenatal and Postpartum care rates
-Tobacco prevention and cessation

**Health Status/Outcomes Quality:**

-Patient satisfaction with care

**Access/Availability of Care:**

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

**Use of Services/Utilization:**

-Adolescent well-care visit rates
-Well-child care visit rates in 3, 4, 5 and 6 years of life
-Well-child care visit rates in first 15 months of life

**Health Plan Stability/ Financial/Cost of Care:**

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

**Performance Measures - Others:**

None

## Performance Improvement Projects

**Project Requirements:**

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

**Clinical Topics:**

-Access to Care Children and Adult
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Childhood obesity
-Diabetes management
-Lead toxicity
-Post-natal Care
-Pre-natal care
-Tobacco prevention and cessation
-Well Child Care/EPSDT

### Non-Clinical Topics:

-Children's access to primary care practitioners
-Health information technology (e.g. state implementation of immunization and other registries, telemedicine initiatives, etc…)
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

## Standards/Accreditation

### MCO Standards:

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

### Accreditation Required for Participation:

-NCQA (National Committee for Quality Assurance)
-URAC

### Non-Duplication Based on Accreditation:

None

### EQRO Name:

-Health Services Advisory Group (HSAG)

### EQRO Organization:

-Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:

-Quality, access and timelines
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of Performance Measures

### EQRO Optional Activities:

-CAHPS - Consumer Survey
-Conduct studies on quality and access that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activites
-Validation of encounter data

## Pay for Performance (P4P)

### Implementation of P4P:

The State has implemented a Pay-for-Performance program with MCO

### Program Payers:

Medicaid is the only payer

### Population Categories Included:

A subset of MCO members, defined by disease and medical condition
Covers all MCO members

### Rewards Model:

Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs

### Clinical Conditions:

Asthma
Blood Lead
Child Immunizations
Diabetes
Perinatal Care
Tobacco Cessation
Well-child visits

### Measurement of Improved Performance:

Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing levels of technology adoption
Assessing patient satisfaction measures
Assessing the adoption of systematic quality improvement processes
Assessing the timely submission of complete and accurate electronic encounter/claims data
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

# MICHIGAN
## Comprehensive Health Plan

**Initial Year of Reward:**
2001

**Evaluation Component:**
The State has conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# MICHIGAN
## Healthy Kids Dental

## CONTACT INFORMATION

**State Medicaid Contact:**

Cheryl Bupp
Michigan Department of Community Health
(517) 241-7933

**State Website Address:**

http://www.michigan.gov/mdch

## 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:**
April 01, 2009

**Implementation Date:**
April 01, 2009

**Waiver Expiration Date:**
March 31, 2011

**Sections of Title XIX Waived:**
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### Dental PAHP - Non-risk Capitation

#### Service Delivery

**Included Services:**
Dental

**Allowable PCPs:**
-Dental Hygenists
-Dentists

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-All Title 19-Eligible Children Under 21

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

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

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Kids Dental

## ADDITIONAL INFORMATION

None

# MINNESOTA
# Consolidated Chemical Dependency Treatment Fund

## CONTACT INFORMATION

**State Medicaid Contact:**

Brian Osberg
Minnesota Department of Human Services
(651) 431-2189

**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:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
January 01, 1998

**Implementation Date:**
January 01, 1998

**Waiver Expiration Date:**
March 31, 2011

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

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

## SERVICE DELIVERY

### County Case Manager - Fee-for-Service

#### Service Delivery

**Included Services:**
Extended Rehabilitation (Extended Care), Inpatient Substance Use Disorders, Outpatient Substance Use Disorders, Transitional Rehabilitation (Halfway House)

**Allowable PCPs:**
-Not Applicable

#### Enrollment

**Populations Voluntarily Enrolled:**
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Special Needs Children (BBA defined)

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Foster Care Children
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

# MINNESOTA
## Consolidated Chemical Dependency Treatment Fund

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

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

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

none

## ADDITIONAL INFORMATION

All Medicaid recipients are eligible to participate in this program.

# MINNESOTA
# Minnesota 1915(b)(4) Case Management Waiver

## CONTACT INFORMATION

**State Medicaid Contact:**

Brian Osberg
Minnesota Department of Human Services
(651) 431-2189

**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)(4)

**Solely Reimbursement Arrangement:**
Yes

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
December 28, 2006

**Implementation Date:**
January 01, 2007

**Waiver Expiration Date:**
December 31, 2010

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

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

## ADDITIONAL INFORMATION

This waiver applies to recipients who receive case management services paid fee-for-service under a 1915(c) Home and Community Based Services waiver. 1915(b)(4) authority is used to limit case management providers to county and tribal entities.

# MISSOURI
# MO HealthNet Managed Care/1915b

## CONTACT INFORMATION

**State Medicaid Contact:**

Shelley Farris
Department of Social Services, MO HealthNet Division
(573) 526-4274

**State Website Address:**

http://www.dss.mo.gov

## PROGRAM DATA

**Program Service Area:**
City
County

**Initial Waiver Approval Date:**
October 01, 1995

**Operating Authority:**
1915(b) - Waiver Program

**Implementation Date:**
September 01, 1995

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

**Waiver Expiration Date:**
June 30, 2012

**Enrollment Broker:**
Infocrossing HealthCare Services

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Adult Day Care, Ambulatory Surgical Care, Case Management, Comprehensive Day Rehabilitation, Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, FQHC, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Physician, Prenatal Case Management, RHC, Transportation, Vision, X-Ray

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

# MISSOURI
# MO HealthNet Managed Care/1915b

## Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Autism Waiver participants
-Children in the Legal Custody of Department of Social Services
-Developmentally Disabled (DD) Waiver participants
-Foster Care Children
-MO HealthNet for Pregnant Women
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Aid to the Blind and Blind Pension Individuals
-AIDS Waiver program participants
-Breast and Cervical Cancer Control Project (BCCCP)
-Children with Developmental Disabilities Program
-Enrolled in Another Managed Care Program
-Individuals eligible under Voluntary Placement Agreement for Children
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Permanently and totally disabled individuals
-Presumptive Eligibility for Children
-Presumptive Eligibility Program for Pregnant Women
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

## Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Data Match with Other State Agencies
-Health Risk Assessment
-Helpline
-MCO uses ER Encounters
-MCOs use Drug Usage
-MCOs use Hospital Admissions
-MCOs use Hospital Encounters
-Reviews grievances and appeals to identify members of

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Other State Agencies as necessary
-Public Health Agency
-Social Security Administration

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Advantage Plus of Kansas City
Harmony Health Plan of Missouri
Missouri Care
Childrens Mercy Family Health Partners
HealthCare USA
Molina Healthcare of Missouri

## ADDITIONAL INFORMATION

PCP Clinics can include FQHCs/RHCs. Vision services for members 21 and over are limited to one eye examination every two years, services related to trauma or treatment of disease/medical condition, and one pair of eyeglasses every two years. Vision services for pregnant women 21 and over are limited to one eye examination per year, services related to trauma or treatment of disease/medical condition, and one pair of eyeglasses per year. Dental services for members 21 and older are limited to treatment of trauma to the mouth, jaw, teeth or contiguous sites as a result of injury or services when the absence of dental treatment would adversely affect a pre-existing medical condition. Dental services for pregnant women 21 and older are limited to dentures and treatment of trauma to the mouth, jaw, teeth or contiguous sites as a result of injury and all other Medicaid State Plan dental services for pregnant members with ME Codes 18, 43, 44, 45, and 61. Medicaid eligibles in the included populations who are receiving Supplemental Security Income (SSI), who meet the SSI medical disability definition, or who receive adoption subsidy may choose to voluntarily disenroll from the MO HealthNet Managed Care Program at any time. Enrollment is mandatory for special needs children but individuals may request to opt out. HealthCare USA, Missouri Care Health Plan, and Molina Healthcare of Missouri health plans participate in Eastern, Central, and Western Regions. Blue-Advantage Plus of Kansas City does not serve Bates, Cedar, Polk, and Vernon counties. MO is a 209(b) State and has no specific eligibility categories for the special needs populations. Advocates for Family Health is an ombudsman service serving the Eastern, Central, and Western regions. Legal Services of Eastern Missouri serves the following counties/city: Franklin, Jefferson, Lincoln, Macon, Madison, Marion, Monroe, Montgomery, Perry, Pike, Ralls, Shelby, St. Charles, St. Francois, St. Louis, Ste. Genevieve, Warren, Washington, and St. Louis City. Legal Aid of Western Missouri serves the following counties: Bates, Benton, Camden, Cass, Clay, Henry, Jackson, Johnson, Lafayette, Linn, Morgan, Pettis, Platte, Ray, Saline, St. Clair, and Vernon. Mid Missouri Legal Services serves the following counties: Audrain, Boone, Callaway, Chariton, Cole, Cooper, Howard, Miller, Moniteau, Osage, and Randolph. Legal Services of Southern Missouri serves the following counties: Cedar, Gasconade, Laclede, Maries, Phelps, Polk, and Pulaski.

Individuals with special health care needs include those with needs due to physical and/or mental illnesses, foster care children, homeless individuals, individuals with serious and persistent mental illness and/or substance abuse, and individuals who are disabled or chronically ill with developmental or physical disabilities.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:

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

### Consumer Self-Report Data:
-CAHPS
Child Medicaid AFDC Questionnaire

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

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

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

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

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Additional Payments
-Admission Date
-Amount Paid
-Capitation Indicator
-Charges
-Hospital EIN (Inpatient)
-Patient Status
-Place of Service
-Rendering Provider ID
-Statement From Date
-Statement Through Date
-Type of Admission
-Type of Bill
-Units of Service

### State conducts general data completeness assessments:
Yes

## Performance Measures

# MISSOURI
## MO HealthNet Managed Care/1915b

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Ambulatory Care
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-Chlamdyia screening in women
-Dental services
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Mental Health Utilization
-Postpartum Care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain 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 dental providers to beneficiaries
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Emergency room visits/1,000 beneficiaries under the age of 19
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Number of PCP visits per beneficiary
-Re-admission rates of MH/SUD

### Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Missouri Department of Insurance, Financial Institutions, and Professional Registration monitors and tracks Health Plan Stability/Financial/Cost of Care

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

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

### Performance Measures - Others:
-Effectiveness of Care
-Satisfaction with Experience of Care

## Performance Improvement Projects

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

### Clinical Topics:
-Adolescent Well Care/EPSDT
-Asthma management
-Cervical Cancer Screening
-Cesarean Wound Infection
-Chlamydia
-Dental Utilization
-Emergency Room service utilization
-Hospital Readmission
-Obesity
-Perinatal Care
-Seven and thirty day follow-up after behavioral health admission
-Women, Infant, and Children Collaboration

### Non-Clinical Topics:
-Encounter acceptance rates
-Grievance/Appeals
-Improved Medical Record Documentation
-Member Satisfaction

# MISSOURI
# MO HealthNet Managed Care/1915b

## Standards/Accreditation

**MCO Standards:**
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
-NCQA (National Committee for Quality Assurance)

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Behavioral Health Concepts (BHC)

**EQRO Organization:**
-QIO-like entity

**EQRO Mandatory Activities:**
-Encounter Data Validation
-Medical Record Validation
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Assessment of MCO information systems
-Calculation of performance measures
-Conduct of performance improvement projects
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by beneficiary age

**Rewards Model:**
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
State measures MCO achievement in reaching established standards of outcome measures

**Initial Year of Reward:**
2001

**Evaluation Component:**
The State has conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# MONTANA
## Passport to Health

## CONTACT INFORMATION

**State Medicaid Contact:**

Nancy Wikle
Department of Health and Human Services
(406) 444-1834

**State Website Address:**

http://www.medicaid.mt.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
Affiliated Computer Services, Inc.

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
1 month guaranteed eligibility

**Initial Waiver Approval Date:**
August 31, 1993

**Implementation Date:**
January 01, 1994

**Waiver Expiration Date:**
March 31, 2012

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Dental, Dialysis, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Home Infusion Therapy, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

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

# MONTANA
# Passport to Health

## Enrollment

**Populations Voluntarily Enrolled:**
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Team Care
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Clients who cannot find a PCP willing to provide case management.
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medically Needy
-Medicare Dual Eligibles
-Only Retroactive Eligibility
-Participate in HCBS Waiver
-Resides in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Subsidized Adoption

**Lock-In Provision:**
No lock-in

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

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

## Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## Nurse First- Selective Contracting - Fee-for-Service

### Service Delivery

**Included Services:**
Nurse Advice Line

**Allowable PCPs:**
-Not Applicable

### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Team Care
-Title XXI CHIP

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Subsidized Adoption

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

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## Enhanced PCCM - Fee-for-Service

### Service Delivery

**Included Services:**
Case Management

**Allowable PCPs:**
-Federally Qualified Health Centers (FQHCs)
-Tribal Health Centers

### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

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

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Improvement Program

Passport to Health

## ADDITIONAL INFORMATION

Nurse First - Nurse Advice Line (sub program of Passport) is under waiver for Selective Contracting, is fee for service reimbursement and a voluntary program for recepients.

Health Improvement Program - an enhanced primary care case management program offers clinical case managment for high risk, high cost recepients, a per member per month payment and is a voluntary program for recepients.

## QUALITY ACTIVITIES FOR PCCM

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

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

### Consumer Self-Report Data:
-State-developed Survey

### Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Appropriate treatment for children with Upper Respiratory Infection (URI)
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of primary care case managers to beneficiaries

### Use of Services/Utilization:
None

### Provider Characteristics:
None

### Beneficiary Characteristics:
-Disenrollment rate

-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to PCCM

**Performance Measures - Others:**
None

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

## CONTACT INFORMATION

**State Medicaid Contact:**

Heather Leschinsky
Nebraska Medicaid
(402) 471-9337

**State Website Address:**

http://www.dhhs.ne.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
The Medicaid Enrollment Center

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
June 05, 1995

**Implementation Date:**
July 01, 1995

**Waiver Expiration Date:**
June 30, 2012

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness - MCO/PCCM only
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, X-Ray

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

#### Enrollment

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

**Populations Voluntarily Enrolled:**
None

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

**Subpopulations Excluded from Otherwise Included Populations:**
-Children with disabilities receiving in-home services
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Clients Participating in the State Disability Program
-Clients Participating in the Subsidized Adoption Program
-Clients receiving Medicaid Hospice Services
-Clients with Excess Income
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Presumptive Eligibles
-Reside in Nursing Facility or ICF/MR
-Retroactively Eligible
-Transplant Recipients

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

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

## MCO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

**Included Services:**
Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

### Enrollment

**Populations Voluntarily Enrolled:**
None

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

**Subpopulations Excluded from Otherwise Included Populations:**
-Children with disabilities receiving in-home services
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Clients Participating in the State Disability Program
-Clients Participating in the Subsidized Adoption Program
-Clients receiving Medicaid Hospice Services
-Clients with Excess Income
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Presumptive Eligibility
-Reside in Nursing Facility or ICF/MR
-Retroactively Eligible
-Transplant Recipients

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

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

### Service Delivery

**Included Services:**
Adult Substance Abuse Treatment, Client Assistance Program, Consultative, Crisis Response, Crisis Stabilization, Educational Activity, Enhanced Treatment Group Home, Home Health RN, Individualized Rehabilitative, Inpatient Hospital, Inpatient Mental Health, Intensive Case Management, Intensive Outpatient, Laboratory, Native American MH/SA, Outpatient Hospital, Outpatient Mental Health, Physician, Psychiatric Nursing, Respite Care, Transportation, Treatment Crisis Intervention, X-Ray

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

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Special Needs Children (State defined)
-Title XXI CHIP

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

**Lock-In Provision:**
12 month lock-in

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

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

**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:**
-Title V Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Magellan Behavioral Health
Primary Care Plus
Share Advantage

## ADDITIONAL INFORMATION

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

MCO and PCCM operates county wide. SPCM operates statewide. The children with Special Health Care Needs (CSHCN) or American Indians/Alaskan Natives (AI/AN) are the only two groups enrolled into the MCO/PCCM program through 1915(b) authority.

Children under 19 years of age who are-1) Eligible for SSI under title XVI; 2) In foster care or other out-of-state home placement; 3) Receiving foster care or adoption assistance; or 4) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

**Use of Collected Data:**
-Data Mining
-Fraud and Abuse
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
-CAHPS
Adult Medicaid AFDC Questionnaire

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

### Encounter Data

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

**Collections: Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Encounters to be submitted based upon national

standardized forms (e.g. NCPDP, ASC X12 837)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

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

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

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

**State conducts general data completeness assessments:**
No

## Performance Measures

**Process Quality:**
-Immunizations for two year olds
-Well-child care visit rates in first 15 months of life

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
None

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

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

**Clinical Topics:**
-Childhood Immunization
-Diabetes management
-Pre-natal care
-Well Child Care/EPSDT

**Non-Clinical Topics:**
None

## Standards/Accreditation

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

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

**Non-Duplication Based on Accreditation:**
-NCQA (National Committee for Quality Assurance)

**EQRO Name:**
-Island Peer Review Organization (IPRO)

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities:**
None

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# NEW JERSEY
## NJ FamilyCare - 1915(b)

## CONTACT INFORMATION

**State Medicaid Contact:**

Karen Brodsky
Office of Managed Health Care
(609) 588-2705

**State Website Address:**

http://www.state.nj.us/humanservices/dmahs/index.html

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
Affiliated Computer Services, Incorporated (ACS)

**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:**
March 31, 2013

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Audiology, Chiropractor, Dental, Durable Medical Equipment, Emergency Medical Care, EPSDT, Family Planning, Hearing Aid Service, Home Health, Hospice, Immunization, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medical Supplies, Optical Appliances, Optometry, Organ Transplants, Outpatient Hospitals, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Podiatry, Post-acute Care, Preventive Health Care, Counseling, and Health Prevention, Prosthetics, Orthotics, Rehabilitation and Special Hospitals, Transportation, Vision, X-Ray

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

#### Enrollment

# NEW JERSEY
## NJ FamilyCare - 1915(b)

**Populations Voluntarily Enrolled:**
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Non Duals DDD/CCW children <19
-Special Needs Children (BBA defined)

**Subpopulations Excluded from Otherwise Included Populations:**
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Full-time students attending school but resides outside the country
-Individuals in out-of-state placements
-Individuals institutionalized in an inpatient psychiatric facility
-Individuals with eligibility period that is only retroactive
-Medically needy and presumptive eligibility beneficiaries
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI
SLMB Plus
Medicaid-only

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Self-Referral
-Surveys medical needs of enrollee to identify members of these groups
-Use of Data Mining
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Developmental Disabilities Agency
-Division of Youth and Family Services Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of New Jersey, Inc.

# NEW JERSEY
## NJ FamilyCare - 1915(b)

AMERIGROUP New Jersey, Inc.

Healthfirst Health Plan of New Jersey, Inc.

Horizon NJ Health

## ADDITIONAL INFORMATION

Lock-in Period: 12-month lock-in is for AFDC/TANF and Title XXI population. There is no lock-in for SSI, Aged, Blind, Disabled, DDD or Division of Youth and Family Services (DYFS) populations.

Populations Excluded: Those that participate in HCBS Waiver except DDD/CCW non-duals. Also, those enrolled in another managed care program without Department of Human Services contract.

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## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Accreditation for Participation
-Appointment Availability Studies
-Care Management
-Consumer Self-Report Data (see below for details)
-Data Analysis
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Geographic Mapping
-Independent Assessment
-MCO Marketing Material Approval Requirement
-Medical and Dental Provider Spot Checks
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Utilization Review

### Use of Collected Data:

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

### Consumer Self-Report Data:

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

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

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

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

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical Cancer Screening
-Check-ups after delivery
-Childhood Immunizations
-Comprehensive Diabetes Care
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Quality and utilization of dental services
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

### Health Status/Outcomes Quality:
-Children with Special Needs Focused Study including DYFS Children
-EPSDT Quality Study/Dental and Lead

### Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries
-Ratio of pharmacies to number of beneficiaries

### Use of Services/Utilization:
-Emergency room visits/1,000 beneficiaries
-Inpatient days per 1000 members
-Percentage of beneficiaries with at least one dental visit
-Percentage of Children who received one or more visits with a PCP during the measurement year
-Percentage of enrollees who receive appropriate immunizations
-Percentage of enrollees who received a blood lead test
-Percentage of enrollees who received one or more dental services during the measurement year
-Percentage of enrollees with one or more emergency room visit
-Percentage of enrollees with one or more inpatient admissions
-Pharmacy services per member
-Physician visits per 1000 members

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

### Health Plan/ Provider Characteristics:
None

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs

### Performance Measures - Others:
-EPSDT Performance
-Lead Screening

## Performance Improvement Projects

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

### Clinical Topics:
-Adolescent Well Care/EPSDT
-Birth Outcomes
-Child/Adolescent Dental Screening and Services
-Lead Screenings
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

### Non-Clinical Topics:
-Children's access to primary care practitioners
-Encounter Data Improvement
-Health information technology (e.g. state implementation of immunization and other registries, telemedicine initiatives, etc…)

## Standards/Accreditation

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

### Accreditation Required for Participation:
-Department of Banking and Insurance

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Michigan Peer Review Organization (MPRO)

### EQRO Organization:
-Quality Improvement Organization (QIO)

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

### EQRO Optional Activities:
-Calculation of performance measures
-Conduct studies on access that focus on a particular aspect of clinical and non-clinical services
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Medical Record review
-Technical assistance to MCOs to assist them in conducting quality improvement activities

## Pay for Performance (P4P)

# NEW JERSEY
## NJ FamilyCare - 1915(b)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# NEW MEXICO
# NEW MEXICO SALUD!

## CONTACT INFORMATION

**State Medicaid Contact:**

Paula McGee
NM HSD/Medical Assistance Division
(505) 827-6234

**State Website Address:**

http://www.state.nm.us/hsd/mad/salud.htm

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
May 13, 1997

**Implementation Date:**
July 01, 1997

**Waiver Expiration Date:**
June 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Ambulatory Surgical, Anesthesia, Case Management, Dental, Dialysis, Durable Medical Equipment and Medical Supplies, EPSDT, EPSDT Private Duty Nursing, Family Planning, Federally Qualified Health Center, Hearing and Audiology, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Medical Providers, Midwife, Nutritional, Occupational Therapy, Outpatient Hospital, Personal Care - EPSDT, Pharmacy, Physical Therapy, Physician, Podiatry, Pregnancy Termination, Prosthetics and Orthotics, Rehabilitation, Reproductive Health, Rural Health Clinic, School Based, Speech Therapy, Telehealth, Transplant, Transportation, Vision, Xray- Diagnostic imaging and therapeutic radiology

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Gerontologists
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives, certified
-Nurse Practioners, certified
-Obstetricans/Gynecologists or Gynecologists
-Other Providers who meet the MCO credentialing requirements for PCP
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Primary Care Teams at Teaching Facilities
-Rural Health Clinics (RHCs)

# NEW MEXICO
## NEW MEXICO SALUD!

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations unless also covered by Medicare.
-Blind/Disabled Adults and Related Populations unless covered by Medicare or under CoLTS Waiver
-Blind/Disabled Children and Related Populations unless covered by Medicare or under CoLTS Waiver
-Foster Care Children except when recipient is out-of-state placement
-Home and Community Based Waiver except for D&E waiver or approved for MiVia waiver due to brain inju
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-American Indian/Alaska Native (may opt in to Salud)
-Children in Out-of-State Foster Care or Adoption Placement
-Clients approved for Adult Personal Care Options Program
-Clients eligible for State Coverage
-Clients in Breast and Cervical Cancer Program
-Clients in Family Planning Waiver
-Clients in Health Insurance Premium Payment Program
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS waiver if participating in the D&E Waiver or the MiVia Waiver due to brain injury
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Individuals identified by service utilization, clinical assessment, or diagnosis
-Referal by family, a public, or community program

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging and Long Term Services Department
-Children, Youth, and Families Department
-Coordinates with schools

-Uses eligibility data to identify members of these groups

-Department of Health
-Statewide Entity for Behavioral Health

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross Blue Shield of New Mexico
Molina Healthcare of New Mexico
Lovelace Community Health Plan
Presbyterian Health Plan

## ADDITIONAL INFORMATION

OptumHealth New Mexico provides behavioral services through BH providers through a PIHP waiver. Lovelace Community Health Plan, Molina Health Care, Blue Cross Blue Shield of New Mexico, and Presbyterian Salud! provide physical health services and those BH services provided by non-BH provider/practitioners. Native Americans have the choice of "opt-in" to managed care, but receive benefits under Fee for Service programs by default.

An Individual with Special Health Care Needs (ISHCN) require a broad range of primary, specialized medical, behavioral health and related services. ISHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition and who require health and related services of a type or amount beyond that required by other individuals. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO/SE can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

Native Americans within other covered categories have the option of choosing to participate in managed care due to tribal agreements.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

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

### Use of Collected Data:

-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing

-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. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of PCPs to beneficiaries

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

# NEW MEXICO
## NEW MEXICO SALUD!

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

### Health Plan/ Provider Characteristics:
-Board Certification

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

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Adult weight management
-Assessment and diagnosis of chronic obstructive pulmonary disease
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Childhood ADHD medication managment
-Childhood Immunization
-Childhood pharyngitis testing
-Childhood upper respiratory infection treatment
-Cholesteral screening for patients with cardiovascular conditions
-Coordination of primary and behavior health care
-Coronary artery disease prevention
-Coronary artery disease treatment
-Diabetes management
-Hypertension management
-Imaging Studies for low back pain
-Post-natal Care
-Pre-natal care
-Sexually transmitted disease screening
-Smoking prevention and cessation
-Teen Maternity care
-Well Child Care/EPSDT

### Non-Clinical Topics:
-Adolescents' access to primary care practitioner
-Children's access to primary care practitioners
-Culturally competent services
-Primary care practitioners availability
-Reducing health care disparities via health literacy/education campaigns or other initiatives

## Standards/Accreditation

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

### Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

# NEW MEXICO
## NEW MEXICO SALUD!

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-New Mexico Medical Review Association

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

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

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by disease and medical condition
Covers all MCO members

**Rewards Model:**
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs
Public reporting to reward MCOs
Withholds as an incentive

**Clinical Conditions:**
Asthma
Cardiac Care
Childhood immunizations
Diabetes
Well-child visits

**Measurement of Improved Performance:**
Assessing levels of technology adoption
Assessing the adoption of systematic quality improvement processes
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
1997

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# NEW MEXICO
## Salud! Behavioral Health

## CONTACT INFORMATION

**State Medicaid Contact:**

Paula McGee
NM HSD/Medical Assistance Division
(505) 827-6234

**State Website Address:**

http://www.state.nm.us/hsd/mad/salud.htm

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
June 23, 2005

**Implementation Date:**
July 01, 2005

**Waiver Expiration Date:**
June 30, 2013

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### Mental Health (MH) PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Inpatient Mental Health, Inpatient Substance Use Disorders, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders, Peer Support for Mental Health, Peer Support for Substance Use Disorders, Pharmacy, Residential Substance Use Disorders Treatment Programs, Substance Use Disorders Support

**Allowable PCPs:**
-Addictionologists
-Clinical Social Workers
-Federally Qualified Health Centers (FQHCs)
-Indian Health Service (IHS) Providers
-Nurse Practitioners
-Other Addiction Professionals (i.e. Substance Use Disorder counselors, alcohol and drug counselors,
-Psychiatrists
-Psychologists
-Rural Health Clinics (RHCs)

**Contractor Types:**
-Behavioral Health MCO (Private)

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-American Indian/Alaskan Native (may Opt-in)
-Breast and cervical cancer medical programs
-Children in out-of-state foster care or adoption placements through CYFD
-Clients eligible for family planning services only
-Clients participating in the Health Insurance Premium Payment Program (HIPP)
-Medicare Dual Eligibles
-Retroactive Eligibility
-State Coverage Initiative (SCI) ages 19-64 for category 062

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

**Medicare Dual Eligibles Included:**
Medicaid only

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Housing Agencies
-Mental Health Agency
-Social Services Agencies
-Substance Abuse Agency

# NEW MEXICO
## Salud! Behavioral Health

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

OptumHealth New Mexico

## ADDITIONAL INFORMATION

The Salud! Behavioral Health waiver is managed as a Prepaid Inpatient Hospital Plan (PIHP).

## QUALITY ACTIVITIES FOR PIHP

### State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

### Use of Collected Data:

-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:

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

PIHPs

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

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Antidepressant medication management
-Depression management/care
-Follow-up after hospitalization for mental illness

**Health Status/Outcomes Quality:**
-Mortality rates
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services
-Ratio of mental health providers to number of beneficiaries

**Use of Services/Utilization:**
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of specialist visits per beneficiary
-Re-admission rates of MH/SUD

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

**Health Plan/ Provider Characteristics:**
-Board Certification
-Provider turnover

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

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-PIHPs are required to conduct a project(s) of their own choosing
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

**Clinical Topics:**
-Followup after hospitalization (7day, 30 day)
-RTC Follow-up care/readmissions
-Subcategory Individuals with Special Health Care Needs (ISHCN)

**Non-Clinical Topics:**
Not Applicable - PIHPs are not required to conduct common

project(s)

## Standards/Accreditation

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

**Accreditation Required for Participation:**
-Not Applicable

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-New Mexico Medical Review Association

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities**
-Technical assistance to PIHPs to assist them in conducting quality activities

# NEW YORK
## Selective Contracting - Bariatric Surgery

## CONTACT INFORMATION

**State Medicaid Contact:**

Joseph Anarella
Division of Quality and Evaluation
(518) 486-9012

**State Website Address:**

http://www.nyhealth.gov

## PROGRAM DATA

**Program Service Area:**
City

**Operating Authority:**
1915(b) - Waiver Program

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

**Solely Reimbursement Arrangement:**
Yes

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
September 01, 2009

**Implementation Date:**
December 01, 2010

**Waiver Expiration Date:**
August 31, 2012

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(13)(A) rate setting procedure
-1902(a)(23) Freedom of Choice
-1902(a)(30)(A) Reimbursement

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

## ADDITIONAL INFORMATION

Negotiated rate with eligible providers. Program Service Area is New York City only.

# NORTH DAKOTA
## Experience Health ND

## CONTACT INFORMATION

**State Medicaid Contact:**

Tania Hellman
Department of Human Services Medical Services Division
(701) 328-3598

**State Website Address:**

http://www.nd.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
January 01, 2007

**Implementation Date:**
October 01, 2007

**Waiver Expiration Date:**
September 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### Disease Management PAHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Disease Management

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

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Receiving services related to transplants, HIV/AIDS, cancer, end stage renal disease and hospice
-Recipients with spend-down
-Reside in Nursing Facility or ICF/MR
-Those that are incarcerated

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ExperienceHealth ND

## ADDITIONAL INFORMATION

This program uses nurse care managers to work with recpients and their providers to provide education, self management tools and other services in this program. Program covers disease management services only. Reimbursement Arrangement rates were developd based on each disease (Asthma, Diabetes, COPD, CHF), therefore there are 4 different rates depending upon the disease. This capitated rate is paid per member, per month.

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**

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

**Use of Collected Data:**

-Enhanced/Revise State managed care Medicaid Quality Strategy
-Program Evaluation

-Monitoring of PAHP Standards
-On-Site Reviews
-Performance Measures (see below for details)

**Consumer Self-Report Data:**
-Recipient knowledge survey (developed by PAHP and approved by State)
-Recipient Satisfaction survey developed by PAHP and approved by State

**Use of HEDIS:**
-The State uses SOME of the HEDIS measures listed for Medicaid
-State uses/requires PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
-Results of progress toward defined performance indcators

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Number of hospital admissions
-Number of inpatient days

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards
-URAC Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# OREGON
## Non-Emergency Transportation

## CONTACT INFORMATION

**State Medicaid Contact:**

Don Ross
Division of Medical Assistance Programs
(503) 945-6084

**State Website Address:**

http://www.oregon.gov/DHS/healthplan/index.shtml

## 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:**
September 01, 1994

**Implementation Date:**
September 01, 1994

**Waiver Expiration Date:**
September 30, 2011

**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

### FFS Transportation Brokers - Fee-for-Service

#### 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:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

# OREGON
## Non-Emergency Transportation

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

**Lock-In Provision:**
No lock-in

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

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
No

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Not Applicable

## ADDITIONAL INFORMATION

The State contracts with transportation brokers on a FFS basis. All enrollees under the Oregon Health Plan Plus are enrolled in this program.

# PENNSYLVANIA
# ACCESS Plus Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Jennifer Basom
Pennsylvania Department of Welfare
(717) 772-6149

**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)(4)

**Enrollment Broker:**
Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
January 01, 2005

**Implementation Date:**
March 01, 2005

**Waiver Expiration Date:**
December 31, 2012

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### PCCM Provider - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Hospital Based Medical Clinic
-Independent Medical/Surgical Clinic
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)
-Specialist Who Meets Special Needs of Client

# PENNSYLVANIA
# ACCESS Plus Program

## Enrollment

**Populations Voluntarily Enrolled:**

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

**Populations Mandatorily Enrolled:**

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Enrolled in Health Insurance Premium Payment (HIPP)
-Enrolled in Long Term Care Capitated Program (LTCCP)
-Incarcerated Recipients
-Medicare Dual Eligibles age 21 and over
-Reside in Nursing Facility or ICF/MR
-Residents of State Institutions
-State Blind Pension Recipients

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only (under age 21)

**Medicare Dual Eligibles Excluded:**

SLMB, QI, and QDWI (age 21 and older)
QMB (age 21 and older)

## Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

# PENNSYLVANIA
# ACCESS Plus Program

## Disease Management PAHP - Risk-based Capitation

### Service Delivery

**Included Services:**
Disease Management

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

### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles under age 21
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Enrolled in Health Insurance Premium Payment (HIPP)
-Enrollen in Long Term Care Capitated Payment (LTCCP)
-Incarcerated Recipients
-Medicare Dual Eligibles age 21 and over
-Reside in Nursing Facility or ICF/MR
-Residence in a State Facility

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only (under age 21)

**Medicare Dual Eligibles Excluded:**
QMB (age 21 and over)
SLMB, QI, and QDWI (age 21 and over)

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# PENNSYLVANIA
## ACCESS Plus Program

## 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
-Department of Public Welfare Offices
-Enrollment Contractor
-Legislative Offices
-Reviews complaints and grievances to identify members of these groups
-Self-Referral
-Surveys medical needs of enrollee to identify members of these groups
-Uses claims to identify special needs
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Juvenile Justice Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Plus Program

APS Healthcare

## ADDITIONAL INFORMATION

Under PCCM, the reason for multiple enrollment basis for the included populations: ACCESS Plus is the default; with exceptions. If a voluntary managed care is in a county with ACCESS Plus, the recipient can choose which delivery system they want. If no choice is made, the recipient is auto-assigned to ACCESS Plus. However, in counties where there is no voluntary managed care program, recipients are mandatorily enrolled into ACCESS Plus. Special Needs Children is broadly defined as non-categorical to include all children.

Reimbursement Arrangement: The providers in the network are reimbursed on a FFS basis. The Access Plus contractor receives a capitation for EPCCM Services and capitation for Disease Management Services.

Enrollees are assigned to the Disease Management program if they have one of the following qualifying chronic diseases: Asthma, Diabetes, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, and Congestive Heart Failure. However, enrollees can choose to opt out of this program.

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**

-Consumer Self-Report Data (see below for details)
-Consumer Surveys
-Focused Studies
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards (see below for details)
-Performance Measures (see below for details)
-Provider Surveys

**Use of Collected Data:**

-Contract Standard Compliance
-Data Mining
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Target areas for new quality improvement activities

# PENNSYLVANIA
## ACCESS Plus Program

**Consumer Self-Report Data:**
-Contractor developed survey for chronic illness satisfaction
-Contractor developed survey for satisfaction

**Use of HEDIS:**
-The State uses ALL of the HEDIS measures listed for Medicaid
-State use/requires PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

### Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
-Chronic Care Satisfaction
-Health Status Reports from Contractors
-Patient satisfaction with care

**Access/Availability of Care:**
-Adolescent access to preventive/ambulatory health services
-Childhood access to preventive/ambulatory health services

**Use of Services/Utilization:**
-Call Abandonment
-Call Timeliness
-Emergency room visits/1,000 beneficiary

**Health Plan Stability/ Financial/Cost of Care:**
-Administrative Costs
-Pay for performance reports on payouts and reserve and withhold
-Total revenue

**Health Plan/ Provider Characteristics:**
-Geo Mapping Report
-Number of Providers Following Standard Practice Guidelines for Chronic Illnesses
-Number of Providers Participating in Disease Management

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
-Other

### Standards/Accreditation

**PAHP Standards:**
-NCQA (National Committee for Quality Assurance) Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

## QUALITY ACTIVITIES FOR PCCM

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

**Use of Collected Data:**
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Target New Areas for Quality Improvement

**Consumer Self-Report Data:**
-CAHP Survey
-Consumer Complaints

### Performance Measures

# PENNSYLVANIA
## ACCESS Plus Program

**Process Quality:**
None

**Health Status/Outcomes Quality:**
-Patient satisfaction with care

**Access/Availability of Care:**
-Adolescent well child visits
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

**Use of Services/Utilization:**
-Call Abandonment
-Call Timeliness
-Emergency room visits/1,000 beneficiaries
-Hospital Readmission Rates
-Inpatient admissions/1,000 beneficiaries
-Number of field staff case manager visits for prenatal maternity care
-Number of OB/GYN visits per adult female beneficiary
-Number of telephonic case manager calls for prenatal maternity care

**Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
-Enrollee Outreach Activities
-Maternity Care

## Performance Improvement Projects

**Clinical Topics:**
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Cervical Cancer Screening initiative to increase screening rates
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Coordination of primary and behavioral health care
-Coronary artery disease prevention
-Depression Screening
-Diabetes management
-Domestic violence
-Emergency Room service utilization
-Post-natal Care
-Pre-natal care
-Sexually transmitted disease screening
-Smoking prevention and cessation
-Well Child Care/EPSDT

**Non-Clinical Topics:**
-Availability of language interpretation services
-Children's access to primary care practitioners
-ER initiative to reduce ER visit rate

# PENNSYLVANIA
## HealthChoices

## CONTACT INFORMATION

**State Medicaid Contact:**

Joan Morgan
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)(4)

**Enrollment Broker:**
Maximus

**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 31, 2012

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based 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, Skilled Nursing Facility, Transportation, Vision, X-Ray

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

# PENNSYLVANIA
# HealthChoices

## Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in a Long Term Care Capitated Program
-Enrolled in Health Insurance Premium Payment (HIPP) with HMO Coverage
-Incarcerated Recipients
-Medicare Dual Eligibles
-Monthly Spend Downs
-Reside in Nursing Facility
-Residence in a State Facility
-State Blind Pension Recipients

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only (under age 21)

**Medicare Dual Eligibles Excluded:**
QMB (age 21 and over)
SLMB, QI, and QDWI (age 21 and over)

## Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
-None - managed care entity provides standard prescription drug coverage

# SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
None

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

# PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of Pennsylvania
AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan
Community Care Behavioral Health - North Central
Community Care Behavioral Health - Northeast

# PENNSYLVANIA
## HealthChoices

Counties of Armstrong/Indiana - Value Behavioral Health of PA

Counties of Bedford/Somerset - Community Behavioral Healthcare Network of Pennsylvania

Counties of Carbon/Monroe/Pike - Community Care Behavioral Health

Counties of Crawford/Mercer/Venango - Value Behavioral Health

Counties of Franklin/Fulton - Community Behavorial Healthcare Network of Pennsylvania

Counties of Lycoming/Clinton - Community Behavioral Healthcare Network of Pennsylvania

County of Adams - Community Care Behavioral Health

County of Allegheny - Community Care Behavioral Health

County of Beaver - Value Behavioral Health of PA

County of Berks - Community Care Behavioral Health

County of Blair County - Community Behavioral Healthcare Network of PA

County of Bucks - Magellan Behavioral Health

County of Butler - Value Behavioral Health of PA

County of Cambria - Value Behavioral Health

County of Chester - Community Care Behavioral Health

County of Cumberland - Community Behavioral Healthcare Network of PA, Inc.

County of Dauphin - Community Behavioral Healthcare Network of PA, Inc.

County of Delaware - Magellan Behavioral Health

County of Erie - Value Behavioral Health

County of Fayette - Value Behavioral Health of PA

County of Lancaster - Community Behavioral Healthcare Network of PA, Inc.

County of Lawrence - Value Behavioral Health of PA

County of Lebanon - Community Behavioral Healthcare Network of PA, Inc.

County of Lehigh - Magellan Behavioral Health

County of Montgomery - Magellan Behavioral Health

County of Northampton - Magellan Behavioral Health

County of Perry - Community Behavioral Healthcare Network of PA, Inc.

County of Philadelphia - Community Behavioral Health

County of Washington - Value Behavioral Health of PA

County of Westmoreland - Value Behavioral Health of PA

County of York - Community Care Behavioral Health

Gateway Health Plan, Inc.

Health Partners of Philadelphia

Keystone Mercy Health Plan

Unison Health Plan / MedPLUS

UPMC Health Plan, Inc./UPMC for You

Value Behavioral Health of PA (Greene County)

## ADDITIONAL INFORMATION

Skilled Nursing Facility is for the first 30 days. Special Needs Children: (state defined) Broadly defined non-categorical to include all children. All consumers receiving behavorial health services are considered to be persons with special needs.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

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

### Use of Collected Data:

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

### Consumer Self-Report Data:

-CAHPS
4.0H adult

### Use of HEDIS:

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

# PENNSYLVANIA
# HealthChoices

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-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 commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO
-Specification/source code review, such as a programming language used to create an encounter data file for submission

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services

### Health Status/Outcomes Quality:
-Patient satisfaction with care

-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Access/Availability of Care:

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

### Use of Services/Utilization:

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

### Health Plan Stability/ Financial/Cost of Care:

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

### Health Plan/ Provider Characteristics:

-Board Certification
-Languages Spoken (other than English)
-Number of years Health Plan in business and total membership
-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 MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

### Performance Measures - Others:

None

## Performance Improvement Projects

### Project Requirements:

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

### Clinical Topics:

-Adolescent Pregnancy
-Asthma management
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Hypertension management
-Smoking prevention and cessation

### Non-Clinical Topics:

-Adult's access to dental care
-Children's access to dental care

## Standards/Accreditation

# PENNSYLVANIA
## HealthChoices

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

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Island Peer Review Organization (IPRO)

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

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

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
Covers all MCO members

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
2006

**Evaluation Component:**
The State has conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# TEXAS
# NorthSTAR

## CONTACT INFORMATION

**State Medicaid Contact:**

Betsy Johnson
Texas Health and Human Services Commission
(512) 491-1199

**State Website Address:**

http://www.hhsc.state.tx.us

## PROGRAM DATA

**Program Service Area:**
Region

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
Maximus

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
November 01, 1999

**Implementation Date:**
November 01, 1999

**Waiver Expiration Date:**
September 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### MH/SUD PIHP - Other-FFS/some Risk Based

#### Service Delivery

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

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

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Children in Protective Foster Care
-Individuals Eligible as Medically Needy
-Individuals receiving inpatient Medicaid IMD services over age 65
-Individuals Residing Outside of the Service Region
-Medicare Dual Eligibles
-Other Insurance
-Qualified Medicare Beneficiaries
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
All clients with full Medicare and Medicaid eligibility

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-DADS
-DFPS
-DSHS
-Local School Districts
-Protective and Regulatory Agency
-Public Health Agency
-Social Services Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ValueOptions

# TEXAS
# NorthSTAR

## ADDITIONAL INFORMATION

Individuals on SSI and QMB plus are the only Medicare dual eligibles that are eligibled to enroll. The program is mostly fee-for-service but on occasions there are some risk based arrangement.

## QUALITY ACTIVITIES FOR PIHP

### State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

### Use of Collected Data:

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

### Consumer Self-Report Data:

-Modified MHSIP survey

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries
-Use of unique NorthSTAR ID # (which includes Medicaid # for the Medicaid enrollees) for beneficiaries

### Collection: Standardized Forms:

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:

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

### PIHP conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment

### State conducts general data completeness assessments:

Yes

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

## Performance Measures

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

### Health Status/Outcomes Quality:
-Clinical outcomes as measures by clinical assessments
-Patient satisfaction with care
-Recidivism to intensive/acute levels of care

### Access/Availability of Care:
-Average distance to mental health provider
-Number and types of providers
-Ratio of mental health providers to number of beneficiaries

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

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

### Health Plan/ Provider Characteristics:
-Behavioral Health Specialty Network
-Languages Spoken (other than English)
-Provider turnover

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Coordination of primary and behavioral health care

### Non-Clinical Topics:
None

## Standards/Accreditation

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

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Institute for Child Health Policy (ICHP)

# TEXAS
# NorthSTAR

**EQRO Organization:**
-QIO-like entity

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

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

# TEXAS
# PCCM Negotiated Hospital Contracting

## CONTACT INFORMATION

**State Medicaid Contact:**

Joseph Morganti
Texas Health and Human Services Commission
(512) 491-1425

**State Website Address:**

http:// www.hhsc.state.tx.us/medicaid/care_case_pr

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(b) - Waiver Program

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

**Solely Reimbursement Arrangement:**
Yes

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
January 01, 2008

**Implementation Date:**
January 01, 2008

**Waiver Expiration Date:**
December 31, 2011

**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

Negotiated hospital rates by the Texas Medicaid claims administrator, Texas Medicaid & Healthcare Partnership (TMHP).

# TEXAS
# STAR

## CONTACT INFORMATION

**State Medicaid Contact:**

Joe Vesowate
Texas Health and Human Services Commission
(512) 491-1379

**State Website Address:**

http://www.hhsc.state.tx.us

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
August 01, 1993

**Implementation Date:**
August 01, 1993

**Waiver Expiration Date:**
June 30, 2012

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

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

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

# TEXAS
# STAR

## Enrollment

**Populations Voluntarily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

**Populations Mandatorily Enrolled:**
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Medicaid Beneficiaries Who Participate in the STAR+PLUS 1915(c) Waiver Program
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

## Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

Aetna
Amerigroup (STAR)
Community First
Community Health Choice
Cook Children's
Driscoll
El Paso First Premier
First Care
Molina (STAR)
Parkland Community Health Plan
Superior HealthPlan (STAR)
Texas Children's Health Plan
Unicare
United

# ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

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

### Use of Collected Data:

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

### Consumer Self-Report Data:

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

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-837 transaction format
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, 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:

-837 transacton format
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-Behavioral health layout
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

### Validation - Methods:

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

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

-Date of Service
-Date of Payment
-Provider ID

### State conducts general data completeness assessments:

Yes

-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Preparing HEDIS and risk adjustment software

## Performance Measures

### Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Depression management/care
-Diabetes care and control
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Good access to behavioral health treatment or Good access to behavioral health treatment
-Good access to routine care
-Good access to special therapies
-Good access to specialist referral
-Good access to urgent care
-Hearing services for individuals less than 21 years of age
-high blood pressure control
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-No delays for approval
-No exam room wait > 15 minutes
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Pregnancy Prevention
-Prenatal/postnatal care
-Smoking prevention
-Vision services for individuals less than 21 years of age
-Wellcare visits
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

### Health Status/Outcomes Quality:

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

### Access/Availability of Care:

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

### Use of Services/Utilization:

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

### Health Plan Stability/ Financial/Cost of Care:

-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

### Health Plan/ Provider Characteristics:

-Languages Spoken (other than English)
-Provider turnover

# TEXAS
# STAR

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

### Performance Measures - Others:
-Member use of services/utilization/satisfaction

## Performance Improvement Projects

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

### Clinical Topics:
-Improve treatment for Ambulatory Care Sensitive Conditions (ACSC) through reduction of emergency department visits.
-Improve treatment for Ambulatory Care Sensitive Conditions (ACSC) through reduction of inpatient admissions.

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

## Standards/Accreditation

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

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

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

### EQRO Organization:
-QIO-like entity

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

### EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Assess performance of improvement projects.
-Calculation of performance measures
-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 encounter data
-Validation of performance improvement projects

## Pay for Performance (P4P)

### Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO, but plans to implement one in the future

### Program Payers:
Medicaid is the only payer

### Population Categories Included:
Covers all MCO members

### Rewards Model:
1% At-risk Premium. HMO at risk for 1% of the capitation rate(s) dependent on the outcome of pre-identified

performance measures
Payment incentives/differentials to reward MCOs
Quality challenge pool award. Based on specific pre-identified clinical performance measures

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
1% At-risk Premium. Standards are established for the SFY time period that must be met in order to retain the point value and percentage of the 1% At-Risk Premium dollars.
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing patient satisfaction measures
Assessing the timely submission of complete and accurate electronic encounter/claims data
Quality Challenge Pool Award is based on a point value and performance standard assigned to the clinical performance measures and overall ranking of managed care organization score.
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

**Member Incentives:**
Not Applicable

# TEXAS
# Texas Medicaid Enhanced Care Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Joe Vesowate
Texas Health and Human Services Commission
(512) 491-1379

**State Website Address:**

http://www.hhsc.state.tx.us/Medicaid

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
August 09, 2005

**Implementation Date:**
November 01, 2004

**Waiver Expiration Date:**
July 31, 2011

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### Disease Management PAHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Disease Management

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

#### Enrollment

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Section 1931 Children and Related Populations

**Populations Mandatorily Enrolled:**
None

# TEXAS
## Texas Medicaid Enhanced Care Program

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

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

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

-Uses other means to identify members of these groups
-Vendors uses claims data to identify clients with certain chronic conditions

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

McKesson Health Solutions

## ADDITIONAL INFORMATION

Only clients with asthma, diabetes, COPD, CHF and CAD are included in this program. Only clients enrolled in Primary Care Case Management and Traditional Medicaid (FFS) are included in this program.

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**

-Consumer Self-Report Data (see below for details)
-Data Analysis
-Enrollee Hotlines
-Independent Assessment

**Use of Collected Data:**

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

-Measure Disparities
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Utilization Review
-Track Health Service provision

**Consumer Self-Report Data:**
-SF-12 Health Survey

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures

## Performance Measures

**Process Quality:**
-Asthma care - medication use
-Chronic obstructive pulmonary
-Coronary artery disease care
-Diabetes medication management
-Disease care
-Heart failure care

**Health Status/Outcomes Quality:**
-Measure health status and outcomes related to clients' specific condition or conditions

**Access/Availability of Care:**
None

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

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-PAHP/PCP-specific disenrollment rate

**Performance Measures - Others:**
None

## Performance Improvement Projects

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

**Clinical Topics:**
-Asthma management
-Coordination of primary and behavioral health care
-Coronary artery disease prevention
-Coronary artery disease treatment
-Diabetes management
-Emergency Room service utilization
-Hospital discharge planning
-Prevention of Influenza

**Non-Clinical Topics:**
-Enrollment and engagement initiative
-Health and wellness initiative

## Standards/Accreditation

**PAHP Standards:**
None

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# UTAH
# Choice Of Health Care Delivery

## CONTACT INFORMATION

**State Medicaid Contact:**

Emma Chacon
Utah State Department of Health
(801) 538-6577

**State Website Address:**

http://www.health.utah.gov/medicaid

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
March 23, 1982

**Implementation Date:**
July 01, 1982

**Waiver Expiration Date:**
December 31, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

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

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

# UTAH
# Choice Of Health Care Delivery

## Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medically Needy Children
-Medicare Dual Eligibles
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**
-1931 Adults
-During Retroactive Eligibility Period
-Eligibility Less Than 3 Months
-Eligible only for TB-related Services
-If Approved as Exempt from Mandatory Enrollment
-Medically Needy Adults
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)

**Lock-In Provision:**
12 month lock-in

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

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

## Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# UTAH
# Choice Of Health Care Delivery

## MCO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

**Included Services:**
Case Management, Diabetes self-management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility if less than 30 days, Vision, X-Ray

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

### Enrollment

**Populations Voluntarily Enrolled:**
None

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

**Subpopulations Excluded from Otherwise Included Populations:**
-Eligibility Less Than 3 Months
-Eligible only for TB-related Services
-Have an eligibility period that is only retroactive
-Individuals residing in the Utah State Hospital of the Utah Developmental Center
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Section 1931 non-pregnant adults age 19 and older and related poverty level populations

**Lock-In Provision:**
12 month lock-in

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

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

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# UTAH
# Choice Of Health Care Delivery

## Medical-only PAHP (risk or non-risk, non-comprehensive) - Non-risk Capitation

### Service Delivery

**Included Services:**
Case Management, Diabetes self-management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Laboratory, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

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

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**
-Eligibility Less Than 3 Months
-Eligible only for TB-related Services
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

**Lock-In Provision:**
12 month lock-in

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

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

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

# UTAH
## Choice Of Health Care Delivery

**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:**
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Employment Agencies
-Housing Agencies
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy U
Select Access
Molina Healthcare of Utah (Molina)

## ADDITIONAL INFORMATION

Children with specieal needs means children under 21 who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and requires health and related services of a type or amount beyond that required by children generally, including a child who, consistent with 1932(a)(2)(A) of the Social Security Act, 42 U.S.C., Section 1396u-2(a)(2)(A): (1) is blind or disabled or in a related population (eligible for SSI under title XVI of the Social Security Act), (2) is in foster care or other out-of-home placement, (3) is receiving foster care or adoption assistance; or (4) is receiving services through a family-centered, community-based coordinated care system that receives grant funds described in section 501(a)(1)(D) of title V.

The contract is non-risk. Medicaid reimburses the PAHP the amount the PAHP pays its providers plus an administrative fee.

## QUALITY ACTIVITIES FOR MCO/HIO

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

### Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

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

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

# UTAH
# Choice Of Health Care Delivery

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-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)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCO

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Use of imaging studies for low back pain
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of adults 50 and older who received an influenza vaccine

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average wait time for an appointment with PCP

### Use of Services/Utilization:
None

-Children's access to primary care practitioners

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

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

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

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

**Clinical Topics:**
-Diabetes management

**Non-Clinical Topics:**
None

## Standards/Accreditation

**MCO Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-HCE Quality Quest
-Utah Department of Health's Office of Health Care Statistics

**EQRO Organization:**
-QIO-like entity
-State entity

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

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

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

## QUALITY ACTIVITIES FOR PAHP

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

**Use of Collected Data:**
-Contract Standard Compliance
-Fraud and Abuse
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

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

**Use of HEDIS:**
-The State uses 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 PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

### Encounter Data

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

**Collections - Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

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

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

**PAHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Duplicate encounter

**State conducts general data completeness assessments:**
Yes

# UTAH
# Choice Of Health Care Delivery

## Performance Measures

**Process Quality:**
-Adolescent well-care visit rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Influenza vaccinationa rate
-Initiation of prenatal care - timeliness of
-Us of imaging studies for low back pain
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

**Health Status/Outcomes Quality:**
-Patient satisfaction with care

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services

**Use of Services/Utilization:**
None

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

**Health Plan/ Provider Characteristics:**
-Board Certification

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

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

**Clinical Topics:**
-Diabetes management

**Non-Clinical Topics:**
None

## Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# UTAH
# Non-Emergency Medical Transportation

## CONTACT INFORMATION

**State Medicaid Contact:**

Anita Hall
Utah State Department of Health
(801) 538-6483

**State Website Address:**

http://www.health.utah.gov/medicaid

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
September 19, 2000

**Implementation Date:**
July 01, 2001

**Waiver Expiration Date:**
June 30, 2013

**Sections of Title XIX Waived:**
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### Transportation PAHP - Risk-based 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:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**

-Medicare Dual Eligibles
-Reside in the State Hospital or in the State Developmental Center

**Lock-In Provision:**

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

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Transportation Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Medical Transportation

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**

-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards

**Use of Collected Data:**

-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

**Consumer Self-Report Data:**

None

**Use of HEDIS:**

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the

HEDIS measure listed for Medicaid

## Encounter Data

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

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

**Collection: Standardized Forms:**
None

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

**PAHP conducts data accuracy check(s) on specified data elements:**
None

**State conducts general data completeness assessments:**
No

## Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# UTAH
# Prepaid Mental Health Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Emma Chacon
Division of Medicaid and Health Financing
(801) 538-6577

**State Website Address:**

http://www.health.utah.gov/medicaid

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
No

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
July 01, 1991

**Implementation Date:**
July 01, 1991

**Waiver Expiration Date:**
December 31, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

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

## SERVICE DELIVERY

### Mental Health (MH) PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Crisis, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Transportation

**Contractor Types:**
-CMHC - some private, some governmental

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

#### Enrollment

**Populations Voluntarily Enrolled:**
None

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

-Medicare Dual Eligibles
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-1925 Adults
-1931 Adults
-Medically Needy Adults
-Medicare Dual Eligibles
-Outpatient services for foster children
-Resident of the State Developmental Center (DD/MR facility)
-Resident of the Utah State Hospital (IMD)

**Lock-In Provision:**

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

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Employment Agencies
-Housing Agencies
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Bear River Mental Health
Central Utah Counseling Center
Davis Behavioral Health
Four Corners Community Behavioral Health
Northeastern Counseling Center
Southwest Behavioral Health Services
Valley Mental Health
Wasatch Mental Health
Weber Human Services

## ADDITIONAL INFORMATION

Community Mental Health Centers serve as Prepaid Mental Health Plan (PMHP) contractors to provide/coordinate all mental health

services in 9 of the 11 mental health service areas. Under the PMHP foster children receive inpatient services only.

## QUALITY ACTIVITIES FOR PIHP

### State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

### Use of Collected Data:

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

### Consumer Self-Report Data:

-MHSIP satisfaction surveys are used by the PMHPs.
-OQ/YOQ outcomes instruments are used by the PMHPs.

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, 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

### Validation - Methods:

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

### PIHP conducts data accuracy check(s) on specified data elements:

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

### State conducts general data completeness assessments:

Yes

-Duplicate encounters

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
-Average time for intake

**Use of Services/Utilization:**
None

**Health Plan Stability/ Financial/Cost of Care:**
-State minimum reserve requirements

**Health Plan/ Provider Characteristics:**
-Information on providers by designated provider groupings

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**

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

**Clinical Topics:**

-Coordination of primary and behavioral health care

**Non-Clinical Topics:**

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

## Standards/Accreditation

**PIHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-HCE Quality Quest

**EQRO Organization:**
-QIO-like entity

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

**EQRO Optional Activities**
-Technical assistance to PIHPs to assist them in conducting quality activities

# VIRGINIA
# MEDALLION/Medallion II

## CONTACT INFORMATION

**State Medicaid Contact:**

Mary Mitchell
Department of Medical Assistance Services
(804) 786-3594

**State Website Address:**

http://www.dmas.virginia.gov/

## PROGRAM DATA

**Program Service Area:**
City
County

**Initial Waiver Approval Date:**
April 01, 2005

**Operating Authority:**
1915(b) - Waiver Program

**Implementation Date:**
April 01, 2005

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

**Waiver Expiration Date:**
June 30, 2013

**Enrollment Broker:**
MAXIMUS, Inc.

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

**For All Areas Phased-In:**
Yes

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

**Guaranteed Eligibility:**
No guaranteed eligibility

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

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

#### Enrollment

# VIRGINIA
# MEDALLION/Medallion II

**Populations Voluntarily Enrolled:**
-Section 1931 Children and Related Populations

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Foster Care
-Hospice
-Medicare Dual Eligibles
-Other Insurance
-Participate in 1915(c) Home & Community Based Waiver
-Refugees enrolled in Refugee Medical Assistance
-Reside in Nursing Facility or ICF/MR
-Spenddown
-Subsidized Adoption

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

## Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# VIRGINIA
# MEDALLION/Medallion II

## MCO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

**Included Services:**
Case Management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

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

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Foster Care
-Hospice
-Medicare Dual Eligibles
-Other Insurance
-Participate in Tech Waiver
-Refugees enrolled in Refugee Medical Assistance
-Reside in Nursing Facility or ICF/MR
-Spend-down
-Subsidized Adoption

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

# VIRGINIA
## MEDALLION/Medallion II

**Program Includes People with Complex (Special) Needs:**

Yes

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

-Asks advocacy groups to identify members of these groups
-Initial Interviews with new Medallion II enrollees
-Review claims activity of all new enrollees for special indicators
-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Education Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Community Care
MEDALLION
Southern Health CareNet
Anthem Healthkeepers Plus
Optima Family Care
Virginia Premier Health Plan

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**

-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Performance Measures Validation

**Use of Collected Data:**

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

**Consumer Self-Report Data:**

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

**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 to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

### Encounter Data

**Collection: Requirements:**

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

**Collections: Submission Specifications:**

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission

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

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

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

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent well-care visit rate
-Ambulatory Care
-Antidepressant medication management
-Asthma care - medication use
-Breast Cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management for people with cardivascular disease
-Controlling high blood pressure
-Diabetes management
-Enrollee rights and protection
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Pharmacology Management of COPD
-Quality Assessment and Performance Improvement
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

### Access/Availability of Care:
-Average distance to PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
None

### Health Plan Stability/ Financial/Cost of Care:
None

### Health Plan/ Provider Characteristics:
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**

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

**Clinical Topics:**

-Childhood Immunization
-Well Child Care

**Non-Clinical Topics:**

None

## Standards/Accreditation

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

**Accreditation Required for Participation:**
-NCQA (National Committee for Quality Assurance)

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-DFMC

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities:**
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# VIRGINIA
## MEDALLION/Medallion II

## QUALITY ACTIVITIES FOR PCCM

### Quality Oversight Activities:
-Enrollee Hotlines

### Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Program Evaluation
-Track Health Service provision

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

# WASHINGTON
# The Integrated Mental Health Services

## CONTACT INFORMATION

**State Medicaid Contact:**

Cyndi LaBrec
Divison of Behavioral Health and Recovery
(360) 725-2029

**State Website Address:**

http://www.dshs.wa.gov/dbhr/mh_information.shtml

## PROGRAM DATA

**Program Service Area:**
County
Region

**Initial Waiver Approval Date:**
April 27, 1993

**Operating Authority:**
1915(b) - Waiver Program

**Implementation Date:**
July 01, 1993

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

**Waiver Expiration Date:**
October 30, 2012

**Enrollment Broker:**
No

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

**For All Areas Phased-In:**
No

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

**Guaranteed Eligibility:**
None

## SERVICE DELIVERY

### Mental Health (MH) PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Crisis, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Rehabilitation Case Management

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

**Contractor Types:**
-12 Regional Support Networks Optum Health
-Regional Authority Operated Entity (Public)

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Other Insurance
-Reside in Nursing Facility or ICR/MR
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-Homeless People not Enrolled in Medicaid
-Medicare Dual Eligibles
-Pregnant Women included in Family Planning Waiver
-Residents of State-owned institutions

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

No

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

-All Persons Meet SCHN

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Education Agency
-Employment Agency
-Housing Agency
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

OptumHealth

Regional Support Network

## ADDITIONAL INFORMATION

# WASHINGTON
## The Integrated Mental Health Services

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. Pregnant women in the Basic Health program (state funded program) are excluded from the Mental Health program.

## QUALITY ACTIVITIES FOR PIHP

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

### Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:
-Consumer/Beneficiary Focus Groups
-MHSIP Child, Family, and Adult Survey

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

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

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

### State conducts general data completeness assessments:
Yes

# WASHINGTON
# The Integrated Mental Health Services

## Performance Measures

### Process Quality:
-Data quality and completeness
-Follow-up after hospitalization for mental illness
-Timeliness of assessment
-Timeliness of routine care

### Health Status/Outcomes Quality:
None

### Access/Availability of Care:
-Access to Appointment
-Availability of MHPs
-Average Distance to Service

### Use of Services/Utilization:
-Crisis Contacts
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Outpatient Mental Health Hours

### Health Plan Stability/ Financial/Cost of Care:
None

### Health Plan/ Provider Characteristics:
None

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Decrease In the Days to First Prescriber Appointment After Request for Service
-Employment Outcomes for Adult Consumers
-Impact of Implementing the PACT Model on the Use of Inpatient Treatment
-Implementing an Evidence-Based Practice in a Regional Support Network
-Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder
-Metabolic Syndrome Screening and Intervention
-Multisystemic Therapy
-Using Assertive Community Treatment to Decrease Consumer Hospital Utilization

### Non-Clinical Topics:
-Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
-Improving Coordination of Care and Outcomes
-Improving Early Engagement in Outpatient Services
-Increased Incident Reporting Compliance
-Increasing Percentage of Medicaid Clients who receive an Intake Service within 14 days of service request
-Reduced Errors in Service Encounter Reporting Through Consistent Interpretation of Reporting Guidelines
-Timeliness of Access to Outpatient Services

## Standards/Accreditation

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

### Accreditation Required for Participation:
None

# WASHINGTON
## The Integrated Mental Health Services

**Non-Duplication Based on Accreditation:**
None

**EQRO Organization:**
-External qualtiy review organization (Acumentra)

**EQRO Name:**
-Acumentra Health

**EQRO Mandatory Activities:**
-Information systems capability assessment
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

**EQRO Optional Activities**
-Encounter validation training
-PIP Training

# WEST VIRGINIA
## Mountain Health Trust

## CONTACT INFORMATION

**State Medicaid Contact:**

Brandy Pierce
Office of Managed Care, Bureau for Medical Service
(304) 356-4912

**State Website Address:**

http://www.wvdhhr.org

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b) - Waiver Program

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

**Enrollment Broker:**
Automated Health Systems, Inc.

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
Continuous eligibility for children under age 19

**Initial Waiver Approval Date:**
July 01, 2010

**Implementation Date:**
July 01, 2010

**Waiver Expiration Date:**
June 30, 2012

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

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

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

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

#### Enrollment

# WEST VIRGINIA
## Mountain Health Trust

**Populations Voluntarily Enrolled:**
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Populations Mandatorily Enrolled:**
-Poverty-Level Pregnant Women
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Title CHIP XXI

**Lock-In Provision:**
1 month lock-in

**Medicare Dual Eligibles Included:**
None

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

## Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## PCCM Provider - Fee-for-Service

### Service Delivery

**Included Services:**
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

### Enrollment

**Populations Voluntarily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

**Populations Mandatorily Enrolled:**
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

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

**Lock-In Provision:**
1 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Reviews complaints and grievances to identify members of these groups
-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:**
-Maternal and Child Health Agency
-Public Health Agency

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carelink Health Plan
Health Plan of the Upper Ohio Valley
Physician Assured Access System
Unicare Health Plan of WV

## ADDITIONAL INFORMATION

Any child who is enrolled in the States Childen with Special Health Care Needs Program administered by the Office of Maternal, Child, Family Health

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Complaints, Grievances, and Disenrollment Data
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:

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

### Consumer Self-Report Data:

-Disenrollment Survey
-State-developed Survey
-State-developed Survey of Children with Special Health Needs

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and

### Validation - Methods:

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

suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

comparisons to submitted bills or cost-ratios)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent well-care visit rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Comprehensive Diabetes Care
-Controlling high blood pressure
-Frequency of on-going prenatal care
-Heart Attack care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Smoking prevention and cessation
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Call Answer Abandonment
-Call Timeliness
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Ambulatory Surgery/Procedures/1,000 members months
-Days/1000 an average length of stay of IP administration, ER visits, ambulatory surgery, maternity care, newborn care
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Maternity - Discharges/1,000 Member Months, Days/1,000 Member Months, and ALOS
-Medicine - Discharges/1,000 member months, Days/1,000 member months, and ALOS
-Number of OB/GYN visits per adult female beneficiary
-Observation Room Stays/1,000 membrer months
-Outpatient Visits/1,000 member months
-Surgery - Discharges/1,000 member months, Days/1,000 Member Months, and ALOS
-Total Inpatient-Discharge/1,000 member months, days/1,000 member months and ALOS

### Health Plan Stability/ Financial/Cost of Care:
None

### Health Plan/ Provider Characteristics:
-Board Certification

# WEST VIRGINIA
## Mountain Health Trust

**Beneficiary Characteristics:**
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

**Performance Measures - Others:**
-Prevention and Screening

## Performance Improvement Projects

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

**Clinical Topics:**
-Asthma
-Childhood Immunization
-Childhood Obesity

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

## Standards/Accreditation

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

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Delmarva

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

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

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-Performance Measures (see below for details)
-Provider Data

**Use of Collected Data:**
-Beneficiary Provider Selection
-Program Evaluation
-Provider Profiling

**Consumer Self-Report Data:**
None

### Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

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

**Use of Services/Utilization:**
None

**Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

# ARIZONA
# Arizona Health Care Cost Containment System (AHCCCS)

## CONTACT INFORMATION

**State Medicaid Contact:**

Tom Betlach
AHCCCS
(602) 417-4483

**State Website Address:**

http://www.AZAHCCCS.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
12 months guaranteed eligibility

**Initial Waiver Approval Date:**
July 13, 1982

**Implementation Date:**
October 01, 1982

**Waiver Expiration Date:**
September 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(10)((a)(ii)(V) - Eligibility based on Inst
-1902(a)(10)(B) - Amount, Duration & Scope
-1902(a)(13) - DSH Requirement
-1902(a)(14) - Cost Sharings
-1902(a)(18) - Estate Recovery
-1902(a)(23) - Freedom of Choice
-1902(a)(34) - Retroactive Coverage
-1902(a)(4) - Proper & Efficient Administration
-1902(a)(54) - Drug Rebate

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-1903(m)(2)(A) except 1903(m)(2)(A)(i), 1903(m)(2)(A)(vi), 1903(m)(2)(H)
-Expenditures Related to Administration Simplication and Delivery Systems
-Expenditures Related to Benefits
-Expenditures Related to Expansion of Existing Eligibility Groups base on Eligibility Simplification

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Maternity, Occupational Therapy, Outpatient Hospital, Outpatient Mental

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners

Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplantation of Organs and Tissue and Related Immunosuppresant Drugs, Transportation, Vision, X-Ray

-Obstetricians/Gynecologists
-Pediatricians
-Physician Assistants

## Enrollment

**Populations Voluntarily Enrolled:**

None

**Populations Mandatorily Enrolled:**

-Adoption Subsidy Children
-Adults Without Minor Children Title XIX Waivers
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Federal Poverty Level Children Under Age 19 (SOBRA)
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XIX Waiver Spend Down Population

**Subpopulations Excluded from Otherwise Included Populations:**

-No populations are excluded

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**

None

## Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

No

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-None - managed care entity provides standard prescription drug coverage

## MH/SUD PIHP - Risk-based Capitation

### Service Delivery

**Included Services:**
Case Management, Crisis, Detoxification, Emergency and Non-emergency Transportation, Individual Therapy and Counseling, Inpatient Mental Health, Inpatient Psychiatric, Inpatient Substance Use Disorders, Laboratory, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Use Disorders, Pharmacy, Residential Substance Use Disorders Treatment Programs, X-Ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants

### Enrollment

**Populations Voluntarily Enrolled:**
None

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

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

**Lock-In Provision:**
No lock-in

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

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
No

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
-None - managed care entity provides standard prescription drug coverage

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

# ARIZONA
## Arizona Health Care Cost Containment System (AHCCCS)

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Acute uses health risk assessment form to identify members
-ALTCS considers all members special needs

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AZ Physicians IPA (Family Planning Extension)
Bridgeway (Family Planning Extension)
Bridgeway Health Solution (PC)
Care 1st Health Plan (Family Planning Extension)
Department of Economic Security/Childrens Medical and Dental Program (Family Planning Extension)
Department of Economic Security/Division of Developmental Disabilities (PC)
Evercare Select (PC)
Health Choice Arizona (HP)
Maricopa County Health Plan (HP)
Mercy Care Plan (HP)
Phoenix Health Plan (Family Planning Extension)
Pima Health System (Family Planning Extension)
Pima Health System (PC)
SCAN
University Family Care (HP)
AZ Physicians IPA (HP)
Bridgeway Health Solution (HP)
Care 1st Health Plan
Cochise Co. Dept. of Health Services (PC)
Department of Economic Security/Childrens Medical and Dental Program (HP)
Department of Health Services (Behavioral Health)
Health Choice Arizona (Family Planning Extension)
Maricopa County Health Plan (Family Planning Extension)
Mercy Care Plan (Family Planning Extension)
Mercy Care Plan (PC)
Phoenix Health Plan (HP)
Pima Health System (HP)
Pinal County Long Term Care (PC)
University Family Care (Family Planning Extension)
Yavapai County Long Term Care (PC)

## ADDITIONAL INFORMATION

12 months guaranteed eligibility for deemed newborns/born to mothers receiving Medicaid (Title XIX). Otherwise, 6 months eligibility guarantee for individuals enrolled with a health plan for the first time and become ineligible prior to 6 months of enrollment. This 6 month guarantee does not apply to members receiving Long Term Care services.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Dentist Survey
-Encounter Data (see below for details)
-Enrollee Hotlines
-EPSDT Annual Reports
-EPSDT Quarterly Reports
-Family Planning Annual Reports
-Focused Studies
-Maternity Annual Reports
-MCO Standards (see below for details)
-Member Survey
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)

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

-Performance Measures (see below for details)
-Physician Survey
-Provider Data
-Quality Management/Quality Improvement Annual Plans and Annual Evaluations

### Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-State-developed Survey

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

## Encounter Data

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

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

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

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

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent well-care visit rates
-Advance Directives
-Annual Dental Visits among Children (ages 3 - 20)
-Asthma - appropriate use of medications
-Children's Access to Primary Care Providers
-Children's Access to Primary Care Providers - KidsCare

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

Population
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Health Screenings
-Immunizations for two year olds
-Influenza Immunizations and Pneumococcal Vaccination Rates in the Elderly and Physically Disabled
-Initiation of prenatal care - timeliness of
-Lead Screening Rate
-Low Birth Weight Infants
-Population in Nursing Facilities and In Home Community Based Setting (ALTCS indicator)
-Utilization of Family Planning Services
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Access/Availability of Care:
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries
-Utilization of Family Planning Services

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

### Health Plan Stability/ Financial/Cost of Care:
-Agency performance bond requirements
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Financial Viability Ratios (i.e., Current Ratio, Medical Expense, Administrative, Equity/Member)
-Minimum equity requirements
-Net income
-Total revenue

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

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

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Medical problems of the elderly
-Pharmacy management
-Prevention of Influenza

### Non-Clinical Topics:
-Advance Directives
-Availability of language interpretation services
-Provider education regarding cultural health care needs of members

# ARIZONA
# Arizona Health Care Cost Containment System (AHCCCS)

## Standards/Accreditation

**MCO Standards:**
-CMS Meaningful Use (electronic medical records)
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-Managed Care Rules (BBA)
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Health Services Advisory Group
-Healthcare Excel
-Mercer

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities:**
-Ad hoc QM reviews
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# QUALITY ACTIVITIES FOR PIHP

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

**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

-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Physician Survey
-PIHP Standards (see below for details)
-Provider Data
-Quality Management/Quality Improvement Annual Plans and Annual Evaluations

### Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-Member Survey
-State-developed Survey

-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

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

### State conducts general data completeness assessments:
Yes

# ARIZONA
# Arizona Health Care Cost Containment System (AHCCCS)

## Performance Measures

### Process Quality:
-Appropriateness of services
-Coordination of care with acute contractors/pcp's
-Member/Family involvement
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Health Status/Outcomes Quality:
-Coordination of Care
-Patient satisfaction with care
-Symptomatic and functional improvement
-Transition of Care

### Access/Availability of Care:
-Access to care/ appointment availability
-Appointment Standards
-Ratio of mental health providers to number of beneficiaries

### Use of Services/Utilization:
-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

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

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

### Beneficiary Characteristics:
-Geographic
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to PIHPs
-PIHP/PCP-specific disenrollment rate

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Access to Care
-Behavior health assessment - birth to 5 years of age
-Coordination of primary and behavioral health care
-Follow-up after hospitalization
-Informed consent for psychotropic medication prescription
-Pharmacy management
-Reducing the use of seclusion & restraint
-Transition of Care

### Non-Clinical Topics:
-Availability of language interpretation services

## Standards/Accreditation

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

### Accreditation Required for Participation:
None

# ARIZONA
## Arizona Health Care Cost Containment System (AHCCCS)

**Non-Duplication Based on Accreditation:**
None

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Name:**
-Health Care Excel

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

**EQRO Optional Activities**
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

# ARKANSAS
## SafetyNet Benefit Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Gene Gessow
State Medicaid Agency
(501) 682-8292

**State Website Address:**

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

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
March 03, 2006

**Implementation Date:**
October 01, 2006

**Waiver Expiration Date:**
September 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration & Scope
-1902(a)(23) Freedom of Choice

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Cost Containment Strategy

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Personal Care, Physical Therapy, Physician, Podiatry, Speech Therapy, X-Ray

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

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-1115 Demonstration Waiver (AR Kids B
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

-Foster Care Children
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligiblity Period that is Retroactive
-family planning waiver
-Medically Needy "Spenddown" Categories
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

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

Connect Care

## ADDITIONAL INFORMATION

This program includes both ConnectCare PCCM Program as well as FFS-based SafetyNet Benefits Program for uninsured employess of eligible providers. Annual benefits for SNBP enrollees are limited to 6 physician visits, 2 outpatient hospital visits, 2 prescriptions and 7 days inpatient hospital stay.

## QUALITY ACTIVITIES FOR PCCM

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

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

**Consumer Self-Report Data:**
-Satisfaction Survey

## Performance Measures

**Process Quality:**
None

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

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

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

**Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

# DELAWARE
## Diamond State Health Plan

## CONTACT INFORMATION

**State Medicaid Contact:**

Mary Marinari
Delaware Medicaid and Medical Assistance
(302) 255-9548

**State Website Address:**

http://www.dmap.state.de.us

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
EDS, Inc

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
May 17, 1995

**Implementation Date:**
January 01, 1996

**Waiver Expiration Date:**
December 31, 2013

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(34)
-1902(a)(43)

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-1902(a)(43)
-Budget Neutrality
-Eligibility Expansion
-Family Planning Expenditures

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

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

**Allowable PCPs:**
-Addictionologists
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Psychiatrists
-Psychologists
-Rural Health Clinics (RHCs)

# DELAWARE
# Diamond State Health Plan

## Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Adults, nonhead of household at or below 100% FPL
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Tricare/CHAMPUS

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

## Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# DELAWARE
# Diamond State Health Plan

## Fee for Service Model - Fee-for-Service

### Service Delivery

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

**Allowable PCPs:**
-Addictionologists
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Psychiatrists
-Psychologists
-Rural Health Clinics (RHCs)

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Expanded Adults at or below 100 % FPL
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

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

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

# DELAWARE
## Diamond State Health Plan

**Program Includes People with Complex (Special) Needs:**

Yes

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

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Delaware Physicians Care, Inc

Unison Health Plan of Delaware, Inc.

Diamond State Partners

## ADDITIONAL INFORMATION

The Diamond State Health Plan (DSHP) is a state-wide mandatory managed care program. Over 80% of the Delaware Medicaid population is included in this program with the exception of member in other community-based waivers and Medicare dual eligibles. The DSHP includes an expansion population of adults with incomes below 100% of FPL.

Under the MCO managed care entity, Special Needs Children (State-defined): All children below 21, no income or resource limit that meet the SSN Functional Disability Requirements. Vision and hearing services are provided to children under 21.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

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

### Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation

### Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups
-State-developed Survey

### Use of HEDIS:

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

### Encounter Data

# DELAWARE
## Diamond State Health Plan

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, 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
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Gender-appropriate diagnosis/procedure

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Antidepressant medication management
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Cholesterol screening and management
-Controlling high blood pressure
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Blood tests results for diabetes
-Obesity rates for adolescents
-Patient satisfaction with care
-Percentage of low birth weight infants
-Provider surveys

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment

### Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary

panels
-Ratio of PCPs to beneficiaries

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

### Health Plan/ Provider Characteristics:
None

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Diabetes management
-Emergency Room service utilization
-Low birth-weight baby
-Pharmacy management
-Pre-natal care

### Non-Clinical Topics:
-Availability of language interpretation services
-Health information technology (e.g. state implementation of immunization and other registries, telemedicine initiatives, etc…)
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

## Standards/Accreditation

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

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Mercer Health & Benefits LLC

### EQRO Organization:
-Quality Improvement Organization (QIO)

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

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

# DELAWARE
## Diamond State Health Plan

### Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# FLORIDA
## Florida Medicaid Reform

## CONTACT INFORMATION

**State Medicaid Contact:**

Linda Macdonald
Florida Agency for Health Care Administration
(850) 412-4031

**State Website Address:**

http://ahca.myflorida.com/Medicaid/medicaid_reform

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Automated Health Systems, Inc.

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
October 19, 2005

**Implementation Date:**
July 01, 2006

**Waiver Expiration Date:**
June 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(A) Eligibility
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(c)(i) Income and Resource Test
-1902(a)(14) Cost Sharing insofar as it incorporate
-1902(a)(23) Freedom of Choice
-1902(a)(27) Provider Agreements
-1902(a)(34) Retroactive Eligibility
-1902(a)(37)(B) Payment Review

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-1903(m)(2)(H) Automoatic Re-enrollemnt Expenditures
-Expenditures for employee costs of insurance for individuals who have opted out of Medicaid
-Expenditures for enhanced benefit accounts
-Expenditures for health care services provided under the Low Income Pool

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Community Mental Health, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mental Health Targeted Case Management, Occupational Therapy,

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists

Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Respiratory Therapy, Speech Therapy, Transportation, Vision, X-Ray

-Pediatricians
-Rural Health Clinics (RHCs)

## Enrollment

**Populations Voluntarily Enrolled:**

-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women

**Populations Mandatorily Enrolled:**

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**

-Family Planning Waiver Eligibles
-Medically Needy
-MediKids
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Women with Breast or Cervical Cancer

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**

None

## Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

No

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-None - managed care entity provides standard prescription drug coverage

## Medical-only PIHP (risk or non-risk, non-comprehensive) - FFS w/ Some Risk Capitation

### Service Delivery

**Included Services:**

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

**Allowable PCPs:**

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

### Enrollment

**Populations Voluntarily Enrolled:**

-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women

**Populations Mandatorily Enrolled:**

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**

-Family Planning Waiver Eligibles
-Medically Needy
-MediKids
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Women with Breast or Cervical Cancer

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**

None

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

# FLORIDA
## Florida Medicaid Reform

**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:**

-Developmental Disabilities Agency
-Maternal and Child Health Agency
-Public Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Better Health, LLC (Reform)
Children's Medical Services (Reform)
Freedom Health Plan, Inc. (Reform)
Humana Medical Plan, Inc. (Reform)
Medica Health Plans of Florida, Inc. (Reform)
Molina Healthcare of Florida, Inc. (Reform)
Sunshine State Health Plan (Reform)
United Healthcare of Florida, Inc. (Reform)
Universal Health Care, Inc. (Reform)

Better Health, LLC (Reform)
First Coast Advantage (Reform)
Freedom Health Plan, Inc. (Reform)
Humana Medical Plan, Inc. (Reform)
Molina Healthcare of Florida, Inc. (Reform)
South Florida Community Care Network (Reform)
United Healthcare of Florida, Inc. (Reform)
Universal Health Care, Inc. (Reform)

## ADDITIONAL INFORMATION

The Provider Service Networks are reimbursed on a fee-for-service basis for all Florida state plan covered services. Under Reform, the fee-for-service PSN must cover transportation, which is done on a capitated basis.

The Childrens Medical Services Network is classified as a Provider Service Network and a speciality plan under Medicaid Reform. This plan was developed to serve children with special health care needs as defined by Florida statutes on a voluntary basis.

AIDS Healthcare Foundation of Florida (AHF MCO), doing business as Positive Health Care, a specialty plan (HMO) for beneficiaries living with HIV/AIDS.

Those children whose serious or chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**

-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Ombudsman

**Use of Collected Data:**

-Contract Standard Compliance
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting

-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionaire (Modified)
  Adult Medicaid SSI Questionaire (Modified)
  Children Medicaid AFDC Questionaire (Modified)
  Children Medicaid SSI Questionaire (Modified)
-Consumer/Beneficiary Focus Groups
-State-developed Survey

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

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCO

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent well-care visit rate
-Adults Access to Preventive/Ambulatory Health Services
-Ambulatory care
-Annual dental visits
-Antidepressant medication management
-BMI Assessment
-Breast Cancer screening rate

### Health Status/Outcomes Quality:
-Comprehensive Diabetes Care
-Controlling high blood pressure

-Cervical cancer screening rate
-Childhood Immunization Status-Combo 2 and 3
-Controlling high blood pressure
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Follow-up Care for Children Prescribed ADHD Medication
-Frequency of HIV Disease Monitoring Lab Tests
-Highly Active Anti-Retroviral Treatment
-HIV-Related Medical Visits
-Immunizations for Adolescents
-Lead Screening in Children (LSC)
-Lipid Profile Annually
-Mental Health Readmission Rate
-Mental Health Utilzation-Inpatient, Intermediate, and Ambulatory Services
-Number of Enrollees admitted to state mental hospital
-Persistence of Beta-Blocker Treatment After a Heart Attack
-Precentage of Enrollees Participating in Disease Management Program
-Prenatal and postpartum care
-Prenatal Care Frequency
-Use of Angiotensin-Converting Enzyme Inhibitors/Angiotensin Receptor Blockers Therapy
-Use of Appropriate Medications for People with Asthma (ASM)
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Access/Availability of Care:
-Annual dental visit

### Use of Services/Utilization:
-Adolecent wellcare visits
-Ambulatory care
-Number of enrollees admitted to the state hospital
-Use of beta agonist
-Well child visit in the 3rd, 4th, 5th, and 6th years of life
-Well child visit in the first 15 months of life

### Health Plan Stability/ Financial/Cost of Care:
None

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

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Adolescent Well Care/EPSDT
-Asthma management
-Child Health Checkups
-Childhood Immunization
-CLAS - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
-Clinical Health Care Disparities - Blood Lead Screening in African American Children
-Clinical Health Care Disparities: Oral Health (Annual Dental Visit)
-Coordination of care for persons with physical disabilities
-Depression management
-Follow-up After Discharge From Mental Health Acute Care Facility
-Improving Ambulatory Follow-up Appointments After Discharge From Inpatient Mental Health Treatment
-Improving Annual Dental Visits
-Inpatient maternity care and discharge planning
-Lead toxicity

-Sexually transmitted disease treatment
-Use of Appropriate Asthma Drug Therapy
-Well Child Care/EPSDT
-Well-Child Visits in the First 15 Months of LIfe - Six or More Visits

### Non-Clinical Topics:

-Adolescent Child Health Check-up Participation Rates within and Across Ratial Groups
-Behavioral Health Discharge Planning
-Disparity in Well-Checkup Visits between Younger and Older Children
-Improving Member Satisfaction With Customer Service
-Language and Culturally Appropriate Access to Preventive Health Care Services
-Member Service Call Answer Timeliness and Call Abandonment Rate
-Quality Assessment and Performance Improvement (QAIP)

## Standards/Accreditation

### MCO Standards:

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

### Accreditation Required for Participation:

-AAAHC (Accreditation Association for Ambulatory Health Care)
-NCQA (National Committee for Quality Assurance)
-URAC

### Non-Duplication Based on Accreditation:

None

### EQRO Name:

-Health Systems Advisory Group (HSAG)

### EQRO Organization:

-Health Systems Advisory Group (HSAG)
-Private accreditation organization

### EQRO Mandatory Activities:

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

### EQRO Optional Activities:

-Assessment of MCO information systems
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

### Implementation of P4P:

The State HAS NOT implemented a Pay-for-Performance program with the MCO

### Program Payers:

Not Applicable

### Population Categories Included:

Not Applicable

### Rewards Model:

Not Applicable

### Clinical Conditions:

Not Applicable

### Measurement of Improved Performance:

Not Applicable

### Initial Year of Reward:

Not Applicable

### Evaluation Component:

Not Applicable

**Member Incentives:**
Not Applicable

## QUALITY ACTIVITIES FOR PIHP

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

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

**Consumer Self-Report Data:**
-CAHPS
Adult Medicaid SSI Questionaire (Modified)
Adult Medicaid TANF Questionaire (Modified)
Children Medicaid SSI Questionaire (Modified)
Children Medicaid TANF Questionaire (Modified)

**Use of HEDIS:**
-The State uses SOME of the HEDIS measures listed for Medicaid
-State uses/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

### Performance Measures

**Process Quality:**
-Adolescent well-care visit rate
-Ambulatory Care
-Annual Dental Visit
-Cervical cancer screening rate
-Controlling high blood pressure
-Diabetes medication management
-Follow-up After Hospitalization for Mental Illness
-Follow-up after hospitalization for mental illness
-Mental Health Readmission Rate
-Mental Health Utilization
-Prenatal and Postpartum Care
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

**Health Status/Outcomes Quality:**
-Comprehensive Diabetes Care
-Controlling high blood pressure

**Access/Availability of Care:**
-Annual Dental Visit
-Prenatal and Postpartum Care

**Use of Services/Utilization:**
-Adolocent Wellcare Visit
-Ambulatory Care
-Number of enrollees admitted to state mental hospitals
-Use of beta agonist
-Wellchild visit in the 3rd, 4th, 5th, and 6th years of life
-Wellchild visit in the first 15 months of life

**Health Plan Stability/ Financial/Cost of Care:**
None

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

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

# FLORIDA
## Florida Medicaid Reform

## Performance Improvement Projects

### Project Requirements:

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

### Clinical Topics:

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Follow-up within Seven Days After Acute Discharge for a Mental Health Diagnosis
-HIV/AIDS Prevention and/or Management
-Well Child Care/EPSDT

### Non-Clinical Topics:

-Decreasing the Time from Claims Receipt to Claims Payment
-FARS/CFARS Submission Rates
-Improvement of Documentation Related to Coordination of Care between Mental Health Providers and PCPs within a Prepaid Mental Health Plan
-Improving Assessment to Care by Reducing Abandoned Call Rate

## Standards/Accreditation

### PIHP Standards:

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

### Accreditation Required for Participation:

-PIHPs not required to be accredited at this time, as they are fee-for-service

### Non-Duplication Based on Accreditation:

None

### EQRO Name:

-Health Systems Advisory Group (HSAG)

### EQRO Organization:

-Private accreditation organization

### EQRO Mandatory Activities:

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

### EQRO Optional Activities

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

# HAWAII
# Hawaii QUEST Expanded (QEx)

## CONTACT INFORMATION

**State Medicaid Contact:**

Noreen "Kookie" Moon-Ng
Hawaii Department of Human Services, Med-QUEST Division
(808) 692-8134

**State Website Address:**

http://www.state.hi.us/dhs/health/medquest

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
ACS

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
July 16, 1993

**Implementation Date:**
August 01, 1994

**Waiver Expiration Date:**
June 30, 2013

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(C)
-1902(a)(17)
-1902(a)(17)(D)
-1902(a)(23) Freedom of Choice
-1902(a)(34)

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-HCBS
-MCO Definition 1903(m)(1)(A)
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)
-MCO Payments in non-rural areas to the extent necessary if a plan exceeds its enrollment cap 1903(m)(2)(A)(xii)

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Cornea and Kidney Transplants and Bone Grafts, Dental, Dietary, Durable Medical Equipment, EPSDT, HCBS, Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Intermediate Care Facility, Laboratory, Language/Interpreter, Long Term Care, Maternity, Occupational Therapy, Optometry, Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Preventive, Skilled Nursing Facility, Speech Therapy, Sterilization/Hysterectomies,

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

Subacute Care (when cost appropriate), Transportation, X-Ray

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Breast and Cervical Cancer Treatment Group
-Childless Adults who meet Medicaid asset limits
-Foster Care Children
-Medically Needy AFDC-related Adults and Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
12 month lock-in

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

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

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
-None - managed care entity provides standard prescription drug coverage

## 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 provider referrals to identify members of these groups

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aloha Care

Evercare
HMSA-Medical
Kaiser Permanente
Ohana

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

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

### Use of Collected Data:

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

### Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

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

### Collection: Standardized Forms:

None

### Validation - Methods:

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

language used to create an encounter data file for submission

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

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-State contracted with HSAG on encounter validation project

**State conducts general data completeness assessments:**

Yes

## Performance Measures

**Process Quality:**

-Adolescent immunization rate
-Adolescent well-care visit rates
-Annual monitoring for patients on persistent medication
-Antidepressant medication management
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Avoidance of antibiotic treatment in adults with acute bronchitis
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Childhood immunizations
-Chlamdyia screening in women
-Cholesterol management for patients with cardiovascular conditions
-Comprehensive diabetes care
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Flu shots for older adults
-Follow-up after hospitalization for mental illness
-Follow-up of care for children prescribed ADHD medication
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Medication reconciliation post-discharge
-Osteoporosis testing in older women
-Persistence of B blocker treatment after a heart attack
-Pneumonia vaccination status for older adults
-Smoking prevention and cessation
-Use of appropriate medications for people with asthma
-Use of high-risk medications in the elderly
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

**Health Status/Outcomes Quality:**

-Blood pressure control
-Cholesterol control (LDL)
-Diabetes care (ALC)
-Emergency room visits
-Inpatient admissions
-Patient satisfaction with care

**Access/Availability of Care:**

-Adult's access to preventive/ambulatory health services
-Average wait time for an appointment with PCP
-CAHPS survey - getting care quickly/getting needed care
-Children's access to primary care practitioners

**Use of Services/Utilization:**

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

-Initiation and engagement of alcohol and other drug dependence treatment
-Prenatal and postpartum care
-Ratio of PCPs to beneficiaries
-Inpatient admissions/1,000 beneficiary
-Inpatient utilization - general hospital/acute care
-Mental health utilization - percentage of members receiving inpatient, day/night care and ambulatory services
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of PCP visits per beneficiary
-Re-admission rates of MH/SUD
-Well-child visits in first 15 months of life
-Well-child visits in the third, fourth, fifth and sixth year of life

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Net worth
-Relative resource use for people with asthma
-Relative resource use for people with diabetes
-State minimum reserve requirements
-Total revenue

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

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Adolescent Well Care/EPSDT
-Asthma management
-Childhood Immunization
-Childhood obesity
-Diabetes management
-Emergency Room service utilization
-Well Child Care/EPSDT

### Non-Clinical Topics:
None

## Standards/Accreditation

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

### Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)
-URAC

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Health Services Advisory Group

### EQRO Organization:
-Private accreditation organization
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Validation of encounter data

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO, but plans to implement one in the future

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by disease and medical condition

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Clinical Conditions:**
Asthma
Childhood immunizations
Diabetes
Prenatal Care
Well-child visits

**Measurement of Improved Performance:**
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# INDIANA
## Healthy Indiana Plan

## CONTACT INFORMATION

**State Medicaid Contact:**

Sarah Jagger
Office of Medicaid Policy & Planning
(317) 234-5545

**State Website Address:**

http://www.in.gov/fssa/2408.htm

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
December 14, 2007

**Implementation Date:**
January 01, 2008

**Waiver Expiration Date:**
December 31, 2012

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13)(A) Disproportionate Share Hospital (DSH)
-1902(a)(23) Freedom of Choice

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Eligibility Expansion

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Durable Medical Equipment, Emergency, EPSDT, Family Planning, Food Supplements, FQHC, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nutritional Supplements, Occupational Therapy, Organ Transplants, Out-of-state Medical, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Respiratory Therapy, RHC, Smoking Cessation, Speech Therapy, X-Ray

**Allowable PCPs:**
-Members are not required to select a primary care provider

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Uninsured Adults Under 200% FPL

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Primary Health Insurance
-Participate in HCBS Waiver
-Persons above 200% FPL
-Persons with employer sponsored insurance
-Persons with insurance during the past six months
-Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

-Claims Analysis
-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:**

-Eligibility Agency
-Enrollment Broker
-Health Plans
-PBM
-State Actuary

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem-Healthy Indiana Plan

Enhanced Services Plan (ESP)-Healthy Indiana Plan

MDwise-Healthy Indiana Plan

## ADDITIONAL INFORMATION

1115(a) Demonstration includes the Hoosier Healthwise program as well (with the exception of the MCHIP population that remains on the 1915(b) Waiver). Enrollees with pre-defined high risk conditions are served by the Enhanced Services Plan (ESP). ESP is delivered fee for service. ESP is administered by contract with vendors that administer the Indiana Comprehensive Health Insurance Association (ICHIA).

# INDIANA
## Healthy Indiana Plan

## QUALITY ACTIVITIES FOR MCO/HIO

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

### Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
None

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

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

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

### State conducts general data completeness assessments:
Yes

-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

## Performance Measures

**Process Quality:**
-Annual Preventive Services

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

**Use of Services/Utilization:**
-Drug Utilization
-Number of PCP visits per beneficiary

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

**Health Plan/ Provider Characteristics:**
-Provider turnover

**Beneficiary Characteristics:**
-MCO/PCP-specific disenrollment rate

**Performance Measures - Others:**
None

## Performance Improvement Projects

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

**Clinical Topics:**
-Annual Preventive Services

**Non-Clinical Topics:**
-Encounter Data

## Standards/Accreditation

**MCO Standards:**
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-URAC Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Burns & Associates

**EQRO Organization:**
-Independent Consultant

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

-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-An Independent Annual Report which documents accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstrations.
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# INDIANA
# Hoosier Healthwise (1115)

## CONTACT INFORMATION

**State Medicaid Contact:**

Sarah Jagger
Office of Medicaid Policy & Planning
(317) 234-5545

**State Website Address:**

http://www.in.gov/fssa/2408.htm

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
December 14, 2007

**Implementation Date:**
January 01, 2008

**Waiver Expiration Date:**
December 31, 2012

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Eligibility Expansion

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Food Supplements, FQHC, Hearing, Home Health, Immunization, Infant Formulas, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nutritional Supplements, Occupational Therapy, Organ Transplants, Out-of-state Medical, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Respiratory Therapy, RHC, Smoking Cessation, Speech Therapy, Transportation, Vision, X-Ray

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

#### Enrollment

# INDIANA
## Hoosier Healthwise (1115)

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Hospice
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Uses Health Needs Screening

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Eligibility Agency
-Enrollment Broker
-Health Plans
-PBM
-State Actuary

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem-Hoosier Healthwise
Managed Health Services (MHS)-Hoosier Healthwise
MDwise-Hoosier Healthwise

## ADDITIONAL INFORMATION

Hoosier Healthwise is authorized by both an 1115(a) Demonstration and a 1915(b) Waiver. The MCHIP and Presumptively Eligible Pregnant Women populations are the only populations still on the 1915(b). The 1115(a) demonstration was established for the Healthy Indiana Plan. The remainder of the Hoosier Healthwise population was placed onto that 1115(a) demonstration for budget neutrality purposes.

State defined special needs children are children who have or at increase risk for a chronic physical, developmental, behavioral, or emotional condition.

# INDIANA
## Hoosier Healthwise (1115)

## QUALITY ACTIVITIES FOR MCO/HIO

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

### Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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

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

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

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

### State conducts general data completeness assessments:
Yes

-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

## Performance Measures

### Process Quality:
-Adolescent well-care visit rate
-Annual Monitoring for Persistant Medications
-Antidepressant medication management
-Appropriate Testing and Treatment for COPD
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Depression management/care
-Diabetes Management
-Follow-up after hospitalization for mental illness
-Follow-Up for Children Prescribed ADHD Medications
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Initiation of Prenatal Care
-Lead screening rate
-Use of Imaging Studies for Low Back Pain
-Utilization for Ambulatory, Inpatient, and Mental Health Treatment
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of 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/SUD facility
-Re-admission rates of MH/SUD

### Health Plan Stability/ Financial/Cost of Care:
-Administrative Cost Ratio
-Claims Payable per Member
-Cost per Member
-Days cash on hand
-Days in Claims Receivable
-Days in unpaid claims/claims outstanding
-Equity per Member
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Ratio Assets to Liabilities

### Health Plan/ Provider Characteristics:
-Grievance and Appeal Timeliness
-Languages Spoken (other than English)
-Provider Complaints
-Provider turnover

-Revenue per Member
-State minimum reserve requirements
-Total revenue

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-ADHD Medication Follow-Up: Initiation Phase
-Adolescent Well-Care Visits
-Behavioral Health Seven Day Follow-Up
-Breast Cancer Screening
-Cervical Cancer Screening
-Diabetes-LDL-C, HbA1c and Eye Exam
-Lead Screening
-Timely Prenatal Visits

### Non-Clinical Topics:
-Program Integrity
-Provider Network Services

## Standards/Accreditation

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

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Burns & Associates

### EQRO Organization:
-Independent Consultant

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

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

## Pay for Performance (P4P)

### Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

### Program Payers:
Medicaid is the only payer

# INDIANA
## Hoosier Healthwise (1115)

### Population Categories Included:
A subset of MCO members, defined by beneficiary age
A subset of MCO members, defined by disease and medical condition

### Rewards Model:
Payment incentives/differentials to reward MCOs
Withholds as an incentive

### Clinical Conditions:
Cervical Cancer Screening
Comprehensive Diabetes Care-LDL-C Screening
Follow Up Care for Children Prescribed ADHD Medication
Follow-Up after inpatient mental health hospitalization-Seven Day
Frequency of Ongoing Prenatal Care
Timeliness of Post Partum Visit
Timeliness of Prenatal Care
Well Child Visit in the Third-Sixth Years of Life, One or More Visits
Well-Child Visits, First 15 Months, Six or More Visits

### Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

### Initial Year of Reward:
2008

### Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

### Member Incentives:
Not Applicable

# KENTUCKY
## Kentucky Health Care Partnership Program

## CONTACT INFORMATION

**State Medicaid Contact:**

April Lowery
Kentucky Department for Medicaid Services
(502) 564-8196

**State Website Address:**

http://www.chfs.ky.gov/dms

## PROGRAM DATA

**Program Service Area:**
Region

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
6 months guaranteed eligibility

**Initial Waiver Approval Date:**
October 06, 1995

**Implementation Date:**
November 01, 1997

**Waiver Expiration Date:**
October 31, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(A) Coverage of Services for FQHCs and RHCs
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(15) Payment for FQHCs and RHCs
-1902(a)(17) Financial Eligibility Standard
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive eligibility
-1902(e)(2) Eligibility

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Expenditures for capitation payments made to MCO not in compliance with section 1903(2)(A)(vi)
-MCO Definition 1903(m)(1)(A)
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)
-MCO Payments to FQHC/RHC 1903(m)(A)(ix)

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Alternative Birth Center, Ambulatory Surgical Centers, Case Management, Chiropractic, Dental, Durable Medical Equipment, End Stage Renal Dialysis, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Independent Laboratory, Inpatient Hospital, Laboratory, Medical Detoxification, Outpatient Hospital, Pharmacy, Physician, Podiatry, Preventive Health, Therapeutic Evaluation & Treatment, Transportation, Urgent Emergency

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

Care, Vision, X-Ray

-Physician Assistants
-Rural Health Centers (RHCs)

### Enrollment

**Populations Voluntarily Enrolled:**

None

**Populations Mandatorily Enrolled:**

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligibility for Spend down
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Psychiatric Residential Treatment Facility PRTF
-Reside in Nursing Facility or ICF/MR
-Residents of Institutions for Mental Disease

**Lock-In Provision:**

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

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

No

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-None - managed care entity provides standard prescription drug coverage

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

# KENTUCKY
## Kentucky Health Care Partnership Program

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Passport Health Plan

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

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

### Use of Collected Data:

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

### Consumer Self-Report Data:

None

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing

### Collection: Standardized Forms:

None

### Validation - Methods:

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

-Per member per month analysis and comparisons across MCOs

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

**State conducts general data completeness assessments:**
No

## Performance Measures

**Process Quality:**
None

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

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

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

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

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

**Clinical Topics:**
-Adolescent Well Care/EPSDT
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment
-Pre-natal care
-Sickle cell anemia management
-Smoking prevention and cessation, "Yes You Can"
-Well Child Care/EPSDT

**Non-Clinical Topics:**
None

## Standards/Accreditation

# KENTUCKY
## Kentucky Health Care Partnership Program

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

**Accreditation Required for Participation:**
-Plan required to obtain MCO accreditation by NCQA or other accrediting body

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Island Peer Review Organization (IPRO)

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects (PIPs)
-Validatioon of performance measures reported by MCO

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

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# MARYLAND
## HealthChoice

## CONTACT INFORMATION

**State Medicaid Contact:**

Nadine Smith
Department of Health and Mental Hygiene
(410) 767-1483

**State Website Address:**

http://www.dhmh.state.md.us/

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
(PSI) Policy Studies, Inc

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
October 30, 1996

**Implementation Date:**
June 02, 1997

**Waiver Expiration Date:**
December 31, 2013

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility
-1902(a)(47) Presumptive Eligibility
-1902(a)(8) - 6-month period of uninsurance for XIX children
-1902(bb) FQHC Payments

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

## SERVICE DELIVERY

### Medical-only PAHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Durable Medical Equipment, Family Planning, Hospital ER facility charges only, Laboratory, Pharmacy, Physician, Substance Abuse, X-Ray

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

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Individuals ages 19 and over with incomes < 116% of FPL

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

## Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# MARYLAND
# HealthChoice

## MCO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

**Included Services:**
Case Management, Chiropractic, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Gynecologists
-Internists
-Nurse Practitioners
-Rural Health Clinics (RHCs)

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency

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

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMERIGROUP - PAC
JAI Medical System
Maryland Physicians Care
Medstar Family Choice
Priority Partners MCO
United Health Care
AMERIGROUP Maryland Inc.
JAI Medical Systems - PAC
Maryland Physicians Care - PAC
Priority Partners - PAC
The Diamond Plan
United HealthCare - PAC

## ADDITIONAL INFORMATION

An eligible HealthChoice enrollee may be permitted to disenroll "for cause" from an MCO and enroll in another MCO outside of his/her annual right to change period if he/she is not hospitalized. The Department is responsible for purchase, examination, or fitting of hearing aids and supplies, tinnitus maskers, dental services provided for enrollees under 21 years old and pregnant women of any age, OT, PT, and ST for children under 21. There are additional optional services that some MCOs provide for their enrollees such as dental services for adults. Pregnant women in the Maryland Childrens Health Program are guaranteed eligibility for the duration of the pregnancy and 2 months postpartum. PAC enrollees with diabetes receive DME, podiatry and vision services.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Report Card

### Use of Collected Data:

-Beneficiary Plan Selection
-Consumer Report Card
-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
Medicaid Adult/ Version 4.0
Medicaid Children/Version 3.0
Special Needs Children with Chronic Conditions

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837,

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

ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

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

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

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Ambulatory Care for SSI Children and Adults
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Diabetes Management
-Frequency of on-going prenatal care
-HEDIS-Prenatal and Postpartum Care
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Lead screening rate
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Call Abandonment
-Call Answer Timeliness
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

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

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income

### Health Plan/ Provider Characteristics:
None

-Net worth
-State minimum reserve requirements
-Total revenue

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to MCO

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Cervical cancer screening (Pap Test)
-Initiation and Engagement of Alcohol and Other Drug Services

### Non-Clinical Topics:
None

## Standards/Accreditation

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

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Delmarva Foundation

### EQRO Organization:
-Quality Improvement Organization (QIO)

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

### EQRO Optional Activities:
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

## Pay for Performance (P4P)

### Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

### Program Payers:
Medicaid is the only payer

### Population Categories Included:
A subset of MCO members, defined by disease and medical condition

### Rewards Model:
Payment incentives/differentials to reward MCOs

### Clinical Conditions:
Adolescent Well Care
Ambulatory Care for SSI Adults
Ambulatory Care for SSI Children
Asthma
Cervical Cancer Screening
Childhood immunizations
Diabetes Eye Exam

### Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Lead Screening
Postpartum Care
Well-child visits

**Initial Year of Reward:**
2002

**Evaluation Component:**
The State has conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-Network Data
-PAHP Standards (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Beneficiary Plan Selection
-Fraud and Abuse
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
-State-developed Survey

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

### Encounter Data

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

**Collections - Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

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

**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 PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation

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

**State conducts general data completeness assessments:**
Yes

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

## Performance Measures

**Process Quality:**
-Access to Preventative Ambulatory Care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes medication management

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries satisfied with their ability to obtain care

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services
-Ratio of PCPs to beneficiaries

**Use of Services/Utilization:**
None

**Health Plan Stability/ Financial/Cost of Care:**
-Actual reserves held by plan
-Expenditures by medical category of service (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:**
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PAHPs

**Performance Measures - Others:**
None

## Standards/Accreditation

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

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# MASSACHUSETTS
## Mass Health

## CONTACT INFORMATION

**State Medicaid Contact:**

Robin Callahan
Office of Medicaid
(617) 573-1745

**State Website Address:**

http://www.mass.gov/masshealth

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
MAXIMUS

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
April 24, 1995

**Implementation Date:**
July 01, 1997

**Waiver Expiration Date:**
June 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(A)
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(C)(I)-(III)
-1902(a)(13) insofar as 1923(a)(1)
-1902(a)(14)
-1902(a)(16)
-1902(a)(17)
-1902(a)(23) Freedom of Choice
-1902(a)(32)
-1902(a)(34)
-1902(a)(4)(A)

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-MCO Definition 1903(m)(1)(A)

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Abortion, Ambulatory Surgery, Audiologist, Chiropractic, Community Health Center, Dental, Diabetes Self-Management Training, Dialysis, Durable Medical Equipment, Early Intervention, Emergency Inpatient Hospital, Emergency Outpatient Hospital, Emergency Transportation, EPSDT, Family Planning, Hearing Aid, Home Health, Immunization Administration, Inpatient Hospital, Laboratory, Medical Nutrition Therapy, Medical/Surgical Supplies, Non-Emergency

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

Transportation, Nurse Midwife, Nurse Practitioner, OB/GYN and Prenatal, Occupational Therapy, Orthotic, Outpatient Hospital, Oxygen and Respiratory Therapy Equipment, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Primary Care and Specialty Care Visits, Prosthetic (i.e. wigs), Radiology and Diagnostic, Skilled Nursing Facility, Speech Therapy, Tobacco Cessation, Transportation, Vision, X-Ray

-Physiatrists
-Rural Health Clinics (RHCs)

## Enrollment

**Populations Voluntarily Enrolled:**

-Foster Care Children

**Populations Mandatorily Enrolled:**

-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Over 65 years old
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

## Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## MH/SUD PIHP - Risk-based Capitation

### Service Delivery

**Included Services:**
Crisis, Detoxification, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Intermediate or Day/Night and Substance Use Disorder Treatment, Mental Health Intermediate or Day/Night, Mental Health Outpatient, Opioid Treatment Programs, Outpatient Substance Use Disorders, Substance Use Disorders Support

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

### Enrollment

**Populations Voluntarily Enrolled:**
-Foster Care Children
-Special Needs Children (BBA defined)

**Populations Mandatorily Enrolled:**
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Over 65
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only (children under age 21)
QMB (children under age 21)
SLMB, QI, and QDWI (children under age 21)

**Medicare Dual Eligibles Excluded:**
QMB Plus, SLMB Plus, and Medicaid only (age 21 and over)
QMB (age 21 and over)
SLMB, QI, and QDWI (age 21 and over)

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
No

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# MASSACHUSETTS
# Mass Health

## MCO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

**Included Services:**
Abortion, Audiologist, Case Management, Chiropractic, Dental - Emergency Related Dental in and Ambulatory Surgery/Outpatient Hospital Care, Diabetes Self-Management Training, Dialysis, Disease Management, Durable Medical Equipment, Early Intervention, Emergency, Emergency Services Program (ESP), EPSDT, Family Planning, Flouride Varnish, Hearing Aids, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional Care - for all Levels of Care Provided at either a Nursing Facility, Chronic, Laboratory, Medical Nutrition Therapy, Mental Health Diversionary, Orthotics, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Oxygen and Respiratory Therapy Equipment, Pharmacy, Physician, Podiatry, Prosthetics, Radiology and Diagnostic Tests - Magnetic Resonance Imagery and other Radiological and Diagnostic, Tobacco Cessation, Transportation (Emergent) - Ambulance (Air and Land) Including Specialty Care Transport, Transportation (Non-Emergent, to Out-of-State Location); Located Outside a 50-Mile Radius of Massachusetts, Vision Care (Medical Component), Wigs, X-Ray

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

### Enrollment

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

**Populations Mandatorily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Over 65 years old
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
HIV/AIDS Dual Eligibles
Severely Physically Disabled Dual Eligibles

**Medicare Dual Eligibles Excluded:**
All categories of Medicare Dual Eligilbes other than HIV/AIDS Dual Eligibles and Severely Physically Disabled Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**
Not Applicable

# MASSACHUSETTS
## Mass Health

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Barbituates
-Benzodiazepines
-Nonprescription drugs

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Department of Mental Retardation
-Department of Youth Services
-Developmental Disabilities Agency
-Education Agency
-Housing Agencies
-Massachusetts Rehabilitation Commision
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Boston Medical Center HealthNet Plan
MA Behavioral Health Partnership
Network Health
Fallon Community Health Plan
Neighborhood Health Plan
Primary Care Clinician Plan

## ADDITIONAL INFORMATION

The PCC Plan Reimbursement arrangement is fee-for-service with enhanced office visit claim - no case management fee paid for each member each month.

Mass Health has a behavioral carve-out for PCCM enrollees and for children in the care or custody of the Commonwealth. Regarding the MH/SUD PIHP included services, there is no long-term care in mental health residential or residential substance abuse treatment programs. The Outpatient Day programs are defined as full or part-time substance abuse or mental health services provided in an ambulatory setting.

Massachusetts Behavioral Health Partnership, the MH SUD PIHP is financed using actuarially sound capitation payments to fund the delivery and provision of behavioral health covered services. The aggregate capitation payments are assessed against actual BH service expenditures by the PIHP. Actual spending is then applied to the established risk-sharing corridors/the financial parameters which limited the extent to which the PIHP may experience earnings or losses. After those parameters are accounted for the State conducts a final financial reconciliation to address "surplus funding" recovery from the PIHP or to cover the cost of excess expenditures. CBHI capitated services are excluded from the risk arrangement.

Childrens Behavioral Health Initiative (CBHI) is an interagency undertaking by the Massachusetts Executive Office of Health and Human Services (EOHHS) and MassHealth whose mission is to strengthen, expand and integrate behavioral health services for MassHealth Members under the age of 21 into a community-based, culturally competent care.

Under the MCOs - Skilled Nursing Facility services are provided in the Institutional Care benefit (which also includes chronic or

rehabilitation hospital) for up to 100 days per enrollee per calendar year. The State is currently in EQRO negotiations.

Under the PIHP: Excluded Populations data element: Persons with other insurance with the exception for youth and adolescents under 21 receiving CNHI services are excluded.

One of the managed care entities, Neighborhood Health Plan (NHP) has two special programs for HIV/AIDS and severely physically disabled dual eligibles. As of 7/1/2010, NHP served 149 dual eligibles. These duals do get their pharmacy benefit from Medicare Part D Prescription Drug Plan. The MCO is responsible for providing the Part D excluded drugs that other MassHealth duals receive. This includes OTCs, Barbituates and Benzodiazepenes and legislatively mandated drugs.

# QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

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

### Use of Collected Data:

-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-State Medicaid Managed Care Quality Strategy
-Track Health Service provision

### Consumer Self-Report Data:

-Consumer Oriented Mental Health Report Card
-MHQP Member Experience Pilot Survey
-State-developed Survey

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

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

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:

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

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Antidepressant medication management
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Controlling high blood pressure
-Dental services
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation and engagement of SUD treatment
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

### Health Status/Outcomes Quality:
-Mortality rates
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Audited Financial Statements
-Cost/Utilization

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

-Days in unpaid claims/claims outstanding
-Debt ratio
-Division of Insurance reports for licensed MCOs
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Liquidity ratios (current ratio and acid test ratio)
-Medical loss ratio
-Net income
-Net worth
-Rate of return on assets
-State minimum reserve requirements
-Total revenue

### Beneficiary Characteristics:

-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

### Performance Measures - Others:

None

## Performance Improvement Projects

### Project Requirements:

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

### Clinical Topics:

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-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
-Inpatient maternity care and discharge planning
-Lead toxicity
-Low birth-weight baby
-Post-natal Care
-Pregnancy Prevention
-Pre-natal care
-Prescription drug abuse
-Smoking prevention and cessation
-Well Child Care/EPSDT

### Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

## Standards/Accreditation

### MCO Standards:

-State-Developed/Specified Standards

### Accreditation Required for Participation:

None

### Non-Duplication Based on Accreditation:

None

### EQRO Name:

-APS Healthcare

# MASSACHUSETTS
## Mass Health

**EQRO Organization:**
-QIO-like entity

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

**EQRO Optional Activities:**
None

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
Covers all MCO members

**Rewards Model:**
Payment incentives/differentials to reward MCOs
Withholds as an incentive

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
2010

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

**Member Incentives:**
Not Applicable

# QUALITY ACTIVITIES FOR PIHP

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

**Use of Collected Data:**
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-State Managed Care Medicaid Quality Strategy
-Track Health Service provision

**Consumer Self-Report Data:**
-MHQP Member Exp. Pilot Survey
-PIHP developed survey

**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 PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

# MASSACHUSETTS
## Mass Health

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

### PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-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:
-Antidepressant medication management
-Depression management/care
-Follow-up care for children prescribed ADHD medication
-Initiation and engagement of SUD treatment

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
-Timely access to MH/SUD services after hospitalization for MH/SUD condition.

### Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Continuing Care Rate
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD
-Timeliness of Post discharge after care

# MASSACHUSETTS
## Mass Health

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by Behavioral Health category of covered service
-Net income
-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
-Percentage of beneficiaries who are auto-assigned to PIHPs
-PIHP/PCP-specific disenrollment rate

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Coordination of primary and behavioral health care
-Depression management
-Emergency room service utilization for MH/SUD conditions
-ETOH and other substance abuse screening and treatment
-Hospital Discharge Planning for MH/SUD condtions
-Substance Use Disorders treatment after detoxification service

### Non-Clinical Topics:
-Member Access to Behavioral Health Services
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

## Standards/Accreditation

### PIHP Standards:
-Timely availability and access to Behavioral Health services following BH hospitalizations

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-APS Healthcare

### EQRO Organization:
-Quality Improvement Organization (QIO)

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

### EQRO Optional Activities
-Assessment of PIHP Information System
-Calculation of performance measures
-Conduct of performance improvement projects
-Technical assistance to PIHPs to assist them in conducting quality activities

# QUALITY ACTIVITIES FOR PCCM

### Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)

### Use of Collected Data:
-Health Services Research

-Enrollee Hotlines
-Focused Studies
-Network Data
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-State Medicaid Managed Care Quality Strategy

### Consumer Self-Report Data:
-The PCC Plan now collects member atisfaction on a biennial schedule. The PCC Plan did not administe

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Behavioral Health screening in children
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia screening in women
-Controlling high blood pressure
-Depression medication management
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Percentage of children with Behavioral Health (BH) screen with BH need identified
-Percentage of children with Behavioral Health need identified who received follow up.

### Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels

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

### Provider Characteristics:
None

### Beneficiary Characteristics:
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries auto-assigned to PCP
-Percentage of beneficiaries who are auto-assigned to PCCM

### Performance Measures - Others:
None

## Performance Improvement Projects

### Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Coordination of primary and behavioral health care
-Depression management
-Diabetes management
-Emergency Room service utilization

### Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Health information technology

-Pharmacy management
-Post-natal Care
-Pre-natal care
-Prescription drug abuse
-Well Child Care/EPSDT

# MINNESOTA
# Minnesota Prepaid Medical Assistance Project Plus-1115(a)

## CONTACT INFORMATION

**State Medicaid Contact:**

Gretchen Ulbee
Minnesota Department of Human Services
(651) 431-2192

**State Website Address:**

http://www.dhs.state.mn.us

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1115(a) - 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 27, 1995

**Implementation Date:**
July 01, 1995

**Waiver Expiration Date:**
December 31, 2013

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(A)(i)(IV) Coverage/Benefits for Pregnant Women
-1902(a)(10)(B) - Amount, Duration & Scope
-1902(a)(17) Comparability of Eligibility Standards
-1902(a)(23)(A) Freedom of Choice

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Eligibility Expansion
-Graduate Medical Education

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Dental, Durable Medical Equipment, Emergency Room, EPSDT, Family Planning, Hearing, Home Health, Hospice, ICF/MR, Community-Based, IEP, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Preventive Visits, Respiratory Therapy, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

# MINNESOTA
# Minnesota Prepaid Medical Assistance Project Plus-1115(a)

## Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-American Indians as defined in 25 U.S.C. 1603(c)
-Children under age 19 who are in state subsidized foster care or other out of home placement
-Children under age 19 who are receiving adoption assistance under Title IV-E
-Children under age 19 who are receiving foster care under Title IV-E
-Children under age 19 with special health care needs who are receiving services under a care system that receives grant funds Section 501(a)(1)(D) of Title V who are not using disabled basis of eligibility
-Disabled children under age 19 who are eligible for SSI under Title XVI who are not using a disabled basis of eligibility
-MA One year olds
-Medicare Dual Eligibles
-MinnesotaCare Caretaker Adults
-MinnesotaCare Children < 21
-MinnesotaCare Pregnant Women

**Subpopulations Excluded from Otherwise Included Populations:**
-Blind and disabled recipients under age 65
-Enrolled in Another Managed Care Program
-Had other health insurance during preceding 4 months (not including Medical Assistance, GAMC, TricCare/CHAMPUS)
-Individuals with household income above 150% of poverty with other health insurance
-Medicare Dual Eligibles
-Non-documented alien recipients who receive only emergency MA under Minn. Stat. 256B.06(4)
-Non-institutionalized recipients eligible on spend down basis
-Pregnant Women Up to 275 of FPG With Other Insurance
-Recipients residing in state institutions
-Recipients with private coverage through a MCO not participating in Medicaid
-Recipients with terminal or communicable diseases at time of enrollment
-Refugee Assistance Program recipients

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only
Under 65 and not using a disabled basis of eligibility

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

## Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

# MINNESOTA
## Minnesota Prepaid Medical Assistance Project Plus-1115(a)

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

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Health Partners
Itasca Medical Care
Medica
Metropolitan Health Plan
PrimeWest Health System
South Country Health Alliance
UCARE

## ADDITIONAL INFORMATION

PCP provider types are designated by MCO, not the State. County staff perform enrollment function.

Included Population- SED/SPMI- Servere Emotional Disturbance/Serious and Persistent Mental Illness

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:

-Assess Program Results
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Access and Utilization

### Consumer Self-Report Data:

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

### Use of HEDIS:

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

## Encounter Data

### Collection: Requirements:

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Specifications for the submission of encounter data to the Medicaid agency

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

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

**Validation - Methods:**
-None

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

**State conducts general data completeness assessments:**
No

## Performance Measures

**Process Quality:**
-Adolescent well-care visit rate
-Adult Preventive Visits
-Antidepressant medication management
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Colorectal Cancer Screening
-Dental services
-Diabetes Screening
-Immunizations for two year olds
-Mental Health Discharges
-Osteoporosis Care After Fracture
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

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

**Use of Services/Utilization:**
-CD Initiating and Treatment
-Mental Health Discharges
-Postpartum Visits
-Primary Care Visitis- 3 - 6 Year Olds
-Well-Care Visits-Adolescents
-Well-child visits in first 15 months of life

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

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

**Clinical Topics:**
-Aspirin Therapy
-Asthma management
-Asthma-Reduction of Emergency Department Visits
-Breast cancer screening (Mammography)
-Calcium and Vitamin D
-Cholesterol screening and management

-Colon Cancer Screening
-Depression management
-Diabetes management
-Diabetic Statin Use 40 to 75 Year Olds
-Human Papillomavirus
-Hypertension management
-Lead toxicity
-Mental Health/Chemical Dependency Dual Diagnoses
-Obesity
-Pneumococcal Vaccine
-Sexually transmitted disease screening

**Non-Clinical Topics:**

-Adults access to preventive/ambulatory health services

## Standards/Accreditation

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

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
-NCQA (National Committee for Quality Assurance)

**EQRO Name:**
-MetaStar (QIO)
-Michigan Performance Review Organization

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
MCOs
Medicaid has collaborated with a public sector entity to support the P4P program

**Population Categories Included:**
A subset of MCO members, defined by disease and medical condition

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Clinical Conditions:**
Cardiac Care
Diabetes

**Measurement of Improved Performance:**
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
1999

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# NEW MEXICO

## New Mexico State Coverage Insurance Section 1115 Demonstration

## CONTACT INFORMATION

**State Medicaid Contact:**

Paula McGee
NM HSD/Medical Assistance Division
(505) 827-6234

**State Website Address:**

http://www.insurenewmexico.state.nm.us/scihome.htm

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
12 months guaranteed eligibility

**Initial Waiver Approval Date:**
December 30, 2009

**Implementation Date:**
January 01, 2010

**Waiver Expiration Date:**
September 30, 2014

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(17) Financial Eligibility Standards
-1902(a)(23) Freedom of Choice
-1902(a)(3) and 1902(a)(8) Reasonable Promptness (Enrollment Cap)
-1902(a)(34) Retroactive Eligibility
-1902(a)(4) Methods of Administration and Transportation
-1902(a)(43) Dental, Hearing, and Vision Services

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Eligibility Expansion
-MCO Choice {1932(a)(3)}
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Diagnostics, Disease Management, Durable Medical Equipment, Emergency, Home Health, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Maternity, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Pre/Post Natal Care, Preventive, Speech Therapy, Urgent Care

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other providers who meet the MCO credentialing requirements for PCP
-Other Specialists Approved on a Case-by-Case Basis

-Physician Assistants
-Primary care teams at teaching facilities
-Rural Health Clinics (RHCs)

### Enrollment

**Populations Voluntarily Enrolled:**
-Non-pregnant childless adults age 19-64 with incomes < 200% FPL

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Eligible only for TB-related Services
-Enrolled in Another Managed Care Program
-May not have voluntarily droped private health insurance within six months of SCI effective date
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Not eligible for regular Medicaid
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive eligibility
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Lovelace Community Health Plan
Molina Healthcare of New Mexico
Presbyterian Health Plan

## ADDITIONAL INFORMATION

Each beneficiary is limited to $100,000 maximum per benefit year. The SCI program requires co-payments for services and prescriptions, and monthly premiums to be paid by the beneficiary and the employer.

## QUALITY ACTIVITIES FOR MCO/HIO

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

### Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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

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

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

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

### State conducts general data completeness assessments:
Yes

# NEW MEXICO
# New Mexico State Coverage Insurance Section 1115 Demonstration

## Performance Measures

### Process Quality:
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes medication management
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to 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 OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days 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

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

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-State allows MCO to self-select area of focus

### Non-Clinical Topics:
-State allows MCO to self select area of focus

## Standards/Accreditation

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

### Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-New Mexico Medical Reveiw Association

### EQRO Organization:
-Quality Improvement Organization (QIO)

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

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

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by disease and medical condition
Covers all MCO members

**Rewards Model:**
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs
Public reporting to reward MCOs
Withholds as an incentive

**Clinical Conditions:**
Diabetes

**Measurement of Improved Performance:**
Assessing levels of technology adoption
Assessing the adoption of systematic quality improvement processes
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
2010

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# NEW YORK
## F-SHRP - Medicaid Advantage

## CONTACT INFORMATION

**State Medicaid Contact:**

Jennfer Dean
Division of Managed Care
(518) 473-1134

**State Website Address:**

http://www.nyhealth.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
MAXIMUS

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
6 months guaranteed eligibility

**Initial Waiver Approval Date:**
September 30, 2006

**Implementation Date:**
October 01, 2006

**Waiver Expiration Date:**
September 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(25) Third Party Liability
-1902(a)(3) Access to State Fair Hearing
-1902(a)(4)(a) MEQC

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Designated State Health Programs
-Dual-Eligibles Appeals
-Exemption from MEQC disallowances {1903(u)}
-Facilitated Enrollment Services
-Institute For Mental Disease Expenditures

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Ambulance, Bone Mass Measurement, Chiropractic, Colorectal Screening, Dental, Diabetes Monitoring, Durable Medical Equipment, Emergency Room, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mammograms, Non-covered Medicare visits, Occupational Therapy, Outpatient Mental Health, Outpatient Substance Use Disorders, Outpatient Surgery, Pap Smear and Pelvic Exams, PCP visits, Physical Therapy, Podiatry, Private Duty Nursing, Prostate Cancer Screening, Prosthetics, Radiation therapy, Routine Physical Exam - 1 year, Skilled Nursing Facility, Specialty Office Visits, Speech Therapy,

**Allowable PCPs:**
-Not Applicable

Transportation, Urgent Care, Vision, X-Ray

### Enrollment

**Populations Voluntarily Enrolled:**
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Eligible for Family Planning services only
-Eligible for TB related services only
-Eligible for the Medicaid buy-in for the working disabled program who pay a premium
-Eligible less than 6 months
-Elilgible for treatment for breast or cervical cancer only
-Enrolled in hospice at the time of enrollment
-In the LTHHCP, except for the DD
-In the Restricted Recipient Program
-Individuals enrolled in a long term care demonstration
-Medicare Dual Eligibles
-Other Insurance
-Persons with ESRD at the time of enrollment, unless meet the Medicare exception
-Placed in a State OMH family care home
-Residents of Residential Health Facility at enrollment whose stay is classified as premanent
-Residents of State operated Psych facilites or residents of State certified treatment facilities for children and youth
-Spend downs

**Lock-In Provision:**
No lock-in

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

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

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Requires MCOs to identify through assessments

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

-Substance Abuse Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity/Medicaid Advantage
HIP Health Plan/Medicaid Advantage
Managed Health Inc/Medicaid Advantage
NYS Catholic Health Plan/Fidelis/Medicaid Advantage
Touchstone/Prestige/Medicaid Advantage
GHI/Medicaid Advantage
Liberty Health Advantage/Medicaid Advantage
MetroPlus/Medicaid Advantage
Senior Whole Health/ Medicaid Advantage

## ADDITIONAL INFORMATION

The Medicaid Advantage program strictly serves dual eligibles. Transportation and dental services are optional outside of NYC. Within NYC, these services are required.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-MCOs must comply with Medicare requirements for quality in 42 CFR 422

### Use of Collected Data:

-Program Evaluation
-Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:

None

### Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures

### Encounter Data

#### Collection: Requirements:

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

#### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-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 commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

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

**State conducts general data completeness assessments:**
No

## Standards/Accreditation

**MCO Standards:**
None

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Island Peer Review Organization

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities:**
-Validation of encounter data

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# NEW YORK
## F-SHRP - Medicaid Managed Care

## CONTACT INFORMATION

**State Medicaid Contact:**

Jennifer Dean
Division of Managed Care
(518) 473-1134

**State Website Address:**

http://www.nyhealth.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
MAXIMUS

**For All Areas Phased-In:**
No

**Initial Waiver Approval Date:**
September 29, 2006

**Implementation Date:**
October 01, 2006

**Waiver Expiration Date:**
September 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(25) Third Party Liability
-1902(a)(4)(a) MEQC

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Designated State Health Programs
-Dual-Eligible Appeals
-Exemption from MEQC disallowances {1903(u)}
-Facilitated Enrollment Services
-Institute For Mental Disease Expenditures
-Twelve Months Continuous Coverage

**Guaranteed Eligibility:**
6 months guaranteed eligibility

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based 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 Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

# NEW YORK
# F-SHRP - Medicaid Managed Care

## Enrollment

**Populations Voluntarily Enrolled:**
-Foster Care Children

**Populations Mandatorily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Admitted to hospice at the time of enrollment
-Eligible less than 6 Months
-Eligible only for TB related services
-Enrolled in Another Managed Care Program
-Enrolled in the Restricted Recipient Program
-Foster children in direct care
-Infants weighing less than 1200 grams or infants who meet SSI criteria
-Medicare Dual Eligibles
-Other Insurance
-Partcipation in LTC Demonstration Program
-Reside in Nursing Facility or ICF/MR
-Reside in residential treatment facility for children and youth
-Reside in State Operated Psychiatric facility
-Special Needs Children (State defined)
-Spend downs

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

## Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## PCCM Provider - Risk-based Capitation

### Service Delivery

**Included Services:**
Case Management, Dental, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray

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

### Enrollment

**Populations Voluntarily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

**Populations Mandatorily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Admitted to hospice at the time of enrollment
-Eligible Less Than 6 Months
-Eligible only for TB-related Services
-Enrolled in Another Managed Care Program
-Enrolled in the Restricted Recipient Program
-Foster Care Children in direct care
-Medicare Dual Eligibles
-Other Insurance
-Participation in LTC Demonstration
-Reside in Nursing Facility or ICF/MR
-Reside in Residential Treatment Facility for children and youth
-Reside in State Operated Psychiatric Facility
-Special Needs Children (State defined)
-Spend downs

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

# NEW YORK
## F-SHRP - Medicaid Managed 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
-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
-Social Services Agencies
-Substance Abuse Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity Health Plan
AmidaCare Special Needs
Excellus
Health Now
HIP Combined
Independent Health/Hudson Valley&WNY
MetroPlus Health Plan Special Needs
Neighborhood Health Providers
NYS Catholic Health Plan 1199
Physician Case Management Program
Southern Tier Pediatrics
United Healthcare
Wellcare
Amerigroup
Capital District Physicians Health Plan
Health First
HealthPlus
Hudson Health Plan
MetroPlus Health Plan
MVP Health Plan
NYPS Select Health Special Needs
NYS Catholic Health Plan/Fidelis
SCHC TotalCare
Southern Tier Priority
Univera Community Health

## ADDITIONAL INFORMATION

This program enrolls ABD populations statewide & AFDC populations in specific counties into mandatory managed care. MCO Optional Services: Dental, Family Planning, and Transportation are included at the option of the MCO.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**

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

**Use of Collected Data:**

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

**Consumer Self-Report Data:**

-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

**Use of HEDIS:**

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

### Encounter Data

# NEW YORK
## F-SHRP - Medicaid Managed Care

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

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

### Collection: Standardized Forms:
None

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

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Alcohol and Substance abuse use screening
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead Screening rate
-Smoking prevention and cessation
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

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

### Access/Availability of Care:
-Average distance to PCP

### Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary

-Ratio of PCPs to beneficiaries

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

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

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

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

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Improving member contact and engatement rates
-Pediatric Obesity

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

## Standards/Accreditation

### MCO Standards:
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Island Peer Review Organization

### EQRO Organization:
-Quality Improvement Organization (QIO)

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

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

## Pay for Performance (P4P)

# NEW YORK
## F-SHRP - Medicaid Managed Care

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

**Rewards Model:**
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs
Public reporting to reward MCOs

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
2000

**Evaluation Component:**
The State has conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-On-Site Reviews
-Performance Measures (see below for details)

**Use of Collected Data:**
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
None

### Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
-Number of primary care case manager visits per beneficiary

**Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

# NEW YORK
## Partnership Plan - Family Health Plus

## CONTACT INFORMATION

**State Medicaid Contact:**

Kathleen Johnson
Division of Coverage & Enrollment
(518) 474-8887

**State Website Address:**

http://www.nyhealth.gpv

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
MAXIMUS

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
6 months guaranteed eligibility

**Initial Waiver Approval Date:**
June 29, 2001

**Implementation Date:**
September 04, 2001

**Waiver Expiration Date:**
March 31, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(14) Cost-Sharing Requirements
-1902(a)(23) Freedom of Choice
-1902(a)(25) Third Party Liability
-1902(a)(34) Retroactive Eligibility
-1902(a)(4)(a) MEQC
-1902(a)(43) EPSDT

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-12 Months Continuos Coverage
-Eligibility Expansion
-Exemption from MEQC disallowances {1903(u)}
-Facilitated Enrollment Services
-Family Planning Expenditures
-Guaranteed Eligibility Expenditures
-HCBS
-Institute For Mental Disease Expenditures

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chemical Dependence, Dental, Diabetic supplies and equipment, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medically

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis

Managed Detox - Inpatient, Medically Supervised Withdrawal Inpatient/Outpatient, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Radiation Therapy, Chemotherapy, Hemodialysis, Smoking cessation products, Transportation, Vision, X-Ray

-Pediatricians
-Qualified Obstetricians/Gynecologists

## Enrollment

**Populations Voluntarily Enrolled:**

None

**Populations Mandatorily Enrolled:**

-Adults 19-64 no children up to 100% FPL
-Adults 19-64 with children up to 150% FPL

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Equivalent Insurance
-Medicare Dual Eligibles

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

## Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

# NEW YORK
# Partnership Plan - Family Health Plus

## PPO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

**Included Services:**
Case Management, Dental, Diabetic supplies and equipment, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medically Necessary Detox Inpatient, Medically Supervised withdrawal service Inp/Out, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Radiation therapy, Chemotherapy, Hemodialysis, Smoking cessation products, Transportation, X-Ray

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

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Adults 19-64 no children up to 100% FPL
-Adults 19-64 with children up to 150% of FPL

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Equivalent Insurance

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity Health Plan
Capital District Physicians Health Plan
GHI
Health Now
HIP Combined
Independent Health/Hudson Valley&WNY
MVP Health Plan
Amerigroup
Excellus
Health First
HealthPlus
Hudson Health Plan
MetroPlus Health Plan
Neighborhood Health Providers

# NEW YORK
## Partnership Plan - Family Health Plus

NYS Catholic Health Plan 1199
SCHC TotalCare
Univera Community Health
NYS Catholic Health Plan/Fidelis
United Healthcare
Wellcare

## ADDITIONAL INFORMATION

PPO in counties where there are no MCOs.

Benefit Limitations: Home Health is limited to 40 visits; Outpatient Substance Use Disorders is limited to 40 visits. Inpatient Mental Health is limited to 30 days per year; Outpatient Mental Health is limited to 60 days per year. Chemical Dependence Inpatient is 30 days.

Effective April 1, 2008, implemented Family Health Plus Premium Assistance Program. Persons with access to qualified cost-effective Employer Sponsored Health Insurance (ESHI) must enroll in the ESHI. The State subsidizes the premiums and reimburses any deductibles and co-pays, to the extent that the co-pays exceed the amount of the enrollees co-payment obligations under FHPlus. The State also pays for any FHPlus benefits not covered by the ESHI when the service is obtained from a Medicaid fee-for-service provider.

## QUALITY ACTIVITIES FOR MCO/HIO

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

### Use of Collected Data:
-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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

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

## Encounter Data

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

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

### Collection: Standardized Forms:
None

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

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

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

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Smoking prevention and cessation
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

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

**Access/Availability of Care:**
-Ratio of PCPs to beneficiaries

**Use of Services/Utilization:**
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

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

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

# NEW YORK
## Partnership Plan - Family Health Plus

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

**Performance Measures - Others:**
None

## Performance Improvement Projects

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

**Clinical Topics:**
-Improve member contact and engagement rates
-Pediatric Obesity

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

## Standards/Accreditation

**MCO Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Island Peer Review Organization

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

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

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

**Rewards Model:**
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
2000

**Evaluation Component:**
The State has conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# NEW YORK
## Partnership Plan Medicaid Managed Care Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Jennifer Dean
Division of Managed Care
(518) 473-1134

**State Website Address:**

http://www.nyhealth.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
MAXIMUS

**For All Areas Phased-In:**
No

**Initial Waiver Approval Date:**
July 15, 1997

**Implementation Date:**
October 01, 1997

**Waiver Expiration Date:**
March 31, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(25) Third Party Liability
-1902(a)(4)(a) MEQC

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-12 Months Continuous Coverage
-Eligibility Expansion
-Enrollment Assistance Service {1903(b)(4)}
-Exemption from MEQC disallowances {1903(u)}
-Family Planning Expenditures
-Guaranteed Eligibility Expenditures
-HCBS
-Institute For Mental Disease Expenditures

**Guaranteed Eligibility:**
6 months guaranteed eligibility

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based 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 Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

# NEW YORK
# Partnership Plan Medicaid Managed Care Program

## Enrollment

**Populations Voluntarily Enrolled:**
-Foster Care Children

**Populations Mandatorily Enrolled:**
-Safety Net Adults
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Admitted to hospice at the time of enrollment
-Eligible less than 6 Months
-Eligible only for TB related services
-Enrolled in Another Managed Care Program
-Enrolled in the Restricted Recipient Program
-Foster children in direct care
-Infants weighing less than 1200 grams or infants who meet SSI criteria
-Medicare Dual Eligibles
-Other Insurance
-Partcipation in LTC Demonstration Program
-Reside in Nursing Facility or ICF/MR
-Reside in residential treatment facility for children and youth
-Reside in State Operated Psychiatric facility
-Special Needs Children (State defined)
-Spend downs

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

## Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## PCCM Provider - Risk-based Capitation

### Service Delivery

**Included Services:**
Case Management, Dental, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray

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

### Enrollment

**Populations Voluntarily Enrolled:**
-Foster Care Children

**Populations Mandatorily Enrolled:**
-Safety Net Adults
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Admitted to hospice at the time of enrollment
-Eligible less than 6 Months
-Eligible only for TB related services
-Enrolled in Another Managed Care Program
-Enrolled in the Restricted Recipient Program
-Foster care children in direct care
-Medicare Dual Eligibles
-Other Insurance
-Participation in a LTC Demonstration Program
-Reside in Nursing Facility or ICF/MR
-Reside in Residential Treatment Facility for children and youth
-Reside in State Operated Psychiatric Facility
-Special Needs Children (State defined)
-Spend downs

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

# NEW YORK
## Partnership Plan Medicaid Managed Care Program

**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 groups

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity Health Plan
AmidaCare Special Needs
Excellus
Health Now
HIP Combined
Independent Health/Hudson Valley&WNY
MetroPlus Health Plan Special Needs
Neighborhood Health Providers
NYS Catholic Health Plan 1199
Physician Case Management Program
Southern Tier Pediatrics
United Healthcare
Wellcare
Amerigroup
Capital District Physicians Health Plan
Health First
HealthPlus
Hudson Health Plan
MetroPlus Health Plan
MVP Health Plan
NYPS Select Health Special Needs
NYS Catholic Health Plan/Fidelis
SCHC TotalCare
Southern Tier Priority
Univera Community Health

## ADDITIONAL INFORMATION

Monthly premium for primary care services and medical care coordination.

## QUALITY ACTIVITIES FOR MCO/HIO

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

**Use of Collected Data:**
-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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

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

# NEW YORK
# Partnership Plan Medicaid Managed Care Program

## Encounter Data

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

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

### Collection: Standardized Forms:
None

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

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Smoking prevention and cessation
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

# NEW YORK
## Partnership Plan Medicaid Managed Care Program

### Access/Availability of Care:
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

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

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

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

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Improve member contact and engagement rates
-Pediatric Obesity

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

## Standards/Accreditation

### MCO Standards:
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Island Peer Review Organization

### EQRO Organization:
-Quality Improvement Organization (QIO)

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

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

# NEW YORK
# Partnership Plan Medicaid Managed Care Program

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

**Rewards Model:**
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs
Public reporting to reward MCOs

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
2000

**Evaluation Component:**
The State has conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-On-Site Reviews
-Performance Measures (see below for details)

**Use of Collected Data:**
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
None

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
-Number of primary care case manager visits per beneficiary

**Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

# OKLAHOMA
## SoonerCare

## CONTACT INFORMATION

**State Medicaid Contact:**

Rebecca Pasternik-Ikard
Oklahoma Health Care Authority
(405) 522-7208

**State Website Address:**

http://www.okhca.org

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
LifeCare

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
October 12, 1995

**Implementation Date:**
January 01, 1996

**Waiver Expiration Date:**
December 31, 2012

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(17) Counting Income and Comparability of
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Eligibility Expansion
-Expenditures for otherwise non-covered costs related to our Health Management Program
-Expenditures for per member per month payments made to our Health Access Networks
-Expenditures for reimbursing out-of-pocket costs in excess of 5 percents of annual gross income for individuals enrolled in our Insure Oklahoma Progra

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

-Rural Health Clinics (RHCs)

## Enrollment

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Children in permanent custody
-Covered by an HMO
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

## Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## American Indian PCCM - Fee-for-Service

### Service Delivery

**Included Services:**
Case Management, Dental, Disease Management, Durable Medical Equipment, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Indian Health Service (IHS) Providers

### Enrollment

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Children in State or Tribal Custody
-Covered by an HMO
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility os ICF/MR

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Asks advocacy groups to identify members of these groups
-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
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency

-Uses provider referrals to identify members of these groups

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

SoonerCare American Indian PCCM

SoonerCare PCCM

## ADDITIONAL INFORMATION

American Indians are the only population that is eligible to enroll in the Amrican Indian PCCM portion of the SoonerCare program. A case management fee is paid per member per month for the PCCM portion of the program.

The Primary Care Provider/Case Manager is capitated for case management for each enrollee.

American Indians have an option of enrolling in the PCCM or American Indian PCCM under the SoonerCare program.

# OREGON
## Oregon Health Plan Plus

## CONTACT INFORMATION

**State Medicaid Contact:**

Jonna Starr
Division of Medical Assistance Programs
(503) 940-1193

**State Website Address:**

http://www.oregon.gov/DHS/healthplan/index.shtml

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**Initial Waiver Approval Date:**
March 19, 1993

**Implementation Date:**
February 01, 1994

**Waiver Expiration Date:**
October 31, 2013

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(A) Eligibility Procedures
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13)(A) DSH
-1902(a)(17) Eligibility Standards
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Coverage
-1902(a)(4) Proper and Efficient Administration of the State Plan
-1902(a)(43)(c) EPSDT
-1902(a)(8) Reasonable Promptness
-2103 Benefits
-2103(e) Cost-Sharing

**For All Areas Phased-In:**
No

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-1903(f)
-Chemical Dependency Treatment 1905(a)(13)
-Eligibility Expansion
-Employer Sponsored Insurance
-Guaranteed Eligibility Expenditures
-MCO Definition 1903(m)(1)(A)
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)

**Guaranteed Eligibility:**
6 months guaranteed eligibility

## SERVICE DELIVERY

### MH/SUD PIHP - Risk-based Capitation

**Service Delivery**

# OREGON
## Oregon Health Plan Plus

**Included Services:**
Crisis, IMD, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Opioid Treatment Programs, Outpatient Substance Use Disorders, Screening, Identification, and Brief Intervention

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

## Enrollment

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

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

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

**Lock-In Provision:**
No lock-in

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

**Medicare Dual Eligibles Excluded:**
None

## Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
No

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# OREGON
# Oregon Health Plan Plus

## PCCM Provider - Fee-for-Service

### Service Delivery

**Included Services:**
Physician

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

### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Populations Mandatorily Enrolled:**
None

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

**Lock-In Provision:**
No lock-in

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

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
No

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# OREGON
# Oregon Health Plan Plus

## Dental PAHP - Risk-based Capitation

### Service Delivery

**Included Services:**
Dental

**Allowable PCPs:**
-Does not apply

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Other Insurance
-QMB and MN Spenddown

**Lock-In Provision:**
6 month lock-in

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

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# OREGON
# Oregon Health Plan Plus

## MCO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

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

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

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Other Insurance
-QMB and MN Spenddown

**Lock-In Provision:**
6 month lock-in

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

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
No

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
-Barbituates
-Benzodiazepines

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

# OREGON
## Oregon Health Plan Plus

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

-Asks advocacy groups to identify members of these groups
-Health Plans use multiple means to identify such members
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Education Agency
-Employment Agencies
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Accountable Behavioral Health
Care Oregon
Central Oregon Independent Health Solutions
Doctors of the Oregon Coast South
FamilyCare (Mental Health)
Greater Oregon Behavioral Health, Inc.
Jefferson Behavioral Health
Lane Care MHO
Managed Dental Care of Oregon
Mid Valley Behavioral Care Network
Multicare Dental
Northwest Dental Services
Oregon Dental Service
PCCM
Tuality Health Care
Willamette Dental
Capitol Dental Care Inc.
Cascade Comprehensive Care
Clackamas County Mental Health
Douglas County IPA
FamilyCare Health Plans
Inter-Community Health Network
Kaiser Permanente Oregon Plus
Lane Individual Practice Association
Marion Polk Community Health Plan
Mid-Rogue Independent Practice Assoc.
Multnomah County Verity
ODS Community Health Inc.
Oregon Health Management Service
Providence Health Assurance
Washington County Health (Mental Health)

## ADDITIONAL INFORMATION

1902(a)(1) Statewideness was waived under the uniformity section.

A $6.00 Case Management Fee is paid on a per member/per month basis. This fee is not a capitation payment. The Oregon PCCM program is fee-for-service.

Under age one is guaranteed 12 months continuous eligibility.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**

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

**Use of Collected Data:**

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

-Provider Data

### Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire
  Child with Special Needs Questionnaire
-Disenrollment Survey
-State-developed Survey

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

## Encounter Data

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

### Collections: Submission Specifications:
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-CMS 1500
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adequacy of Prenatal Care while on OHP
-Asthma care - medication use
-Asthma ED visits
-Breast Cancer screening rate
-Cervical cancer screening rate
-Colon Rectal Cancer Screening Rate
-Dental services

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with obtaining care

-Follow-up after hospitalization for mental illness
-Follow-up visits to Asthma ED
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Prostate Cancer Screening Rate
-Smoking prevention and cessation

### Access/Availability of Care:
-Adult and Youth Use of Preventive Services
-Average wait time for an appointment with PCP
-Children's Use of Preventive Services
-Prevention Quality Indicator - Ambulatory Care Sensitive Conditions Hospitalizations

### Use of Services/Utilization:
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

### 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

### Health Plan/ Provider Characteristics:
None

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Asthma management
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment
-Pre-natal care
-Smoking prevention and cessation

### Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Physical Health and Behavioral Health Integration

## Standards/Accreditation

### MCO Standards:
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Accumentra

### EQRO Organization:
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Rapid Cycle Review
-Validation of encounter data

### Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

## QUALITY ACTIVITIES FOR PIHP

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

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

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

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

### Encounter Data

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

**Collections: Submission Specifications:**
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

# OREGON
## Oregon Health Plan Plus

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Health Status/Outcomes Quality:
-Patient satisfaction with care

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

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

### 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

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

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Coordination of primary and behavioral health care
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment

# OREGON
## Oregon Health Plan Plus

**Non-Clinical Topics:**

-Adults access to preventive/ambulatory health services

## Standards/Accreditation

**PIHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Accumentra

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities**
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects

# QUALITY ACTIVITIES FOR PAHP

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

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

**Consumer Self-Report Data:**
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire
-Disenrollment Survey

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

## Encounter Data

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

**Collections - Submission Specifications:**
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting

**Validation - Methods:**
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency

health care claims data
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

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

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Dental services

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
-Ratio of dental providers to beneficiaries

**Use of Services/Utilization:**
-Percentage of beneficiaries with at least one dental visit

**Health Plan Stability/ Financial/Cost of Care:**
-Actual reserves held by plan
-Expenditures by medical category of service (ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

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

**Beneficiary Characteristics:**
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-PAHP/PCP-specific disenrollment rate

**Performance Measures - Others:**
None

## Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-Consumer Self-Report Data (see below for details)

**Use of Collected Data:**
-Health Services Research

-Enrollee Hotlines
-Focused Studies
-Ombudsman
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
- "Cores" Adult/Child Survey with elected Medicaid and Special Needs Questions

# RHODE ISLAND
## Connect Care Choice

## CONTACT INFORMATION

**State Medicaid Contact:**

Ellen Mauro
RI Department of Human Services
(401) 462-0140

**State Website Address:**

http://www.dhs.ri.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
January 16, 2009

**Implementation Date:**
January 16, 2009

**Waiver Expiration Date:**
December 31, 2013

**Sections of Title XIX Waived:**
-1092(a)(32) Payment for Self-Directed Care
-1092(a)(8) Reasonable Promptness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(14) Cost-Sharing Requirements
-1902(a)(17) Comparability of Eligibility Standards
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility
-1902(a)(37)(B) Payment Review

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Benefit Expansion
-HCBS
-MCO Definition 1903(m)(1)(A)
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)
-Secretary Definition 1903(m)(2)(A)(i)

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Clinical Case Management, Disease Management, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Smoking

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists

Cessation, Speech Therapy, State Plan Benefits, Transportation, Vision, X-Ray

### Enrollment

**Populations Voluntarily Enrolled:**
None

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

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles
-Other Health Insurance

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Developmental Disabilities Agency
-Mental Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Connect Care Choice

## ADDITIONAL INFORMATION

Connect Care Choice is a primary care case management program for adults with Medicaid coverage who are 21 years old or older. The

goal is to provide improved access to a persons primary care doctor and nurse case manager so they can better manage chronic illnesses and conditions. Emphasis is placed on preventive and primary care and teaching self-management skills to optimize wellness and reduce illness and hospitalizations.

To be able to enroll, individuals must not have other comprehensive health insurance coverage and must live in the community: at home, in assisted living, or in a group home.

Global Consumer Choice Compact program includes Connect Care Choice, Rhody Health Partners and RIte Smiles.

Under Data Element: Section of Title XIX Waived: 1902(a)(14) Cost Sharing Requirements in so far as it incorporates 1916

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Monitor Quality Improvement
-Program Evaluation

**Consumer Self-Report Data:**
None

### Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
-SF-36 Survey

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
-Drug Utilization

**Provider Characteristics:**
None

**Beneficiary Characteristics:**
-Katz Index of ADL
-PHQ-9 Patient Health Questionnaire
-SF-36 Survey

**Performance Measures - Others:**
None

### Performance Improvement Projects

**Clinical Topics:**
-Beta Blocker treatment after a heart attack
-Deprssion management
-Diabetes management
-Hypertension management
-Smoking prevention and cessation

**Non-Clinical Topics:**
None

# RHODE ISLAND
## Global Consumer Choice Compact

## CONTACT INFORMATION

**State Medicaid Contact:**

Deborah J. Florio
Center for Child & Family Health
(401) 462-0140

**State Website Address:**

http://www.dhs.ri.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
January 16, 2009

**Implementation Date:**
January 16, 2009

**Waiver Expiration Date:**
December 31, 2013

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(14) Cost-Sharing Requirements
-1902(a)(17) Comparability of Eligibility Standards
-1902(a)(23) Freedom of Choice
-1902(a)(32) Payment for Self-Directed Care
-1902(a)(34) Retroactive Eligibility
-1902(a)(37)(B) Payment Review
-1902(a)(8) Reasonable Promptness

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Benefit Expansion
-Expenditures for core and preventive services for at-risk youth
-HCBS
-MCO Definition 1903(m)(1)(A)
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)
-Population Expansion
-Secretary Definition 1903(m)(2)(A)(i)
-Substitute Care Provision for behavioral health

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter, Laboratory, Nutrition, Occupational Therapy, Outpatient Hospital,

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists

Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Smoking Cessation, Speech Therapy, State Plan Benefits, Transportation, Vision, X-Ray

-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)
-School-based health clinics

### Enrollment

**Populations Voluntarily Enrolled:**

-Foster Care Children

**Populations Mandatorily Enrolled:**

-Poverty-Level Pregnant Women
-Pregnant Women above Poverty Level
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-Access to Cost Effective, Comprehensive, Employer-Sponsored Coverage
-Exclusion of individuals with TPL except pregnant women b/w 185-250 with TPL can enroll
-Medicare Dual Eligibles
-Other Insurance
-Special Needs Children with Other Insurance Coverage

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

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

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Child Welfare Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross & Blue Shield of Rhode Island
Neighborhood Health Plan of Rhode Island
United HealthCare of New England

## ADDITIONAL INFORMATION

Since September 2003, Children with Special Health Care Needs are offered enrollment in Rite Care unless they have comprehensive medical insurance from another source -- these children include SSI recipients, children eligible through Katie Beckett provisions, and children in subsidized adoption settings. Managed care enrollment is mandatory for these groups, but is not offered if children are covered by comprehensive third-party insurance. Coordination with other agencies in the care of Children with Special Health Care Needs takes place through the CEDARR program, available to children in managed care as well as to those in fee-for-service Medicaid -- this program combines evaluation, diagnosis, referral, reevaluation and a range of other services for families of Children with Special Needs. Definition of Special Needs Children (State defined): SSI/State Supplement-eligible child; Child eligible under Katie Beckett provisions; Child in subsidized adoption setting. Rite Care was first implemented in August 1994 under a distinct 1115 Demonstration waiver. Effective January 16, 2009 it was incorporated into the RI Global Consumer Choice Compact 1115(a) Demonstration, which encompasses almost the entire RI Medicaid Program. Enrollment became mandatory in October 2008.

Global Consumer Choice Compact program includes Connect Care Choice, Rhody Health Partners and RIte Smiles.

Under Data Element: Section of Title XIX Waived: 1902(a)(14) Cost Sharing Requirements in so far as it incorporates 1916

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-EQRO
-Focused Studies
-Grievances and Appeals
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:

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

### Consumer Self-Report Data:

-CAHPS
Adult Medicaid AFDC Questionnaire
-Consumer Advisory Committee
-State-developed Survey

### Use of HEDIS:

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

### Encounter Data

# RHODE ISLAND
## Global Consumer Choice Compact

### 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 elements for all services on UB-04 and CMS-1500
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
None

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison of State data with plan-specifc data
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Monitoring submision processes from providers to health plans to assure complete and timely submissions
-Per member per month analysis and comparisons across MCOs

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

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent well-care visit rate
-Adult BMI Assessment
-Antidepressant medication management
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Comprehensive Diabetes Care
-Follow-up after hospitalization for mental illness
-Follow-up for Children Prescribed ADHD Medication
-Frequency of on-going prenatal care
-Immunizations for Adolescents
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

-Smoking Cessation
-Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

### Access/Availability of Care:
-Adolescents' Access to PCPs
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Complaint Resolution Statistics
-Patient/Member Satisfaction with Access to Care

### Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Discharges from Neonatal Intensive Care Unit per 1,000 live births
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Inpatient days per 1,000
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Prescriptions per 1,000 population by category (name brand, generic and OTC)
-Re-admission rates of MH/SUD

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

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

### Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

### Performance Measures - Others:
None

## Performance Improvement Projects

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

### Clinical Topics:
-Antidepressant Medication Management
-ED Visits for Ambulatory Care Sensitive Conditions
-Follow-up for Children Prescribed ADHD Medications
-Frequency of Ongoing Prenatal Care

### Non-Clinical Topics:
-Notifying the State of TPL Data within Five Days
-Work Distribution in the Grievance and Appeals Unit

## Standards/Accreditation

### MCO Standards:
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

### Accreditation Required for Participation:
-NCQA (National Committee for Quality Assurance)

# RHODE ISLAND
## Global Consumer Choice Compact

**Non-Duplication Based on Accreditation:**
-None

**EQRO Name:**
-IPRO, Inc.

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Detailed technical report for each MCO
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of encounter data

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by disease and medical condition
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Clinical Conditions:**
ADHD
Adolescent Immunizations
Adult preventive care
Cervical Cancer Screening
Childhood immunizations
Chlamydia Screening
Depression
Diabetes
Lead Screening
Obesity
Perinatal Care
Smoking Cessation
Well-child visits

**Measurement of Improved Performance:**
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, etc.)

**Initial Year of Reward:**
1999

**Evaluation Component:**
The State has conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# RHODE ISLAND
## Rhody Health Partners

## CONTACT INFORMATION

**State Medicaid Contact:**

Deborah J. Florio
Center for Child and Family Health
(401) 462-0140

**State Website Address:**

http://www.dhs.ri.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
January 16, 2009

**Implementation Date:**
January 16, 2009

**Waiver Expiration Date:**
December 31, 2013

**Sections of Title XIX Waived:**
-1092(a)(32) Payment for Self-Directed Care
-1092(a)(8) Reasonable Promptness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(14) Cost-Sharing Requirements
-1902(a)(17) Comparability of Eligibility Standards
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility
-1902(a)(37)(B) Payment Review

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Benefit Expansion
-HCBS
-MCO Definition 1903(m)(1)(A)
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)
-Secretary Definition 1903(m)(2)(A)(i)

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter, Laboratory, Nutrition, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Smoking Cessation, Speech Therapy, Transportation, Vision, X-Ray

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

-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants
-Rural Health Centers (RHCs)

### Enrollment

**Populations Voluntarily Enrolled:**
None

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

**Subpopulations Excluded from Otherwise Included Populations:**
-Access to Cost Effective, Comprehensive, Employer-Sponsored Coverage
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Developmental Disabilities Agency
-Mental Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Neighborhood Health Plan of Rhode Island

United HealthCare of New England

# RHODE ISLAND
## Rhody Health Partners

## ADDITIONAL INFORMATION

Rhody Health Partners is a mandatory managed care program for adults on Medical Assistance. Eligible clients are enrolled on a monthly basis, and can choose between 2 health plans (Neighborhood Health Plan of RI or United Healthcare of New England) or Connect Care Choice. Connect Care Choice is a primary care physician practice model, that offers on-site nurse care management. Rhody Health Partners is a traditional MCO model.

Global Consumer Choice Compact program includes Connect Care Choice, Rhody Health Partners and RIte Smiles.

Under Data Element: Section of Title XIX Waived: 1902(a)(14) Cost Sharing Requirements in so far as it incorporates 1916

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Grievances and Appeals
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-CAHPS
Adult Medicaid AFDC Questionnaire
-Consumer Advisory Committee
-State-developed Survey

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

## Encounter Data

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

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison of State data with plan-specifc data
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO

commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Monitoring submision processes from providers to health plans to assure complete and timely submissions
-Per member per month analysis and comparisons across MCOs

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

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Adult BMI Assessment
-Antidepressant medication management
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services
-Complaint Resolution Statistics
-Patient/Member Satisfaction with Access to Care

**Use of Services/Utilization:**
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Inpatient days per 1,000
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Prescriptions per 1,000 population by category (name brand, generic, OTC)
-Re-admission rates of MH/SUD

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

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

# RHODE ISLAND
## Rhody Health Partners

**Beneficiary Characteristics:**
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

**Performance Measures - Others:**
None

## Standards/Accreditation

**MCO Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
-NCQA (National Committee for Quality Assurance)

**Non-Duplication Based on Accreditation:**
-None

**EQRO Name:**
-IPRO, Inc.

**EQRO Organization:**
-Quality Improvement Organization (QIO)

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

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of encounter data

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by disease and medical condition
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Clinical Conditions:**
Adult preventive care
Cervical Cancer screening
Depression
Diabetes
Obesity
Smoking and Tobacco Use

**Measurement of Improved Performance:**
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing patient satisfaction measures

**Initial Year of Reward:**
2010

**Evaluation Component:**
The State has conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# RHODE ISLAND
## RIte Smiles

## CONTACT INFORMATION

**State Medicaid Contact:**

Deborah J. Florio
Center for Child and Family Health
(401) 462-0140

**State Website Address:**

http://www.dhs.ri.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**Initial Waiver Approval Date:**
January 16, 2009

**Implementation Date:**
January 16, 2009

**Waiver Expiration Date:**
December 31, 2013

**Sections of Title XIX Waived:**
-1092(a)(8) Reasonable Promptness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(14) Cost-Sharing Requirements
-1902(a)(17) Comparability of Eligibility Standards
-1902(a)(23) Freedom of Choice
-1902(a)(32) Payment for Self-Directed Care
-1902(a)(34) Retroactive Eligibility
-1902(a)(37)(B) Payment Review

**For All Areas Phased-In:**
Yes

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

**Guaranteed Eligibility:**
None

## SERVICE DELIVERY

### Dental PAHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Dental

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

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles

-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-Children born before 5/1/2000
-Children residing out of state
-Other Dental Insurance
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**

Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**

None

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Uses enrollment forms 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

United HealthCare Dental - RIte Smiles

## ADDITIONAL INFORMATION

RIte Smiles is a children's dental program only covering those born on or after May 1, 2000. It was originally implemented on May 1, 2006 under 1915(b) authority and was subsumed into the Rhode Island Global Consumer Choice Compact 1115(a) Demonstration, as of 1/16/2009.

Under Data Element: Section of Title XIX Waived: 1902(a)(14) Cost Sharing Requirements in so far as it incorporates 1916

## QUALITY ACTIVITIES FOR PAHP

# RHODE ISLAND
## RIte Smiles

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Network Data
-PAHP Standards (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:
-Contract Standard Compliance
-Health Services Research
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

### Consumer Self-Report Data:
-State-developed Survey

### Use of HEDIS:
-The State 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 PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
None

### Validation - Methods:
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per Member per month analysis
-Specification/source code review, such as a programming language used to create an encounter data file for submission

### PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Percentage of beneficiaries having at least one dental prophy visit per year
-Percentage of beneficiaries having at least one dental sealant per year

### Health Status/Outcomes Quality:
None

# RHODE ISLAND
## RIte Smiles

**Access/Availability of Care:**
-Average Speed to Answer
-Call Abandonment Rate
-Complaint Resolution Statistics
-Ratio of dental providers to beneficiaries

**Use of Services/Utilization:**
-Annual Dental Visit by age
-Percentage of beneficiaries with at least one dental visit

**Health Plan Stability/ Financial/Cost of Care:**
-Risk Share Reporting

**Health Plan/ Provider Characteristics:**
-Provider Specialty Types

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-Individual PAHPs are required to conduct a project prescribed by the State Medicaid agency

**Clinical Topics:**
-Annual Dental Visit for 2-3, 4-6 and 7-10 year olds
-Postcard Outreach to Parents of Non-Utilizing Children

**Non-Clinical Topics:**
Not Applicable - PAHPs are not required to conduct common project(s)

## Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# TENNESSEE
# TennCare II

## CONTACT INFORMATION

**State Medicaid Contact:**

Darin J. Gordon
TennCare
(615) 507-6443

**State Website Address:**

http://www.tn.gov/tenncare

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Initial Waiver Approval Date:**
May 30, 2002

**Implementation Date:**
July 01, 2002

**Waiver Expiration Date:**
June 30, 2013

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness/Uniformity
-1902(a)(10) Access to FQHCs and RHCs
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(17) Comparability and Amount, Duration, and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility
-1902(a)(4)(A) Proper and Efficient Administration
-1902(a)(54) Payment for Outpatient Drugs
-1902(a)(8) Reasonable Promptness

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-CHIP-Related Medicaid Expansion Demonstration Population Children
-Continuing Receipt of Home and Community-Based Services
-Continuing Receipt of Nursing Facility Care
-Expenditures for Expanded Benefits and Coverage of Cost-Effective Alternative Services
-Expenditures for Pool Payments
-Expenditures Related to Eligibility Expansion
-Expenditures Related to Expansion of Existing Eligibility Groups
-Expenditures related to MCO Enrollment and Disenrollment
-HCBS Services for SSI-Eligibles
-Indirect Payment of Graduate Medical Education
-LTC Partnership
-Payments for Non-Risk Contractor
-The 217-Like HCBS Group

**Guaranteed Eligibility:**
No guaranteed eligibility

## SERVICE DELIVERY

# TENNESSEE
# TennCare II

## MCO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

**Included Services:**

Bariatric Surgery, Case Management, Chiropractic, Community Health Services, Crisis, Detoxification, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Medical Supplies, Mental Health Rehabilitation, Mental Health Residential, Methadone Clinic Services Under Age 21 Only, Occupational Therapy, Organ & TissueTransplant Services and Donor Organ/Tissue Procurement Services, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Physician Inpatient Services, Physician Outpatient Services/Community Health Clinics/Other Clinical Services, Podiatry, Private Duty Nursing, Psychiatric Inpatient Facility Services, Psychiatric Rehabilitation Services, Psychiatric Residential Treatment Services, Reconstructive Breast Surgery, Renal Dialysis Clinic Services, Residential Substance Use Disorders Treatment Programs, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**

-Family Practitioners
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Physician Assistants

### Enrollment

**Populations Voluntarily Enrolled:**

None

**Populations Mandatorily Enrolled:**

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Institutionalized adults
-Institutionalized children
-Medically Needy (Pregnant Women and Children)
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-SSI eligible children
-Uninsurable children (Title XIX)
-Uninsured children (Title XXI)

**Subpopulations Excluded from Otherwise Included Populations:**

-Medicare Dual Eligibles

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## Prepaid Inpatient Health Plan (partial risk, comprehensive) - Partial Capitation

### Service Delivery

**Included Services:**
Bariatric Surgery, Case Management, Chiropractic, Community Health Services, Crisis, Detoxification, Disease Management, Donor Organ/Tissue Procurement Services, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Medical Supplies, Mental Health Rehabilitation, Mental Health Residential, Methadone Clinic Services (under age 21 only), Occupational Therapy, Organ and Tissue Transplant Services, Outpatient Hospital, Outpatient Substance Use Disorders, Physical Therapy, Physicial Outpatient Services, Physician, Physician Inpatient Services, Podiatry, Private Duty Nursing, Psychiatric Inpatient Facility Services, Psychiatric Rehabilitation Services, Psychiatric Residential Treatment Services, Reconstructive Breast Surgery, Renal Dialysis Clinic Services, Residential Substance Use Disorders Treatment Programs, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Children and Adults in HCBS
-Children in Nursing Facility or ICF/MR
-Foster Care Children
-Medicare Dual Eligibles
-SSI Eligible Children

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only (under age 21)

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# TENNESSEE
# TennCare II

## Pharmacy Benefit Manager PAHP - Administrative Services Fee

### Service Delivery

**Included Services:**
Pharmacy

**Allowable PCPs:**
-Not applicable, contractors are not required to identify PCPs

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Institutionalized Adults
-Institutionalized Children
-Medically Needy (Pregnant Women and Children)
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-SSI Eligible Children
-Uninsurable Children (Title XIX)
-Uninsured Children (Title XXI)

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only (under age 21)

**Medicare Dual Eligibles Excluded:**
SLMB, QI, and QDWI
QMB
QMB Plus, SLMB Plus, and Medicaid only (age 21 and older)

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## Dental Benefit Manager PAHP - Administrative Services Fee

### Service Delivery

**Included Services:**
Dental

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-All TENNCARE Standard and TENNCARE Medicaid under age 21
-Medicare Dual Eligibles

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only (under age 21)

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI
QMB Plus, SLMB Plus, and Medicaid only (age 21 and older)

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Social Services Agencies
-Substance Abuse Agency

# TENNESSEE
## TennCare II

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice - East TN
AmeriChoice - Middle TN
AmeriChoice - West TN
AmeriGroup Community Care
DentaQuest
SXC Health Solutions Corporation
Volunteer State Health Plan (Bluecare) - East
Volunteer State Health Plan (Bluecare) - West
Volunteer State Health Plan (TennCare Select)

## ADDITIONAL INFORMATION

1. Phased-In: As of July 1, 2010, the CHOICES program in TennCare was NOT fully phased in. On July 1, 2010, Nursing Facility (NF) services and Home and Community Based Services (HCBS) for persons considered to be institutionalized were provided through the MCOs and the PIHP (TennCare Select) in Middle Tennessee. NF services and HCBS in East and West Tennessee continued to be provided on a fee-for-service basis until August 1, 2010, when the CHOICES program was implemented statewide.

2. Guaranteed Eligibility is offered to Pregnant Women only - 60 days post delivery. The total period of eligibility will vary depending on the number of months the enrollees was pregnant at the time eligibility was granted.

3. Not all categories included in TennCare are mandatory Medicaid categories.

4. MCO /PIHP included Services: Chiropractic, Hearing, and Methadone Clinic Services are covered as medically necessary for under 21. Private Duty Nursing services are subject to specific limitations and medical necessity. Emergency Air and Ground Transportation is covered. Non-Emergency Transportation including Ambulance services is covered.

5. PIHP: TennCare Select is a prepaid inpatient health plan (PIHP) (as defined in 42 CFR 438.2) which operates in all areas of the State and covers the same services as the MCOs for the individuals described in paragraph 7 below. The State's TennCare Select contractor is reimbursed on a partial risk basis for services rendered to covered populations, and in addition receives fees from the State to offset administrative costs. TennCare Select is at risk for meeting EPSDT Screening Rate targets as reported annually on the CMS 416 report. TennCare Select is also at risk for medical and mental health services.

6. Lock-in: MCOs: Enrollees have 45 days after initial enrollment to change plans, after which they must stay in their plan until the annual re-determination unless there is a good cause reason.

7. Lock-in: PIHP: Children eligible for SSI, children receiving care in a NF or Intermediate Care Facility for Persons with Mental Retardation, and children and adults in a Home and Community Based Services 1915(c) Waiver for individuals with mental retardation are not locked into TennCare Select and may enroll in an MCO if one is available. Children in State custody and children leaving State custody for six months post-custody who remain eligible and enrollees living in areas where there is insufficient capacity to serve them are locked into TennCare Select.

8. MCO/PIHP: Full Benefit Medicare Dual Eligibles are enrolled in managed care programs. QMB only, SLMB only, QI and QDWI are not enrolled in managed care.

9. The Dental Benefits Manager (DBM) and Pharmacy Benefits Manager (PBM) are PAHPs and are paid an Administrative Services Fee. The managers handle claims administrative and are reimbursed for the claims amount(s). The DBM and PBM are currently non-risk but may be renegotiated as at risk. Provider rates are established in accordance with the State plan.

10. In both the DBM and the PBM, full benefit dual eligibles under age 21 are included. Partial benefit dual eligibles of any age and full benefit dual eligibles age 21 and older are excluded.

11. Some of our managed care entities have separate Medicare Advantage Plans, but these are independent of the Medicaid Program. The Bureau of TennCare does not have separate contracts with these plans for passive enrollment of dual eligibles into their Medicare Advantage Plans.

## QUALITY ACTIVITIES FOR MCO/PIHP

# TENNESSEE
# TennCare II

### State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Development of Quality Strategy for Tennessee
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO/PIHP Standards
-Monitoring of MCO/PIHP Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:
-ANOVA (Analysis of Variance)
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-CAHPS
Health Plan Survey Adult Version (CPA)
Health Plan Survey Child Version: Children with Chronic Conditions (CCC)
Health Plan Survey Child Version: General Population (CPC)
Medicaid Adult Questionnaire
Medicaid Child Questionnaire

### 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/PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO/PIHP
-Specification/source code review, such as a programming language used to create an encounter data file for submission

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment

### State conducts general data completeness assessments:
Yes

-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Breast Cancer and Cervical Cancer rates
-Infant Mortality
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Children's and adolescents access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Prenatal and Postpartum Care
-Ratio of dental providers to beneficiaries
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of home health visits per 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:
-Actual reserves held by plan
-Annual Financial Statements
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Quarterly Financial Statements
-State minimum reserve requirements
-Total revenue
-Weekly Claims Inventory Reports

### Health Plan/ Provider Characteristics:
-Board Certification
-Provider turnover

### Beneficiary Characteristics:
-Beneficiary need for interpreter

### Performance Measures - Others:
None

-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCO/PIHP
-Weeks of pregnancy at time of enrollment in MCO/PIHP, for women giving birth during the reporting period

## Performance Improvement Projects

### Project Requirements:

-MCOs/PIHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

### Clinical Topics:

-Cholesterol screening and management
-Diabetes management
-Emergency Room service utilization
-Inpatient maternity care and discharge planning
-Low birth-weight baby
-Post-natal Care
-Pre-natal care

### Non-Clinical Topics:

-Adults access to preventive/ambulatory health services

## Standards/Accreditation

### MCO Standards:

-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

### Accreditation Required for Participation:

-NCQA (National Committee for Quality Assurance)

### Non-Duplication Based on Accreditation:

None

### EQRO Name:

-Q-Source

### EQRO Organization:

-Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:

-Review of MCO/PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

### EQRO Optional Activities:

-Administration or validation of consumer or provider surveys
-Assessment of MCO/PIHP information systems
-Calculation of performance measures
-Technical assistance to MCOs/PIHPs to assist them in conducting quality activities

## Pay for Performance (P4P) for MCO

### Implementation of P4P:

The State has implemented a Pay-for-Performance program with MCO

### Program Payers:

Medicaid is the only payer

### Population Categories Included:

Covers all MCO members

### Rewards Model:

Payment incentives/differentials to reward MCOs
Withholds as an incentive

### Clinical Conditions:

Not Applicable

### Measurement of Improved Performance:

Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of

MCO response to grievances, improving customer service, etc.)
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
2006

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

**Member Incentives:**
Not Applicable

## Quality Activities for Dental Benefit Manager PAHP

**State Quality Assessment and Improvement Activities:**
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-Network Data
-On-Site Reviews
-PAHP Standards (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

**Use of Collected Data:**
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Track Health Service provision

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

### Encounter Data

**Collection: Requirements:**
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections - Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

**Validation - Methods:**
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for

submission

**PAHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Amount of Payment

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Dental services

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries satisfied with their ability to obtain care

**Access/Availability of Care:**
-Dental Screening ratio (observed/expected)
-Ratio of dental providers to beneficiaries

**Use of Services/Utilization:**
-Percentage of beneficiaries with at least one dental visit

**Health Plan Stability/ Financial/Cost of Care:**
-Expenditures by medical category of service (ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Prompt Pay Review

**Health Plan/ Provider Characteristics:**
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

**Beneficiary Characteristics:**
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-PAHPs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
-Child/Adolescent Dental Screening and Services

**Non-Clinical Topics:**
Not Applicable - PAHPs are not required to conduct common project(s)

## Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

# TENNESSEE
# TennCare II

**Non-Duplication Based on Accreditation:**
None

## QUALITY ACTIVITIES FOR PHARMACY BENEFIT MANAGER PAHP

**State Quality Assessment and Improvement Activities:**
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PAHP Standards
-Network Data
-On-Site Reviews
-PAHP Standards (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

**Use of Collected Data:**
-Contract Standard Compliance
-Fraud and Abuse
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

### 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 PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections - Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

**Validation - Methods:**
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

**PAHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID

**State conducts general data completeness assessments:**
Yes

-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Amount of Payment

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
-Drug Utilization

**Health Plan Stability/ Financial/Cost of Care:**
-Net Worth
-Total Revenue

**Health Plan/ Provider Characteristics:**
-Pharmacy Taxonomy (retail vs. specialty vs. LTC, etc)
-Valid Pharmacy License

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-PAHPs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
None

**Non-Clinical Topics:**
-Network Access
-Trends in Pharmacy Appeals

## Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# UTAH
# Primary Care Network (PCN)

## CONTACT INFORMATION

**State Medicaid Contact:**

Emma Chacon
Utah State Department of Health
(801) 538-6577

**State Website Address:**

http://www.health.utah.gov/medicaid

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
February 08, 2002

**Implementation Date:**
July 01, 2002

**Waiver Expiration Date:**
June 30, 2013

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(14) Enrollment Fee
-1902(a)(23) Freedom of Choice

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Eligibility Expansion
-Restrictions on Coverage

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Dental, Diabetes self-management, Durable Medical Equipment, Emergency Room, ESRD, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Medical Detoxification, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Primary Care, Speech Therapy, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians

#### Enrollment

# UTAH
## Primary Care Network (PCN)

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-American Indian/Alaska Native
-Medically Needy (not aged, blind, or disabled) Adults
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Reside in Nursing Facility or ICF/MR
-Resident of the State Developmental Center (DD/MR facility)
-Resident of the Utah State Hospital (IMD)

**Lock-In Provision:**
None

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# UTAH
# Primary Care Network (PCN)

## MCO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

**Included Services:**

Case Management, Diabetes self-management, Durable Medical Equipment, ESRD, Family Planning, Hearing, HIV Prevention, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient medical detoxification, Laboratory, Medical Supples, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Speech Therapy, Vision, X-Ray

**Allowable PCPs:**

-Family Practitioners
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians

### Enrollment

**Populations Voluntarily Enrolled:**

None

**Populations Mandatorily Enrolled:**

-American Indian/Alaska Native
-Medically Needy (not aged, blind, or disabled) Adults
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-Demonstration Population I, under the Waiver III, IV, V, VI
-During Retroactive Eligibility Period
-Eligibility Less Than 3 Months
-Eligible only for TB-related Services
-If approved as exempt from mandatory enrollment
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)

**Lock-In Provision:**

None

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

# UTAH
# Primary Care Network (PCN)

## Medical-only PAHP (risk or non-risk, non-comprehensive) - Non-risk Capitation

### Service Delivery

**Included Services:**
Case Management, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-American Indian/Alaska Native
-Medicare Dual Eligibles
-Section 1925 & 1931 Adults and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Eligibility Less Than 3 Months
-Eligible only for TB-related Services

**Lock-In Provision:**
None

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Surveys medical needs of enrollee to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Developmental Disabilities Agency
-Education Agency
-Mental Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

# UTAH
## Primary Care Network (PCN)

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy U
Select Access

Molina Healthcare of Utah (Molina)

## ADDITIONAL INFORMATION

PCN program is a statewide section 1115 demonstration to expand Medicaid coverage. PCN also offers the full Medicaid state plan package to certain high-risk pregnant women with assets in excess of state plan levels, and a primary/preventive package to certain adults age 19 and above, with incomes under 150% FPL, who are not otherwise Medicaid-eligible. However, these groups are not enrolled in managed care entities. Under the PCCM, QMB Plus, SLMB Plus, and Medicaid-only duals are included in the Non-Traditional Plan of the waiver.

Mental Health is covered under the Prepaid Mental Health Plans which are under the State's 1915(b) Prepaid Mental Health Waiver. The mental health costs incurred by the PMHPs are included in the 1115 waiver costs to calculate the cost neutrality of the waiver.

The contract is classified as non-risk. Medicaid reimburses the PAHP the amount the PAHP paid its providers plus an administrative fee.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:
-CAHPS
Adult Medicaid AFDC Questionnaire

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

### 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 MCO

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Possible duplication of encounter.

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Cholesterol screening and management
-Colorectal Cancer Screening
-Diabetes medication management
-Immunizations for two year olds
-Influenza vaccination rate

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services

**Use of Services/Utilization:**
-Inpatient admissions/1,000 beneficiary

**Health Plan Stability/ Financial/Cost of Care:**
-Actual reserves held by plan
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Total revenue

**Health Plan/ Provider Characteristics:**
-Board Certification

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-MCOs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
-Diabetes management

**Non-Clinical Topics:**
None

## Standards/Accreditation

**MCO Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-HCE Quality Quest

# UTAH
## Primary Care Network (PCN)

**EQRO Organization:**
-QIO-like entity

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
None

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# VERMONT
# Global Commitment to Health

## CONTACT INFORMATION

**State Medicaid Contact:**

Mark Larson
Department of Vermont Health Access
(802) 879-5900

**State Website Address:**

http://dvha.vermont.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1115(a) - Demonstration Waiver Program

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
September 27, 2005

**Implementation Date:**
October 01, 2005

**Waiver Expiration Date:**
December 31, 2013

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(c)(i)(III)
-1902(a)(14)
-1902(a)(17)
-1902(a)(17)(D)
-1902(a)(23) Freedom of Choice
-1902(a)(4)

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
-Expenditures related to additional services
-Expenditures related to defining the uninsured
-Expenditures related to Eligibility Expansion Demo Populations 3-10
-Expendiures related to MCO cap payment
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nearing Home Health, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Pharmacy,

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists

Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)

### Enrollment

**Populations Voluntarily Enrolled:**

None

**Populations Mandatorily Enrolled:**

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**

-CHIP XXI
-Individuals covered under Choices for Care 1115 Waiver except those Community Rehabilitation and Treatment Program
-Unqualified Alients, Documented and Undocumented

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**

None

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Agents when used for anorexia, weight loss, weight gain
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Developmental Disabilities Agency
-Education Agency

-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Global Committment to Health

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Ombudsman
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:

-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

None

### Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

### Encounter Data

#### Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data

#### 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 commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

-Specification/source code review, such as a programming language used to create an encounter data file for submission

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

**State conducts general data completeness assessments:**
No

## Performance Measures

**Process Quality:**
-Adolescent well-care visit rate
-Asthma care - medication use
-Dental services

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

**Use of Services/Utilization:**
-Adolescent well-care visits utilization
-Drug Utilization
-Inpatient admissions/1,000 beneficiary
-Well-child visits in first 15 months of life
-Well-child visits in the 3,4,5 and 6 years of life

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-MCOs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
Not Applicable - MCOs are not required to conduct common project(s)

**Non-Clinical Topics:**
-Fostering Healthy Families

## Standards/Accreditation

**MCO Standards:**
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Health Services Advisory Group

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance measures

**EQRO Optional Activities:**
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# CALIFORNIA
## Sacramento Geographic Managed Care

## CONTACT INFORMATION

**State Medicaid Contact:**

Tanya Homman
Medi-Cal Managed Care Division
(916) 449-5000

**State Website Address:**

http://www.dhcs.ca.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Health Care Options/Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 01, 1994

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Adoption Assist/Medically Indigent-Child

**Populations Mandatorily Enrolled:**
-Public Assistance-Family

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Foster Care/Medically Indigent Child
-Medicare Dual Eligibles
-Pregnant/Medically Indigent-Adult
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Program/Percent/Children

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligibility Less Than 3 Months
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

## 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 - progam linkage and/or family contact
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Developmental Disabilities Agency
-Education Agency
-Home and Community Based Care
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Title V

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem Blue Cross Partnership Plan - Sacramento

# CALIFORNIA
## Sacramento Geographic Managed Care

KP Cal, LLC - Sacramento

Health Net Community Solutions, Inc. - Sacramento

Molina Healthcare of California Partner Plan, Inc. - Sacramento

## ADDITIONAL INFORMATION

Restricts aid code beneficiaries designated mandatory to enroll in 1 of 4 health plans and 1 of 5 dental plans. This program operates under the combined authorities of Section 1932(a) and 1915(b). The corresponding 1915(b) waiver is the California CCS/Dental Waiver Program, which provides authority for mandatory enrollment in Sacramento GMC of those populations that would otherwise be excluded from mandatory enrollment under Section 1932(a). The CCS/Dental waiver also provides the authority for the mandatory dental managed care component of Sacramento GMC.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

### Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved

### Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Avoidance of antibiotic treatment in adults with acute Bronchitis
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes Management/Care
-Diabetes medication management
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Postpartum care
-Use of imaging studies for low back pain
-Weight assessment & counseling for nutrition & physical activity for children & adolescents
-Well-child care visit rates in 3,4,5, and 6 years of life

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

**Access/Availability of Care:**
-Average distance to PCP
-Ratio of PCPs to beneficiaries

**Use of Services/Utilization:**
-Ambulatory care - ambulatory surgery/procedures
-Ambulatory care - emergency department visits
-Ambulatory care - observation room stays
-Ambulatory care - outpatient visits
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Frequency of selected procedures
-Inpatient admissions/1,000 beneficiary

**Health Plan Stability/ Financial/Cost of Care:**
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

**Health Plan/ Provider Characteristics:**
-Board Certification
-Languages Spoken (other than English)

**Beneficiary Characteristics:**
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

**Performance Measures - Others:**
None

# CALIFORNIA
## Sacramento Geographic Managed Care

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

### Clinical Topics:
-Cervical cancer screening among seniors and persons with disabilities
-Childhood obesity
-Emergency Room service utilization
-Hypertension management
-Postpartum care

### Non-Clinical Topics:
None

## Standards/Accreditation

### MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Health Services Advisory Group

### EQRO Organization:
-Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

### EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

### Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

### Program Payers:
Medicaid is the only payer

### Population Categories Included:
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

### Rewards Model:
Preferential auto-enrollment to reward MCOs

### Clinical Conditions:
Not Applicable

### Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)
Utilization of safety net providers by MCOs

### Initial Year of Reward:
2005

### Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

### Member Incentives:
Not Applicable

# CALIFORNIA
## San Diego Geographic Managed Care

## CONTACT INFORMATION

**State Medicaid Contact:**

Tanya Homman
Medi-Cal Managed Care Division
(916) 449-5000

**State Website Address:**

http://www.dhcs.ca.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Health Care Options/Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
October 17, 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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Transportation, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Adoption Assist/Medically Indigent-Child

**Populations Mandatorily Enrolled:**
-Public Assistance-Family

-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Foster Care/Medically Indigent-Child
-Medicare Dual Eligibles
-Pregnant/Medically Indigent-Adult
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Program/Percent/Children

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligibility Period Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Developmental Disabililties
-Education Agency
-Home and Community Based Care
-Local Schools
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Title V

# CALIFORNIA
## San Diego Geographic Managed Care

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Care 1st Health Plan-San Diego
Health Net Community Solutions, Inc.-San Diego
Molina Healthcare of California Partner Plan, Inc. - San Diego
Community Health Group Partnership Plan-San Diego
KP Cal, LLC-San Diego

## ADDITIONAL INFORMATION

Restricts aid code beneficiaries designated as mandatory to enroll in 1 of 5 health plans. This program operates under the combined authorities of Section 1932(a) and 1915(b). The corresponding 1915(b) waiver is the California CCS/Dental Waiver Program.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms,

data between trading partners, such as hospitals, long term care facilities, etc.

comparisons to submitted bills or cost-ratios)

### MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes

### State conducts general data completeness assessments:

Yes

## Performance Measures

### Process Quality:

-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Avoidance of antibiotic treatment in adults with acute Bronchitis
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes Management/Care
-Diabetes medication management
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Postpartum care
-Use of imaging studies for low backpain
-Weight assessment and counseling for nutrition and physical activity for children and adolescents
-Well-child care visit rates in 3,4,5, and 6 years of life

### Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:

-Average distance to PCP
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:

-Ambulatory care - ambulatory surgery/procedures
-Ambulatory care - emergency department visits
-Ambulatory care - observation room stays
-Ambulatory care - outpatient visits
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Frequency of selected procedures
-Inpatient admissions/1,000 beneficiary

### Health Plan Stability/ Financial/Cost of Care:

-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

### Health Plan/ Provider Characteristics:

-Board Certification
-Languages Spoken (other than English)

### Beneficiary Characteristics:

-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

### Performance Measures - Others:

None

## Performance Improvement Projects

# CALIFORNIA
## San Diego Geographic Managed Care

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

### Clinical Topics:
-Chronic Obstructive Pulmonary Disease
-Emergency Room service utilization
-Improving cervical cancer screening among seniors and persons with disabilities
-Positive post-partum screens
-Post-natal Care
-Upper Respiratory Infection

### Non-Clinical Topics:
None

## Standards/Accreditation

### MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Health Services Advisory Group

### EQRO Organization:
-Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

### EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

### Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

### Program Payers:
Medicaid is the only payer

### Population Categories Included:
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

### Rewards Model:
Preferential auto-enrollment to reward MCOs

### Clinical Conditions:
Not Applicable

### Measurement of Improved Performance:
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)
Utilization of safety net providers by MCOs

### Initial Year of Reward:
2005

### Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

### Member Incentives:
Not Applicable

# CALIFORNIA
## Two-Plan Model Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Tanya Homman
Medi-Cal Managed Care Division
(916) 449-5000

**State Website Address:**

http://www.dhcs.ca.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Health Care Options/Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
January 23, 1996

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Cultural/Linguistic, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Preventive Health Screening, Specialist, Speech Therapy, Transportation, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Adoption Assistance/Medically Indigent Children

**Populations Mandatorily Enrolled:**
-Public Assistance - Family

-Aged and Related Populations
-American Indian/Alasaka Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Pregnant/Medically Indigent Adults
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Program/Percent/Children
-Title XXI CHIP (non-State only Healthy Families)

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligibility Period Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Title XXI CHIP (State only Healthy Families)

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

## 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 other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-California Childrens Services
-Department of Managed Health Care
-Developmental Disabilities Agency
-Early Periodic Screening Diagnosis and Treatment Program
-Education Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency

# CALIFORNIA
## Two-Plan Model Program

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Alameda Alliance for Health
Contra Costa Health Plan
Health Plan of San Joaquin
Kern Family Health Care
Molina Healthcare of California Partner Plan, Inc.-TPMP
Santa Clara Family Health Plan
Anthem Blue Cross Partnership Plan-TPMP
Health Net Community Solutions, Inc.-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. Transportation services are included when medically necessary. This program operates under the combined authorities of Section 1932 (a) and 1915 (b). The corresponding 1915(b) waiver is the California CCS/Dental Waiver Program.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Ombudsman
-On-site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

### Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs

### Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes Management/Care
-Diabetes medication management
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Postpartum Care
-Use of imaging studies for low back pain
-Weight assessment & counseling for nutrition & physical activity for children & adolescents
-Well-child care visit rates in 3,4,5, and 6 years of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Ambulatory care - ambulatory surgery/procedures
-Ambulatory care - emergency department visits
-Ambulatory care - observation room stays
-Ambulatory care - outpatient visits
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Frequency of selected procedures
-Inpatient admissions/1,000 beneficiary

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

### Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)
-Provider turnover

# CALIFORNIA
## Two-Plan Model Program

**Beneficiary Characteristics:**
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

**Clinical Topics:**
-Adolescent obesity
-Asthma management
-Attention deficit hyperactivity disorder management
-Childhood obesity
-Comprehensive diabetic quality improvement
-Diabetic testing & retinal exam screening
-Emergency Room service utilization
-Improving postpartum care rates
-Reducing Health Disparities
-Sexually transmitted disease screening

**Non-Clinical Topics:**
-Improving the patient experience

## Standards/Accreditation

**MCO Standards:**
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Health Services Advisory Group

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

**Rewards Model:**
Preferential auto-enrollment to reward MCOs

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Using clinically-based outcome measures (e.g., HEDIS,

NQF, etc.)
Utilization of safety net providers by MCOs

**Initial Year of Reward:**
2005

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

**Member Incentives:**
Not Applicable

# COLORADO
## Primary Care Physician Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Curtis Johnson
Department of Health Care Policy and Financing
303-866-3830

**State Website Address:**

http://www.colorado.gov/hcpf

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Maximus, INC.

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
June 30, 2003

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
EPSDT, Hearing, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Pharmacy, Physician, X-Ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Physician Assistants

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
No

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## ePCCM - Fee-for-Service

### Service Delivery

**Included Services:**
Case Management

**Allowable PCPs:**
-Not Applicable

### Enrollment

**Populations Voluntarily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# COLORADO
## Primary Care Physician Program

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Developmental Disabilities Agency
-Public Health Agency
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ePCCM

Primary Care Physician Program

## ADDITIONAL INFORMATION

This program provides beneficiaries the option of a fee-for-service physician who acts as a gatekeeper and refers for specialty care. In addition to the gatekeeper "Primary Care Case Management Program" called the "Primary Care Physician Program", Colorado offers an enhanced Primary Care Case Management (ePCCM) program with two levels of enhanced services. All three versions share the common elements: Reimbursement for medical services is fee-for-service, Enrollment is voluntary (a "passive" or default enrollment mechanism is available), There is a 12 month lock-in period (until the Enrollees next birthday), and Most medical services provided by someone other than the chosen Primary Care Provider need a referral.

The two enhanced version of the program have these additional characteristics: Per Member per Month (PMPM) case management payments depending upon the level of "enhancements" provided and the kinds of clients enrolled, and Ability to earn bonus incentive payments attributable to a reduction in utilization or costs after recovery of PMPM expenditures.

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-Consumer Self-Report Data (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
-CAHPS
Adult Medicaid 4.0 H
Child Medicaid 4.0 H

### Performance Measures

**Process Quality:**
-Adolescent well-care visits rates
-Annual Monitoring for Patients on Persistent Medications
-Childhood Immunization Status
-Chlamydia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Depression medication management

**Health Status/Outcomes Quality:**
-CAHPS Health Plan
-Survey 4.0 H Adult
-Survey 4.0 H Child

-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Prenatal and Postpartum Care

### Use of Services/Utilization:
-Antibiotic Utilization
-Frequency of Selected Procedures
-Inpatient Utilization - General Hospital/Acute Care

### Provider Characteristics:
None

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

# DISTRICT OF COLUMBIA
## District of Columbia Medicaid Managed Care Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Lisa Truitt
Department of Health Care Finance
(202) 442-9109

**State Website Address:**

http://www.dchealth.dc.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Houstons Associates Inc., A Raytheon Company

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 01, 1994

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Addictionologists
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Psychiatrists
-Psychologists

#### Enrollment

# DISTRICT OF COLUMBIA
## District of Columbia Medicaid Managed Care Program

**Populations Voluntarily Enrolled:**
-Children receiving adoption assistance
-Immigrant Children (State only)
-Special Needs Children (State defined)

**Populations Mandatorily Enrolled:**
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-TANF HIV Patients: Pregnant > 26 weeks
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Developmental Disabilities Agency
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

DC Chartered Health Plan, Incorporated

Unison Health Plan of the Capital Area

## ADDITIONAL INFORMATION

Adult Day Treatment applies to Mental Health Retardation. TANF HIV patients can opt out of managed care, pregnant women do not have opt out provision unless they are HIV positive or have AIDS.

Children with Special Health Care Needs: Those children who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond those required by

children generally. This definition includes children who receive Supplemental Security Income (SSI), children whose disabilities meet the SSI definition, children who are or have been in foster care, and children who meet the standard of limited English proficiency.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Accreditation for Participation
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

None

### Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

## Encounter Data

### Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

### Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Adolescent immunization rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

**Health Status/Outcomes Quality:**
-Number of children with diagnosis of rubella(measles)/1,000 children
-Patient satisfaction with care
-Percentage of low birth weight infants

**Access/Availability of Care:**
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

**Use of Services/Utilization:**
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

**Health Plan Stability/ Financial/Cost of Care:**
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

# DISTRICT OF COLUMBIA
## District of Columbia Medicaid Managed Care Program

### Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

### Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Adult hearing and vision screening
-Asthma management
-Beta Blocker treatment after a heart attack
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Depression management
-Diabetes management/care
-Low birth-weight baby
-Newborn screening for heritable diseases
-Post-natal Care
-Pre-natal care
-Primary and behavioral health care coordination
-Well Child Care/EPSDT

### Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

## Standards/Accreditation

### MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

### Accreditation Required for Participation:
-AAAHC (Accreditation Association for Ambulatory Health Care)
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-MCO must be accredited by appropriate body
-NCQA (National Committee for Quality Assurance)

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Delmarva Foundation for Medical Care

### EQRO Organization:
-Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

### EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

## Pay for Performance (P4P)

### Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

### Program Payers:
Medicaid is the only payer

### Population Categories Included:
Covers all MCO members

### Rewards Model:
Payment incentives/differentials to reward MCOs

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Assessing patient satisfaction measures
Ratio of Encounter to Financial Data
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# GEORGIA
## Georgia Better Health Care

## CONTACT INFORMATION

**State Medicaid Contact:**

Juanita Hines
Director, GBHC
(404) 657-0623

**State Website Address:**

http://www.dch.ga.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
October 01, 1993

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Physician

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

**Lock-In Provision:**

Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Public Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Georgia Better Health Care

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PCCM

# GEORGIA
## Georgia Better Health Care

**Quality Oversight Activities:**
-Enrollee Hotlines
-Performance Measures (see below for details)

**Use of Collected Data:**
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
None

## 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:**
-Drug Utilization
-Emergency room visits/1,000 member months
-Inpatient admissions/1,000 member months
-Number of primary care case manager visits per beneficiary

**Provider Characteristics:**
-Board Certification
-Languages spoken (other than English)

**Beneficiary Characteristics:**
-Percentage of beneficiaries who are auto-assigned to PCCM

**Performance Measures - Others:**
None

# GEORGIA
## Georgia Families

## CONTACT INFORMATION

**State Medicaid Contact:**

Jerry Dubberly
GA Department of Community Health
(404) 651-8681

**State Website Address:**

http://www.dch.ga.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
June 01, 2006

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Ambulatory Surgical, Audiology, Case Management, Childbirth Education, Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, FQHC, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Nurse Midwife, Nurse Practitioner, Obstetrical, Occupational Therapy, Oral Surgery, Orthotic, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Pregnancy Related, Private Duty Nursing, Prosthetic, Radiology, RHC, Skilled Nursing Facility, Speech Therapy, Swing Bed, Targeted Case Management, Transplants, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Public Health Department
-Rural Health Clinics (RHCs)

#### Enrollment

# GEORGIA
## Georgia Families

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Low-income Medicaid
-Poverty-Level Pregnant Women
-Refugees
-Right from State Medicaid
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Women with Breast or Cervical Cancer

**Subpopulations Excluded from Otherwise Included Populations:**
-Aged, Blind, and Disabled
-Foster Care Children
-Long Term Care (includes Hospice)
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-SSI and Members of Federally Recognized Indian Tribes

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Public Health Agency
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Community Care
Peach State Health Plan
WellCare

## ADDITIONAL INFORMATION

None

# GEORGIA
## Georgia Families

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-Network Data
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-CAHPS

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)

### Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-CMS1500
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:
-A monthly reconcilation of submitted encounters
-Periodic audit of encounter transaction to source document

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Age-appropriate diagnosis/procedure
-A unique TCN
-All required CMS1500 and UB04 codes
-CMO Paid Amount

### State conducts general data completeness assessments:
Yes

-Date of Birth
-Diagnosis Primary and Secondary
-Facility Code
-NPI Number
-Patient Name
-Place of Service
-Tax Identification Number
-Treating Provider
-Units of Service

## Performance Measures

### Process Quality:
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Comprehensive Diabetes Management
-Dental services
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Emergency room visits/1,000 member months
-Inpatient admissions/1,000 member months
-Re-admission rates of MH/SUD

### Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Total revenue

### Health Plan/ Provider Characteristics:
None

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCO

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

### Clinical Topics:
-Adult Access
-Blood Lead Screening
-Dental
-Emergency Room Service Utilization
-Immunization
-Obesity
-Well Child Care/EPSDT

# GEORGIA
## Georgia Families

**Non-Clinical Topics:**
None

## Standards/Accreditation

**MCO Standards:**
-NCQA (National Committee for Quality Assurance) Standards
-URAC 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)

**Non-Duplication Based on Accreditation:**
-NCQA (National Committee for Quality Assurance)

**EQRO Name:**
-Health Services Advisory Group (HSAG)

**EQRO Organization:**
-Private accreditation organization
-QIO-like entity
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of health plan compliance with State and Federal Medicaid Managed Care Regulations
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
Covers all MCO members

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)

**Initial Year of Reward:**
2009

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

**Member Incentives:**
Not Applicable

# ILLINOIS
## Illinois Health Connect Primary Care Case Management

## CONTACT INFORMATION

**State Medicaid Contact:**

Michelle Maher
Illinois Department of Healthcare and Family Services
(217) 524-7478

**State Website Address:**

http://www.hfs.illinois.gov/

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Automated Health Systems

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
July 01, 2006

**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:**
Assisted/Augmentative Communication Devices, Audiology, Blood and Blood Components, Case Management, Chiropractic, Clinic, Dental, Diagnosis and treatment of medical conditions of the eye, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Psychiatric Care, Inpatient Substance Use Disorders, Laboratory, Non-Durable Medical Equipment and Supplies, Nurse Midwives, Occupational Therapy, Orthotic/Prosthetic Devices, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Psychiatric Care, Skilled Nursing Facility, Speech Therapy, Transplants, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Certified Local Health Departments
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)
-School-Based/Linked Clinics

#### Enrollment

# ILLINOIS
## Illinois Health Connect Primary Care Case Management

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP
-Veterans Care Population

**Subpopulations Excluded from Otherwise Included Populations:**
-All Kids Rebate and Family Care Rebate Program
-Blind Disabled Children and Related Populations
-Emergency Medical Only
-Individuals enrolled for treatment in the health benefit for persons with Breast or Cervical Cancer Program
-Individuals enrolled in programs with limited benefits
-Individuals in Presumptive Eligible Programs
-Medicare Dual Eligibles
-Non-citizens only receiving emergency services
-Other Insurance (High Level)
-PACE Participants
-Refugees
-Reside in Nursing Facility or ICF/MR
-Some people who receive Home and Community Based services
-Special Needs Children (BBA defined)
-Spendown Eligibles
-Transitional Assistance, Age 19 and Older

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Uses claims data 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
-All local agencies under administrative oversight of State agencies
-Employment Agencies
-Housing Agencies
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Illinois Health Connect

## ADDITIONAL INFORMATION

Enrollment in Illinois Health Connect is mandatory , in areas with voluntary managed care, most clients have the option to choose a primary care provider in Illinois Health Connect or a managed care organization.

Illinois Health Connect coordinates with Your Healthcare Plus which is a statewide disease management support program for three targeted populations, disabled adults with chronic or complex health issues, children or adults with asthma or COPD, and high frequency ER users. The program is designed to help patients manage their total healthcare. The goals include: improve health and wellness of participants; reduce avoidable inpatient and ER use; increase use of medical home; promote adherence to drug regimens that are cost and clinically effective; increase the number of patients who receive care consistent with evidence-based practice guidelines; provide office support that allows better communication across all team members, and reduces costs.

## QUALITY ACTIVITIES FOR PCCM

### Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Network Data
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service Provision and Health Outcomes

### Consumer Self-Report Data:
-Enrollee Survey
-Health Needs Assessment

### Performance Measures

#### Process Quality:
-Access to Preventive/Ambulatory Health Services
-Ace Inhibitor/ARB Therapy
-Adolescent well-care visits rates
-Ambulatory Care Sensitive Hospital Visits for CHF, Angina, Diabetes, Cellulitis, Asthma, COPD, Bacte
-Annual Urine Microalbuminuria Testing
-ASA, other antiplatelet or anticoagulant
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Blood Pressure Control
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol Screening
-Chronic Obstructive Pulmonary Disease - Care and Management
-Depression medication management
-Developmental Screening age 12 - 24 months
-Developmental Screening before age 12 months
-Diabetes management/care

#### Health Status/Outcomes Quality:
-Comparison to statewide averages and HEDIS 50th percentile benchmarks to measure performance
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

-Diuretic - Heart Failure
-Foot Exams
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Pneumonia vaccination
-Prenatal and Postpartum Care
-Prenatal and Postpartum Screening for Depression
-Retinal Exam
-Statin Therapy
-Vision Services for 3, 4, 5, and 6 year olds
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Children's access to primary care practitioners
-Enrollee Helpline to locate providers for services
-Percent of PCPs with open or closed patient assignment panels
-Ratio of primary care case managers to beneficiaries

### Use of Services/Utilization:
-Emergency room visits/1,000 beneficiaries
-Hospitalizations for ambulatory sensitive conditions/1,000 beneficiaries
-Increase in Well Child Visits/3,4,5 and 6 yrs
-Increase in Well Child Visits/first 15 months

### Provider Characteristics:
-Gender
-Languages spoken (other than English)
-Office hours
-Panel Availability
-Specialties

### Beneficiary Characteristics:
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM

### Performance Measures - Others:
None

# IOWA
# Iowa Medicaid Managed Health Care

## CONTACT INFORMATION

**State Medicaid Contact:**

Dennis Janssen
Department of Human Services
(515) 256-4643

**State Website Address:**

http://www.dhs.state.ia.us

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
December 01, 1986

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Durable Medical Equipment, EPSDT, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Rural Health Centers (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-Aged (over 65)
-American Indian/Alaskan Native
-Medically Needy
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Recipients placed into the "lock-in" program by the Department
-Recipients who have an eligibility period that is only retroactive
-Recipients who have commecial insurance paid under the Health Insurance Payment Program
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)

**Lock-In Provision:**

6 month lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medipass

## ADDITIONAL INFORMATION

Selected Medicaid member categories are required to select (or accept) a primary care provider (PCP) who will provide services or make a referral for services not offered at the PCP practice location.

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**

-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Performance Measures (see below for details)

**Use of Collected Data:**

-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling

**Consumer Self-Report Data:**

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

### Performance Measures

# IOWA
## Iowa Medicaid Managed Health Care

**Process Quality:**
None

**Health Status/Outcomes Quality:**
-Patient satisfaction with care

**Access/Availability of Care:**
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners

**Use of Services/Utilization:**
-Emergency room visits/1,000 beneficiaries

**Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

# KANSAS
## HealthConnect Kansas

## CONTACT INFORMATION

**State Medicaid Contact:**

Tracy Conklin
Kansas Health Policy Authority
(785) 296-7788

**State Website Address:**

http://www.khpa.ks.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
HP

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
Continuous eligibility for children under age 19

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
January 01, 1984

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Chiropractic, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Obstetrical, Occupational Therapy, Outpatient Hospital, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Local Health Departments (LHDs)
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Osteopaths
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native
-Blind/Disabled Children and Related Populations
-Special Needs Children (BBA-defined)

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Aliens who are eligible for Medicaid for emergency conditions only
-Clients participating in the Refugee Resettlement Program
-Clients residing out of State
-Clients with an eligibility period that is only retroactive
-Enrolled in Another Managed Care Program
-Foster Care Children
-Medically Needy-eligible
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Receive Adoption Support
-Reside in Juvenile Justice Facility
-Reside in Nursing Facility or ICF/MR
-Reside in State Institution
-Retroactive Eligibility
-Spenddown Eligible

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses information from Title V agency to identify members
-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
-Social Services Agencies

# KANSAS
## HealthConnect Kansas

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HealthConnect Kansas

## ADDITIONAL INFORMATION

TANF and PLE beneficiaries choose between the MCO and PCCM programs in counties where only one MCO is available. Otherwise, mandatory beneficiaries have their choice between PCPs within the PCCM.

## QUALITY ACTIVITIES FOR PCCM

### Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:
-CAHPS
- Adult Medicaid AFDC Questionnaire
- Adult Medicaid SSI Questionnaire
- Child Medicaid AFDC Questionnaire
- Child Medicaid SSI Questionnaire
- Child with Special Needs Questionnaire

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain 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:
None

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

# KANSAS
# HealthWave 19

## CONTACT INFORMATION

**State Medicaid Contact:**

Tracy Conklin
Kansas Health Policy Authority
(785) 296-7788

**State Website Address:**

http://www.khpa.ks.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
HP

**For All Areas Phased-In:**
No

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
December 01, 1995

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

**Guaranteed Eligibility:**
Continuous eligibility for children under age 19

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Newborn, Nutrition, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Prenatal Health Promotion, Speech Therapy, Transfusions, Transplants (limited to Kidney and Cornea), Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native
-Special Needs Children (BBA-defined)

**Populations Mandatorily Enrolled:**
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Aliens eligible for Medicaid for emergency conditions only
-Blind/Disabled Adults
-Blind/Disabled Children
-Clients participating in Refugee Resettlement program
-Clients participating in the subsidized adoption program
-Clients residing in State Institutions
-Clients under the custody of Juvenile Justice Authority
-Clients who are residing out of state
-Clients whose eligibility is only retro-active
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Reside in State Hospitals
-Retroactive Eligibility
-Spenddown
-Title XXI CHIP

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses information from the Title V agency to identify members
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

# KANSAS
## HealthWave 19

Children's Mercy's Family Health Partners

UniCare Health Plan of Kansas, Inc.

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

### Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

### Validation - Methods:

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

### MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes

### State conducts general data completeness assessments:

Yes

# KANSAS
## HealthWave 19

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

### Health Status/Outcomes Quality:
-Asthma treatment outcomes
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Panel size
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary

### Health Plan Stability/ Financial/Cost of Care:
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-Total revenue

### Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

### Clinical Topics:
-Diabetes management
-Pre-natal care

### Non-Clinical Topics:
-Telephonic Improvement of Customer Care

## Standards/Accreditation

### MCO Standards:
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Kansas Foundation for Medical Care

# KANSAS
## HealthWave 19

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys
-Assessment of MCO information systems
-Calculation of performance measures
-Focused Studies
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# KENTUCKY
# Kentucky Patient Access and Care (KENPAC) Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Lee Barnard
Division of Medical Management
(502) 564-9444

**State Website Address:**

http://www.chfs.ky.gov/dms

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 01, 2000

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Centers (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

# KENTUCKY
## Kentucky Patient Access and Care (KENPAC) Program

**Subpopulations Excluded from Otherwise Included Populations:**

-American Indian/Alaskan Native
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Spenddown

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Kentucky Patient Access and Care (KenPAC)

## ADDITIONAL INFORMATION

For the following Included services- EPDST, Mental Health, and Maternity Care including prenatal care delivery and post partum beneficiary may go to any participating providers for these services without a referral.

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**

-Enrollee Hotlines
-Ombudsman
-Provider Data

**Use of Collected Data:**

-Beneficiary Provider Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation

-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

**Consumer Self-Report Data:**
None

# LOUISIANA
## Community Care Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Angela Mastainich
Department of Health and Hospitals
(225) 342-4810

**State Website Address:**

http://www.dhh.state.la.us

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
ACS Government Healthcare Solutions

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
Children under 19 have 12 months guaranteed eligibility
months guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 01, 2006

**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:**
EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-American Indian/Alaskan Native
-CHAMP pregnant women
-Eligibility Less Than 3 Months
-Enrollees in the PACE Program
-Foster children, or children receiving adoption assistance
-Medically high-risk on a case-by-case basis
-Medicare Dual Eligibles
-Office of Youth Development recipients
-Prseumptive Eligible (PE) recipients
-Recipients in SURS lock-in (except "pharmacy-only" lock in)
-Recipients in the Family Planning Waiver Program
-Recipients in the Hospice Program
-Recipients in the LaChip Affordable Plan
-Recipients under the age of 19 in the NOW and Childrens Choice Waiver Programs
-Recipients under the age of 19 in the Supports Waiver and Supports SSI Programs
-Recipients who are 65 and older
-Recipients who have other primary insurance that includes physician benefits
-Reside in Nursing Facility or ICF/MR
-Residents of Psychiatric facilities
-Retroactive Eligibility
-SSI recipients under the age of 19

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Reviews complaints and grievances to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Education Agency
-Mental Health Agency
-Public Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care

# LOUISIANA
## Community Care Program

## ADDITIONAL INFORMATION

Program includes a $3 monthly case management fee. Community Care was converted from a 1915(b) to a 1932(a). Laboratory and X-Ray services are included but services are limited.

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-Enrollee Hotlines
-Performance Measures (see below for details)

**Use of Collected Data:**
-Fraud and Abuse
-Program Improvements

**Consumer Self-Report Data:**
None

### Performance Measures

**Process Quality:**
-Adolescent well-care visits rates
-Adult well care visits
-Breast Cancer screening rate
-Cervical cancer screening rate
-Childhood Immunization Status
-Cholesterol Management for People w/cardiovascular conditions
-Cholesterol screening and management
-Lead screening rate
-Use of Appropriate Medications for People with Asthma
-Well child visits 7-11 years of life
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
-Adolescent access to primary care practitioners
-Adult access to preventive/ambulatory health services
-Annual dental visits
-Children's access to primary care practitioners

**Use of Services/Utilization:**
None

**Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

# MAINE
# MaineCare Primary Care Case Management

## CONTACT INFORMATION

**State Medicaid Contact:**

Brenda McCormick
MaineCare Services
(207) 287-1774

**State Website Address:**

http://www.maine.gov/

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Public Consulting Group, Inc.

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
May 01, 1999

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Ambulatory Surgical Center, Certain Family Planning, Chiropractic, Clinic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatric, Speech/Language Pathology, Vision, X-Ray

**Allowable PCPs:**
-Ambulatory Care Clinic or Hospital Based Outpatient Clinic
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Alaska Natives and Native Americans

**Populations Mandatorily Enrolled:**
-Blind/Disabled Adults and Related Populations

-American Indian/Alaska Native

-Blind/Disabled Children and Related Populations
-Children Receiving Adoption Assistance
-Non Categorical Adults
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Title XXI CHIP
-Women with Breast or Cervical Cancer

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligibility Period Less Than 3 Months
-Foster Care Children placed in state without TANF
-Individuals eligible for SSI
-Individuals on Medicaid recipient restriction program
-Katie Beckett Eligibles
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

MaineCare Primary Care Case Management

# MAINE
# MaineCare Primary Care Case Management

## ADDITIONAL INFORMATION

Included Services: Certain family planning services and family planning are different in the sense that all family planning services are exempt when provided in a family clinic. Certain family planning services generally refers to services in other setting such as a physicians office. Clinic services may include FQHCs and RHCs.

Special Needs Children (State defined) are children who have or are at increased risk for a chronic, physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

## QUALITY ACTIVITIES FOR PCCM

### Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-Asthma Dx For Pediatrics
-HIV/AIDS Survey
-Pregnancy Status
-SCHIP Survey
-Smoking Status
-State-developed Survey

### Performance Measures

### Process Quality:
-Ace Inhibitor/ARB Therapy
-Adolescent immunization rate
-Adolescent well-care visits rates
-Appropriate testing for children with Pharyngitis
-Appropriate treatment for children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamydia screening in women
-Cholesterol screening and management
-Colorectal Cancer Screening
-Dental services
-Diabetes management/care
-HIV/AIDS care
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care

### Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager

### Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiaries

-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of dental providers to beneficiaries
-Ratio of primary care case managers to beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of OB/GYN visits per adult female beneficiary
-Number of primary care case manager visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

### Provider Characteristics:
-Board Certification
-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
-Pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

### Performance Measures - Others:
None

## Performance Improvement Projects

### Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-HIV/AIDS Prevention and/or Management
-Lead toxicity
-Otitis Media management
-Prescription drug abuse
-Prevention of Influenza
-Smoking prevention and cessation
-Well Child Care/EPSDT

### Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

# MINNESOTA
# Minnesota Prepaid Medical Assistance Program-1932(a)

## CONTACT INFORMATION

**State Medicaid Contact:**

Brian Osberg
Minnesota Department of Human Services
(651) 431-2914

**State Website Address:**

http://www.dhs.state.mn.us

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 01, 1993

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Dental, Durable Medical Equipment, Emergency Room, EPSDT, Family Planning, Hearing, Home Health, Hospice, ICF/MR, Community-Based, IEP, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Preventive Visits, Respiratory Therapy, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
-Enrolled in another managed care program
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Foster Care Children

-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-Blind and disabled recipients under age 65
-Medicare Dual Eligibles
-Non-documented alien recipients who receive only emergency MA under Minn. Stat. 256B.06(4)
-Non-institutionalized recipients eligible on spend down basis
-Recipients residing in state institutions
-Recipients with private coverage through a MCO not participating in Medicaid
-Recipients with terminal or communicable diseases at time of enrollment
-Refugee Assistance Program recipients

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

No

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-None - managed care entity provides standard prescription drug coverage

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Surveys medical needs of enrollee to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Itasca Medical Care
Metropolitan Health Plan
South Country Health Alliance
Health Partners
Medica
PrimeWest Health System
UCARE

# MINNESOTA
## Minnesota Prepaid Medical Assistance Program-1932(a)

## ADDITIONAL INFORMATION

PCP provider types are designated by MCO, not the State. County staff perform enrollment function.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Assess program results
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track access and utilization

**Consumer Self-Report Data:**
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
  Child with Special Needs Questionnaire
-Disenrollment Survey

**Use of HEDIS:**
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

### Encounter Data

**Collection: Requirements:**
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Specifications for the submission of encounter data to the Medicaid agency

**Collections: Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

**Validation - Methods:**
-None

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-None

**State conducts general data completeness assessments:**
No

### Performance Measures

**Process Quality:**
-Adolescent well-care visit rate
-Adult Preventive Visits
-Antidepressant medication management

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Colorectal Cancer Screening
-Dental services
-Diabetes Screening
-Immunizations for two year olds
-Mental Health Discharges
-Osteoporosis Care After Fracture
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

### Use of Services/Utilization:
-Chemical Dependency Initiation or Treatment
-Mental Health Discharges
-Postpartum Visits
-Primary Care Visits 3 to 6-Year-Olds
-Well Care Visits, Adolescents
-Well Chile Visits - First 15 Months

### Health Plan Stability/ Financial/Cost of Care:
None

### Health Plan/ Provider Characteristics:
None

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

### Clinical Topics:
-Aspirin Therapy
-Asthma - Reduction of Emergency Department Visits
-Asthma management
-Breast cancer screening (Mammography)
-Calcium and Vitamin C
-Cervical cancer screening (Pap Test)
-Choleserol Screening and Management
-Colon Cancer Screening
-Depression management
-Diabetes management
-Diabetic Statin Use - 40 to 75 Year Olds
-Human Papillomavirus
-Hypertension management
-Lead toxicity
-Mental Health/Chemical Dependency Dual-Diagnoses
-Obesity
-Pneumococcal Vaccine
-Sexually transmitted disease screening

### Non-Clinical Topics:
-Adults access to preventive/ambulatory health services

## Standards/Accreditation

# MINNESOTA
## Minnesota Prepaid Medical Assistance Program-1932(a)

**MCO Standards:**
-NCQA (National Committee for Quality Assurance) Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
-NCQA (National Committee for Quality Assurance)

**EQRO Name:**
-MetaStar (QIO)
-Michigan Performance Review Organization

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
MCOs
Medicaid has collaborated with a public sector entity to support the P4P program

**Population Categories Included:**
A subset of MCO members, defined by disease and medical condition

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Clinical Conditions:**
Cardiac Care
Diabetes

**Measurement of Improved Performance:**
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
1999

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# NEBRASKA
# Nebraska Health Connection Combined Waiver Program - 1932(a)

## CONTACT INFORMATION

**State Medicaid Contact:**

Heather Leschinsky
Nebraska Medicaid
(402) 471-9337

**State Website Address:**

http://www.dhhs.state.ne.us

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Medicaid Enrollment Center

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
July 01, 1995

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-American Indian/Alaskan Native
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Clients Participating in the State Disability Program
-Clients Participating in the Subsidized Adoption Program
-Clients Receiving Medicaid Hospice Services
-Clients with Excess Income
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Presumptive Eligibility
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (State defined)
-Transplant Recipients

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

## Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## MCO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

**Included Services:**
Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-American Indian/Alaskan Native
-Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
-Clients Participating in the State Disability Program
-Clients Participating in the Subsidized Adoption Program
-Clients Receiving Medicaid Hospice Services
-Clients with Excess Income
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Presumptive Eligibility
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (State defined)
-Transplant Recipients

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

# NEBRASKA

## Nebraska Health Connection Combined Waiver Program - 1932(a)

**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:**

-Title V Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Primary Care Plus

Share Advantage

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Non-Duplication Based on Accreditation
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

**Use of Collected Data:**

-Data Mining
-Fraud and Abuse
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**

-CAHPS
Adult Medicaid AFDC Questionnaire

**Use of HEDIS:**

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

### Encounter Data

**Collection: Requirements:**

-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections: Submission Specifications:**

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing

**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

data between trading partners, such as hospitals, long term care facilities, etc.

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

**State conducts general data completeness assessments:**
No

## Performance Measures

**Process Quality:**
-Immunizations for two year olds
-Well-child care visit rates in first 15 months of life

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
None

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

**Clinical Topics:**
-Childhood Immunization
-Diabetes management
-Pre-natal care
-Well Child Care/EPSDT

**Non-Clinical Topics:**
None

## Standards/Accreditation

**MCO Standards:**
-NCQA (National Committee for Quality Assurance) Standards

**Accreditation Required for Participation:**
-Department of Insurance Certification
-NCQA (National Committee for Quality Assurance)

**Non-Duplication Based on Accreditation:**
-NCQA (National Committee for Quality Assurance)

**EQRO Name:**
-Island Peer Review Organization (IPRO)

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
None

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-On-Site Reviews
-Provider Data

**Use of Collected Data:**
-Data Mining
-Fraud and Abuse
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
-CAHPS
Adult Medicaid AFDC Questionnaire

# NEVADA
# Mandatory Health Maintenance Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Tom Sargent
Division of Health Care Financing and Policy
(775) 684-3698

**State Website Address:**

http://www.nv.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
October 31, 1998

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Ambulatory Surgery Center, Case Management, Certified Registered Nurse Practitioner, Chiropractic, Dental, Disposable Medical Supplies, Durable Medical Equipment, End Stage Renal Disease Facilities, EPSDT, Family Planning, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Intravenous Therapy, Laboratory, Medical Rehabilitation Center, Mental Health Rehabilitative, Noninvasive Diagnostic Centers, Nurse Anesthetist, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Physician Assistants, Podiatry, Prosthetics, Pyschologist, Respiratory Therapy, Rural Health Clinics, Skilled Nursing Facility, Special Clinics, Speech Therapy, Transitional Rehabilitative Center, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Obstetricians/Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

# NEVADA
## Mandatory Health Maintenance Program

### Enrollment

**Populations Voluntarily Enrolled:**
-American Indian
-Seriously Mentally Ill Adults
-Severely Emotionally Disturbed Children
-Special Needs Children (State defined)

**Populations Mandatorily Enrolled:**
-Child Health Assurance Program (CHAP)
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Residents in Nursing Facilities beyond 45 Days

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Community Care
Health Plan of Nevada

## ADDITIONAL INFORMATION

# NEVADA
## Mandatory Health Maintenance Program

Temporary Assistance for Needy Families/Child Health Assurance Program is included in the Mandatory 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.

Transportation is included but for emergency only.

Special Needs Children (State defined) is any child with a parent that deems them to have a special need.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-State's Quality Assessment and Performance Improvement Strategy and Work Plan

### Use of Collected Data:
-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:
-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, 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
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for

submission

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Check-ups after delivery
-Chlamdyia screening in women
-Dental services
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Screening for Human Immunodeficiency Virus
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

**Health Status/Outcomes Quality:**
-Blood Lead Screening
-Diabetes
-Improving Immunization Rates

**Access/Availability of Care:**
-Children's access to primary care practitioners

**Use of Services/Utilization:**
-Percentage of beneficiaries with at least one dental visit

**Health Plan Stability/ Financial/Cost of Care:**
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

**Health Plan/ Provider Characteristics:**
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

**Beneficiary Characteristics:**
-Information of beneficiary ethnicity/race
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

**Performance Measures - Others:**
None

-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

## Performance Improvement Projects

### Project Requirements:

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

### Clinical Topics:

-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Lead toxicity
-Well Child Care/EPSDT

### Non-Clinical Topics:

None

## Standards/Accreditation

### MCO Standards:

-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-NCQA (National Committee for Quality Assurance) Standards

### Accreditation Required for Participation:

-NCQA (National Committee for Quality Assurance)

### Non-Duplication Based on Accreditation:

None

### EQRO Name:

-Health Services Advisory Group

### EQRO Organization:

-Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

### EQRO Optional Activities:

-Administration or validation of consumer or provider surveys
-Assessment of MCO information systems
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-FFS HEDIS Rates
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of encounter data

## Pay for Performance (P4P)

### Implementation of P4P:

The State has implemented a Pay-for-Performance program with MCO

### Program Payers:

Medicaid is the only payer

### Population Categories Included:

A subset of MCO members, defined by beneficiary age
A subset of MCO members, defined by disease and medical condition

### Rewards Model:

Payment incentives/differentials to reward MCOs

### Clinical Conditions:

Annual Dental Visits
Childhood immunizations
Well-child visits

### Measurement of Improved Performance:

Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

# NEVADA
## Mandatory Health Maintenance Program

**Initial Year of Reward:**
2006

**Evaluation Component:**
The State has conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# NEW JERSEY
## NJ FamilyCare - 1932(a)

## CONTACT INFORMATION

**State Medicaid Contact:**

Karen Brodsky
Office of Managed Health Care
(609) 588-2705

**State Website Address:**

http://www.state.nj.us/humanservices/dmahs/index.html

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Affiliated Computer Services, Incorporated (ACS)

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
September 01, 1995

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Assistive Technology, Audiology, Chiropractor, Dental, Durable Medical Equipment, Emergency Medical Care, EPSDT, Family Planning, Hearing Aid, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medical Supplies, Optical Appliances, Optometrist, Organ Transplants, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Podiatrist, Post-acute care, Preventive Health Care and Counseling and Health Promotion, Prosthetics, Orthotics, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Certified Nurse Specialists
-Family Practitioners
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants

#### Enrollment

**Populations Voluntarily Enrolled:**
-Foster Care Children

**Populations Mandatorily Enrolled:**
-Aged and Related Populations

-Medicare Dual Eligibles

-Blind/Disabled Adults and Related Populations
-Non-dual DDD/CCW Adults
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-American Indian/Alaskan Native
-Enrolled in Another Managed Care Program
-Institutionalized in inpatient psychiatric facility
-Medically needy and presumptive eligibility beneficiaries
-Medicare Dual Eligibles
-Participate in HCBS Waiver except for CCW
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

QMB Plus

**Medicare Dual Eligibles Excluded:**

SLMB Plus
Medicaid-only
SLMB, QI, and QDWI
QMB

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Self-Referral
-Surveys medical needs of enrollee to identify members of these groups
-Use of Data Mining
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Developmental Disabilities Agency
-Division of Youth and Family Services Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of New Jersey, Inc.
AMERIGROUP New Jersey, Inc.
Healthfirst Health Plan of New Jersey, Inc.
Horizon NJ Health

# NEW JERSEY
## NJ FamilyCare - 1932(a)

## ADDITIONAL INFORMATION

Lock-in Period: 12 month lock-in is for AFDC/TANF and Title XXI population. There is no lock-in for SSI, Aged, Blind, Disabled, DDD or DYFS populations.

Populations Excluded: Those that participate in HCBS Waiver except DDD/CCW non-duals. Also, those enrolled in another Managed Care Program without Department of Human Services contract.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Accreditation for Participation
-Appointment Availability Studies
-Care Management
-Consumer Self-Report Data (see below for details)
-Data Analysis
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Geographic Mapping
-Independent Assessment
-MCO Marketing Material Approval Requirement
-Medical and Dental Provider Spot Checks
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Utilization Review

### Use of Collected Data:

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
  Child Medicaid AFDC Questionnaire
-Disenrollment Survey

### Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

### Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Per member per month analysis and comparisons across MCOs

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Reported Changes of Reasonable and Customary Fees

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Childhood Immunizations
-Comprehensive Diabetes Care
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Quality and utilization of dental services
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

**Health Status/Outcomes Quality:**
-Children with Special Needs Focused Study including DYFS Children
-EPSDT Quality Study/Dental and Lead

**Access/Availability of Care:**
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries
-Ratio of pharmacies to number of beneficiaries

**Use of Services/Utilization:**
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Percentage of children who received one or more visits with a PCP during the measurement year
-Percentage of enrollees who receive appropriate immunizations
-Percentage of enrollees who received a blood lead test
-Percentage of enrollees who received one or more dental services during the measurement year
-Percentage of enrollees with one or more emergency room visit
-Percentage of enrollees with one or more inpatient admissions
-Pharmacy services/per beneficiaries
-Physician visits/per 1,000 beneficiaries

**Health Plan Stability/ Financial/Cost of Care:**
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements

**Health Plan/ Provider Characteristics:**
None

-Total revenue

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs

### Performance Measures - Others:
-EPSDT Performance
-Lead Screening

## Performance Improvement Projects

### Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

### Clinical Topics:
-Adolescent Well Care/EPSDT
-Birth Outcomes
-Child/Adolescent Dental Screening and Services
-Lead Screenings
-Postnatal care
-Pre-natal care
-Well Child Care/EPSDT

### Non-Clinical Topics:
-Children's access to primary care practitioners
-Encounter Data Improvement
-Health information technology (e.g. state implementation of immunization and other registries, telemedicine initiatives, etc…)

## Standards/Accreditation

### MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

### Accreditation Required for Participation:
-Department of Banking and Insurance

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Michigan Peer Review Organization (MPRO)

### EQRO Organization:
-Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

### EQRO Optional Activities:
-Calculation of performance measures
-Conduct studies on access that focus on a particular aspect of clinical and non-clinical services
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Medical Record Review
-Technical Assistance to MCOs to assist them in conducting quality improvement activities

## Pay for Performance (P4P)

### Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

### Program Payers:
Not Applicable

### Population Categories Included:
Not Applicable

### Rewards Model:
Not Applicable

# NEW JERSEY
## NJ FamilyCare - 1932(a)

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# NORTH CAROLINA
## Carolina ACCESS

## CONTACT INFORMATION

**State Medicaid Contact:**

Betty West
Program Manager, CA/CCNC
(919) 855-4784

**State Website Address:**

http://www.ncdhhs.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 01, 1991

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Chiropractic, Dialysis, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Outpatient Hospital, Personal Care, Physician, Private Duty Nursing, X-Ray

**Allowable PCPs:**
-Community Health Centers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Health Clinics
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Public Health Departments
-Rural Health Centers (RHCs)

#### Enrollment

# NORTH CAROLINA
## Carolina ACCESS

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Special Needs Children (BBA defined)

**Populations Mandatorily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Qualified Aliens
-Section 1931 Adults and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Any Recipient Currently Under a Deductible
-Eligibility Period that is only Retroactive
-MAF-D Family Planning Waiver Program
-MAF-W Breast and Cervical Cancer Control Program
-Medicare Dual Eligibles
-Refugees
-Reside in Nursing Facility or ICF/MR
-SAA Special Assistance to the Aged

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
Medicaid-only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI
QMB Plus
SLMB Plus

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Community Care of North Carolina Networks
-Division of Mental Health
-Division of Rural Health and Community Care
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carolina Access

# NORTH CAROLINA
## Carolina ACCESS

## ADDITIONAL INFORMATION

The recipient must choose and enroll with or be assigned to a primary care provider who is paid a monthly case management fee of $1.00 for each enrollee in addition to regular fee for service payments. Hearing services do not include hearing aids for recipients age 21 years and above.

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

### Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners

**Use of Services/Utilization:**
None

**Provider Characteristics:**
None

**Beneficiary Characteristics:**
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to PCCM

**Performance Measures - Others:**
-Afterhours
-Enrollment
-Overrides

### Performance Improvement Projects

**Clinical Topics:**
None

**Non-Clinical Topics:**
None

# NORTH CAROLINA
# Community Care of North Carolina (ACCESS II/III)

## CONTACT INFORMATION

**State Medicaid Contact:**

Betty West
Program Manager, CA/CCNC
(919) 855-4784

**State Website Address:**

http://www.ncdhhs.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
July 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

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Chiropractic, Dialysis, Disease Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Private Duty Nursing, Speech Therapy, X-Ray

**Allowable PCPs:**
-Community Health Centers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Health Clinics
-Health Departments
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

#### Enrollment

# NORTH CAROLINA
## Community Care of North Carolina (ACCESS II/III)

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Special Needs Children (BBA defined)

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Qualified Aliens
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Any Recipient Currently Under a Deductible
-Eligibillity Period that is only Retroactive
-MAF-D Medicaid Family Planning Waiver Program
-MAF-W Breast and Cervical Cancer Control Program
-Medicare Dual Eligibles
-Refugees
-Reside in Nursing Facility or ICF/MR
-SAA Special Assistance to the Aged

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
Medicaid-only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI
QMB Plus
SLMB Plus

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Reviews complaints and grievances to identify members of these groups
-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 health assessment forms and claims data to identify members
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Community Care of North Carolina Networks
-Division of Mental Health
-Division of Rural Health and Community Care
-Maternal and Child Health Agency
-North Carolina Community Care Networks, Inc
-Public Health Agency
-Social Services Agency

# NORTH CAROLINA
## Community Care of North Carolina (ACCESS II/III)

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care of North Carolina (Access II/III)

## ADDITIONAL INFORMATION

An Administrative Entity is paid an additional PCCM case management fee of at least $3.72 per recipient participating in Access II/III to monitor care and implement disease management initiatives and target preventive studies. ACCESS II/III manages the highest risk Medicaid enrollees to improve coordination and continuity of care. Hearing services do not include hearing aids for recipients age 21 years and older.

## QUALITY ACTIVITIES FOR PCCM

### Quality Oversight Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Consumer/beneficiary Focus Groups

### Performance Measures

#### Process Quality:
-Adolescent well-care visits rates
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Cholesterol screening and management
-Controlling high blood pressure
-Depression medication management
-Diabetes management/care
-Hearing services for individuals less than 21 years of age
-Heart Failure care
-Influenza vaccination rate
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

#### Health Status/Outcomes Quality:
-Asthma Emergency Department Visit Rates
-Asthma Inpatient Rates
-Congestive Heart Failure
-Diabetes eye exams
-ED & Hospitalization Rates
-Patient satisfaction with care
-Preventable Hospital Readmissions

#### Access/Availability of Care:
-Adult access to preventive/ambulatory health services
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

#### Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary only Aged, Blind, Disabled population
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admission for MH/SUD conditions per 100 members/month for Aged, Blind, Disabled population

-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Inpatient Readmission
-Inpatient Stays
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries under 21 with at least one dental visit

### Provider Characteristics:
-Best Practices for Asthma and Diabetes
-Best Practices for Heart Failure/Cardiovascular disease
-Board Certification
-Languages spoken (other than English)

### Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of enrollees with chronic illnesses, asthma, diabetes, CHF and COPD

### Performance Measures - Others:
None

## Performance Improvement Projects

### Clinical Topics:
-Adolescent Well Care/EPSDT
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Cholesterol screening and management
-Colorectal Cancer Screening
-Coordination of primary and behavioral health care
-Depression management
-Developmental Screening
-Diabetes management
-Emergency Room service utilization
-Hospital Discharge Planning
-Hypertension management
-Pharmacy management
-Prevention of Influenza
-Smoking prevention and cessation
-Well Child Care/EPSDT

### Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners
-Health Information Technology
-Practice Readiness for Quality Improvement
-Reducing health care disparities

# NORTH DAKOTA
## North Dakota Medicaid Managed Care Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Tania Hellman
Department of Human Services Medical Services Division
(701) 328-2321

**State Website Address:**

http://www.nd.gov/dhs

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
January 01, 1994

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

**Guaranteed Eligibility:**
Continuous eligibility for children under age 19

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Ambulatory Surgical Centers, Chemical Dependency, Chiropractic, Dental, Durable Medical Equipment, Emergency Follow Up Care, EPSDT, Family Planning, Follow Up/Post Stabilization Care, Hearing, Home Health, Hospice, Immunization, Inpatient Admissions, Inpatient Hospital, Inpatient Mental Health, Institutional, Laboratory, Mid-level Practitioner, Nutritional, Observation/Hospital, Occupational Therapy, Oral Surgery, Outpatient Hospital, Outpatient Mental Health, Partial Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Private Duty Nursing, Prosthetic Devices, Radiology, Reconstructive Surgery, Rehabilitation Hospital, Skilled Nursing Facility, Speciality Care Physician, Speech Therapy, Transportation, Urgent Care/After Hours, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Rural Health Centers (RHCs)

#### Enrollment

# NORTH DAKOTA
## North Dakota Medicaid Managed Care Program

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-American Indian/Alaska Native
-Medically Needy
-Optional Categorically Needy
-Poverty Level
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Transitional Medicaid

**Subpopulations Excluded from Otherwise Included Populations:**
-Adoption Assistance
-Aged
-Blind
-Disabled
-Eligiblity Period that is only Retroactive
-Enrolled in Another Managed Care Program
-Enrolled in CDC BCCT Program
-Foster Care
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Refugee Assistance
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)

**Lock-In Provision:**
6 month lock-in

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Primary Care Case Management

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-Consumer Self-Report Data (see below for details)
-Focused Studies
-Provider Data

**Use of Collected Data:**
-Beneficiary Provider Selection
-Fraud and Abuse
-Health Services Research

-Program Evaluation
-Program Modification, Expansion, or Renewal

**Consumer Self-Report Data:**
-State-developed Survey

# OHIO
# State Plan Amendment for Ohio's full-risk managed care program

## CONTACT INFORMATION

**State Medicaid Contact:**

Dale Lehman
Ohio Department of Job and Family Services
(614) 752-4788

**State Website Address:**

http://jfs.ohio.gov/OHP/index.stm

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Automated Health Systems, Inc.

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
July 01, 2005

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Care Management, Certified Family Nurse Practitioner, Certified Pediatric Nurse Practitioner, Chiropractic, Dental, Developmental Therapy, Durable Medical Equipment, EPSDT, Family Planning, FQHC, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Podiatry, Prescription Drugs Administered In A Provider Setting, Private Duty Nurse, RHC, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Clinical Nurse Specialists
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Registered Nurse Anesthetists
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native
-Foster Care Children
-Special Needs Children (BBA defined)

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Enrolled in CDC BCCT Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Care management identification and assessment
-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
-Uses self referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-National Alliance on Mental Illness
-Ohio Academy of Family Physicians
-Ohio Association of County Behavioral Health Authorities
-Ohio Association of Health Plans
-Ohio Council of Behavioral Healthcare Providers
-Ohio County Departments of Job and Family Services
-Ohio Hospital Association
-Ohio Psychological Association
-Ohio State Medical Association
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agencies

# OHIO
## State Plan Amendment for Ohio's full-risk managed care program

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Ohio
CareSource
Paramount Advantage
WellCare of Ohio
Buckeye Community Health Plan
Molina Healthcare of Ohio
Unison Health Plan of Ohio

## ADDITIONAL INFORMATION

Regarding Program Service Area:
Services are provided in all eighty-eight Ohio counties which are divided into eight regions.

Regarding Included Services:
Effective February 1, 2010, pharmacy benefits (specified prescribed drugs and certain medical supplies) for MCO enrollees were removed from the risk-based managed care program and placed under the Medicaid fee-for-service delivery system. MCO enrollees access the carved-out pharmacy benefits through the Medicaid fee-for-service delivery system. Pharmaceuticals administered in certain provider settings continue to be provided by MCOs.

For CFC consumers, services provided in a skilled nursing facility are covered only when they are provided for a short-term rehabilitative stay. For ABD consumers, nursing facility services are covered for short-term stays up to 62 days.

Chiropractic and independent psychology services are covered when provided to members less than 21 years of age.

Mental health and substance abuse services are covered through the MCP only when a member is unable or unwilling to access such services through the Ohio Department of Mental Health (ODMH) community mental health centers and Ohio Department of Alcohol and Drug Abuse Services (ODADAS) certified Medicaid providers.

Transportation services include ambulance and ambulette services.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Care management
-Consumer complaints and grievances
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-Non-compliance penalties
-Non-Duplication Based on Accreditation
-Pay 4 performance (P4P) program
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Primary care provider data
-Provider complaints
-Provider Data
-State hearings

### Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Health Services Research
-Monitor Quality Improvement
-Performance Incentive System Determination
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-State Medicaid Managed Care Quality Strategy
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire
-State-developed Survey

### Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

## Encounter Data

### Collection: Requirements:

-Actuarial reviews
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Encounter Data Testing
-EQRO accuracy studies
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-ISCAT (EQRO), as needed
-Requirements for data validation
-Requirements for MCO data certification
-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:

-Certification Letters for Encounter Data Submissions
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Delivery Payment Submission Specifications
-Encounters to be submitted based upon national standardized forms (e.g., UB-92, NCPDP, NSF)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Payment data submission specifications
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92, electronic media claims 4.0

### Validation - Methods:

-Actuarial review
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-EQRO studies
-ISCAT (EQRO), as needed
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

### MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Type of Provider, Specialty Code

### State conducts general data completeness assessments:

Yes

## Performance Measures

### Process Quality:
-Adolescent well-care visit rates
-Antidepressant medication management
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Care management of high-risk members
-Care management of members
-Check-ups after delivery
-Cholesterol screening and management
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Heart Attack care
-Heart Failure care
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Spirometry testing in the assessment and diagnosis of COPD
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

### Health Status/Outcomes Quality:
-Emergency hospital discharge rates, inpatient hospital discharge rates, and inpatient hospital readmission rates, for chronic disease conditions
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Emergency department diversion
-Provider Panel Requirements for PCP Capacity and Provider Type, by Region and County

### Use of Services/Utilization:
-Adult preventive care visit rates
-Ancillary services/1,000 member months
-Behavioral health services/1,000 member months
-Care management of high-risk members
-Care management of members
-Child primary care visit rates
-Dental visits/1,000 member months
-Drug Utilization
-Durable medical equipment/supply services/1,000 member months
-Emergency department utilization rates for chronic disease conditions
-Emergency room visits/1,000 member months
-Follow up after hospitalization for mental illness
-Initiation and engagement of AOD treatment
-Inpatient discharges/1,000 member months
-Inpatient hospital discharge rates for chronic disease conditions
-Inpatient hospital readmission rates for chronic disease conditions
-Maternity/deliveries/1,000 member months
-Percentage of beneficiaries with at least one dental visit
-Perinatal care visit rates
-Pharmacy prescriptions/1,000 member months
-Primary care visits/1,000 member months
-Vision visits/1,000 member months
-Well child visit rates

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Administrative Expense Ratio
-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
-Overall Expense Ratio
-Prompt payment requirements
-State minimum reserve requirements
-Total revenue

### Health Plan/ Provider Characteristics:
-Provider Panel by specialty and service area and capacity

**Beneficiary Characteristics:**
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Members with special health care needs
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

**Clinical Topics:**
-Adolescent Well Care/EPSDT
-Child/Adolescent Dental Screening and Services
-Well Child Care/EPSDT

**Non-Clinical Topics:**
-Timely identification, assessment, and care management for members with special health care needs

## Standards/Accreditation

**MCO Standards:**
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards
-URAC Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
-NCQA (National Committee for Quality Assurance)
-URAC

**EQRO Name:**
-Health Services Advisory Group

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of encounter data

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by beneficiary age
A subset of MCO members, defined by disease and medical condition
Covers all MCO members

**Rewards Model:**
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs
The state takes back premiums at risk should an MCP fail to meet P4P standards.

# OHIO
## State Plan Amendment for Ohio's full-risk managed care program

### Clinical Conditions:
Adult preventive care visits
Asthma
Cardiac Care
Care management of high-risk members
Child preventive care visits
Dental care
Diabetes
Inpatient hospital discharge rate (chronic conditions composite)
Lead screening
Mental health
Perinatal Care
Well-child visits

### Measurement of Improved Performance:
Assessing achievement in access to care
Assessing improvement in care management of high risk members over time
Assessing improvement in clinical quality (by condition) overtime
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

### Initial Year of Reward:
2002

### Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

### Member Incentives:
Not Applicable

# SOUTH CAROLINA
# Health Maintenance Organization (HMO)

## CONTACT INFORMATION

**State Medicaid Contact:**

Roy Hess
Division of Care Management
(803) 898-4614

**State Website Address:**

http://www.scdhhs.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
August 01, 1996

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Alcohol and Drug Screening, Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Interactive Psychiatric Interview Exam with other Mechanisms of Communication, Laboratory, Outpatient Hospital, Pharmacy, Physical Exam through the SC Department of Alcohol and other Drug Abuse, Physician, Psychiatric Diagnostic Interview Exam, Skilled Nursing Facility, Transportation, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Rural Health Centers (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-Age 65 Or Older
-Enrolled In An HMO Through Third Party Coverage
-Hospice Recipients
-Medically Fragile Children Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Developmental Disabilities Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Absolute Total Care
First Choice by Select Health of South Carolina, Inc.
BlueChoice Health Plan
Unison Health Plan of SC

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
None

### Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State generates from encounter data ALL of the HEDIS measures listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-NSF (National Standard Format)
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Date of Admission Invalid
-Date of Discharge Invalid
-Dollar amount billed not greater than zero

### State conducts general data completeness assessments:
Yes

-Drug Quantity Units not greater than zero
-Invalid Drug Unit Type
-Prescribing Provider Number Not on File
-Submitting Provider Not on File

## Performance Measures

### Process Quality:
-Ace Inhibitor/ARB Therapy
-Adolescent immunization rate
-Adolescent well-care visit rate
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Heart Attack care
-Heart Failure care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

### Access/Availability of Care:
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Re-admission rates of MH/SUD

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-State minimum reserve requirements

### Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

### Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

### Performance Measures - Others:
None

## Performance Improvement Projects

# SOUTH CAROLINA
## Health Maintenance Organization (HMO)

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

### Clinical Topics:
-(Newborn) Failure to thrive
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Coronary artery disease prevention
-Depression management
-Diabetes management
-Emergency Room service utilization
-Hypertension management
-Inpatient maternity care and discharge planning
-Lead toxicity
-Low birth-weight baby
-Otitis Media management
-Pharmacy management
-Post-natal Care
-Pregnancy Prevention
-Pre-natal care
-Prescription drug abuse
-Sickle cell anemia management
-Smoking prevention and cessation
-Well Child Care/EPSDT

### Non-Clinical Topics:
None

## Standards/Accreditation

### MCO Standards:
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards
-URAC Standards

### Accreditation Required for Participation:
-AAAHC (Accreditation Association for Ambulatory Health Care)
-NCQA (National Committee for Quality Assurance)
-URAC

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Carolinas Center for Medical Excellence

### EQRO Organization:
-Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

### EQRO Optional Activities:
-Assessment of MCO information systems
-Calculation of performance measures
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

# SOUTH CAROLINA
## Health Maintenance Organization (HMO)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Population Categories Included:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Member Incentives:**
Not Applicable

**Program Payers:**
Not Applicable

**Rewards Model:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Evaluation Component:**
Not Applicable

# SOUTH CAROLINA
## Medical Homes Network

## CONTACT INFORMATION

**State Medicaid Contact:**

Roy Hess
Division of Care Management
(803) 898-4614

**State Website Address:**

http://www.scdhhs.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
October 01, 2006

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

**Populations Mandatorily Enrolled:**
None

-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**

None

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

No

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Developmental Disabilities Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

South Carolina Solutions

## ADDITIONAL INFORMATION

Children with special health care needs are those who have a chronic physical, developmental, behavioral, or emotional condition and who also require heatlh and related services of a type or amount beyond that required by children generally.

# SOUTH CAROLINA
## Medical Homes Network

## QUALITY ACTIVITIES FOR PCCM

### Quality Oversight Activities:
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
None

## Performance Measures

### Process Quality:
-Ace Inhibitor/ARB Therapy
-Adolescent immunization rate
-Adolescent well-care visits rates
-Appropriate testing for children with Pharyngitis
-Appropriate treatment for children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Depression medication management
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

### Access/Availability of Care:
-Average distance for PCP
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-Ratio of primary care case managers to beneficiaries

### Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

### Provider Characteristics:
-Board Certification
-Languages spoken (other than English)
-Provider turnover

### Beneficiary Characteristics:
-Information on primary languages spoken by beneficiaries
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

### Performance Measures - Others:
None

# SOUTH CAROLINA
## Medical Homes Network

### Performance Improvement Projects

**Clinical Topics:**
-Asthma management
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-Low birth-weight baby
-Pharmacy management
-Pre-natal care

**Non-Clinical Topics:**
None

# SOUTH DAKOTA
## PRIME

## CONTACT INFORMATION

**State Medicaid Contact:**

Tracy Shields
Office of Medical Services
(605) 773-3495

**State Website Address:**

http://dss.sd.gov/sdmedx/

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
September 01, 1993

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Laboratory, Opthalmology, Outpatient Hospital, Outpatient Mental Health, Physician, Residential Treatment Centers, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Centers (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**

-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (BBA defined)

**Lock-In Provision:**

1 month lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Provider contacts - Medically fragile protocol
-Uses eligibility data to identify members of these 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
-Social Services Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

PRIME

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**

-Consumer Self-Report Data (see below for details)

**Use of Collected Data:**

-Beneficiary Provider Selection

-Focused Studies
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling

### Consumer Self-Report Data:
-Disenrollment Survey
-State-developed Survey

## Performance Measures

### Process Quality:
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### 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
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

### Use of Services/Utilization:
-Emergency room visits/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary

### Provider Characteristics:
None

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

## Performance Improvement Projects

### Clinical Topics:
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Diabetes management
-Pre-natal care

### Non-Clinical Topics:
None

# TEXAS
## Non-Emergency Transportation

## CONTACT INFORMATION

**State Medicaid Contact:**

Sheryl Woolsey
Texas Health and Human Services Commission
(512) 706-4901

**State Website Address:**

http://www.hhsc.state.tx.us/QuickAnswers/index.shtml

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
June 01, 2006

**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

### NEMT - Fee-for-Service

#### Service Delivery

**Included Services:**
Non-Emergency Transportation

**Allowable PCPs:**
-Not Applicable

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Special Needs Children (BBA defined)

**Populations Mandatorily Enrolled:**
-Foster Care Children
-Medicaid Qualified Medicare Beneficiary
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-SSI Medicaid

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

-Title CHIP XXI

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles except Medicaid QMB

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Not Applicable

## ADDITIONAL INFORMATION

NEMT services are provided in accordance with the federal regulations 42 CFR §§ 431.53, 440.170. NEMT services are arranged through competitively procured contracts with public and private transportation providers. NEMT also provides mileage reimbursement to persons enrolled as Individual Transportation Provider (ITPs). Eligible beneficiaries through age 20, may receive advance funds for meals and lodging when an overnight stay is medically necessary. The beneficiary's parent or guardian may also qualify for meals and lodging. The beneficiary or the beneficiary's parent or guardian may also receive funds in advance for mileage, when necessary.

# TEXAS
# PCCM

## CONTACT INFORMATION

**State Medicaid Contact:**

Joseph Morganti
Texas Health and Human Services Commission
(512) 491-1425

**State Website Address:**

http://www.hhsc.state.tx.us/medicaid/care_case_pro

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
September 01, 2005

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Blind/Disabled Children and Related Populations

**Populations Mandatorily Enrolled:**
-Aged and Related Populations

-Blind/Disabled Adults and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Lock-In Provision:**

Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

PCCM

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**

-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines

**Use of Collected Data:**

-Beneficiary Provider Selection
-Contract Standard Compliance

-Focused Studies
-Network Data
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Fraud and Abuse
-Monitor Quality Improvement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Child Medicaid AFDC Questionnaire

## Performance Measures

### Process Quality:

-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Controlling high blood pressure
-Dental services
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:

-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners

### Use of Services/Utilization:

-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of OB/GYN visits per adult female beneficiary

### 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
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

### Performance Measures - Others:

None

## Performance Improvement Projects

### Clinical Topics:

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization

### Non-Clinical Topics:

-Children's access to primary care practitioners

-Hypertension management
-Newborn screening for heritable diseases
-Pre-natal care
-Well Child Care/EPSDT

# WASHINGTON
# Chronic Care Management Program (CCMP)

## CONTACT INFORMATION

**State Medicaid Contact:**

Munkberg Shirley
Health and Recovery Services Administration
(360) 725-1648

**State Website Address:**

http://www.dshs.wa.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
January 01, 2007

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### Disease Management PAHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Disease Management

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-TANF

**Lock-In Provision:**
No lock-in

# WASHINGTON
## Chronic Care Management Program (CCMP)

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Developmental Disabilities Agency
-Housing Agencies
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

City of Seattle Human Services

## ADDITIONAL INFORMATION

Chronic Care Management program provides disease management services to clients who are categorically needy, aged, blind and disabled and who receive Medicaid and other services through fee-for-service system. The program provides intensive educational services, coordination with other needed services and assistance in accessing care.

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Monitoring of PAHP Standards
-On-Site Reviews
-Performance Measures (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance
-Data Mining
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

# WASHINGTON
## Chronic Care Management Program (CCMP)

**Consumer Self-Report Data:**
-CAHPS
Adult Medicaid SSI Questionnaire
-State-developed Survey

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries satisfied with their ability to obtain care

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
-Drug Utilization
-Emergency room visits/1,000 beneficiary

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
-PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to PAHPs

**Performance Measures - Others:**
None

## Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# WASHINGTON
## Healthy Options

## CONTACT INFORMATION

**State Medicaid Contact:**

Shirley Munkberg
Division of Healthcare Services, DSHS-HRSA
(360) 725-1648

**State Website Address:**

http://www.dshs.wa.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
12 months guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
July 01, 2002

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Vision, X-Ray

**Allowable PCPs:**
-Indian Health Service (IHS) Providers

#### Enrollment

**Populations Voluntarily Enrolled:**
-AI/AN Poverty Level Pregnant Women
-AI/AN Section 1931 (TANF Related) Adults
-AI/AN Section 1931 (TANF Related) Children
-AI/AN Title XXI CHIP
-American Indian/Alaska Native (AI/AN)

**Populations Mandatorily Enrolled:**
-AI/AN Children Below 200 Percent of FPL

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

## Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

# WASHINGTON
# Healthy Options

## MCO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

**Included Services:**
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

### Enrollment

**Populations Voluntarily Enrolled:**
-Special Needs Children (State defined)

**Populations Mandatorily Enrolled:**
-Optional Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Aged, Blind and Disabled SSI Related Programs
-Enrolled in Another Managed Care Program
-Foster Care/Adoption Support Children Programs
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

# WASHINGTON
## Healthy Options

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Obtains an electronic listing from Department of Health, a separate agency
-Uses enrollment forms to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Asuris Northwest Health
Columbia United Providers
Community Health Plan
Group Health Cooperative
Kaiser Foundation Health Plan
Molina Healthcare
PCCM Tribal Clinics
Regence Blue Shield

## ADDITIONAL INFORMATION

Children with Special Health Care Needs are defined as children identified by DSHS to the contractor as children served under provisions of Title V of the Social Security Act.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**

-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**

-Conduct Performance Improvement Projects
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

**Consumer Self-Report Data:**

-State-developed Survey

**Use of HEDIS:**

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

### Encounter Data

**Collection: Requirements:**

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections: Submission Specifications:**

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Use of Medicaid Identification Number for beneficiaries

-Use of Medicaid Provider Identification Numbers for providers

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent well-care visit rate
-Childhood Immunization
-Diabetes medication management
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-HbA1c Control

### Access/Availability of Care:
-Prenatal/postpartum measures

### Use of Services/Utilization:
-Ambulatory Care Utilization
-Inpatient Acute Care Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient Non-acute care Utilization
-Re-admission rates of MH/SUD

### Health Plan Stability/ Financial/Cost of Care:
None

### Health Plan/ Provider Characteristics:
None

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

### Clinical Topics:
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Childhood Immunization
-Depression management
-Diabetes management
-Emergency Room service utilization
-Obesity management

-Well Child Care/EPSDT
-Well-infant Care/EPSDT

**Non-Clinical Topics:**

-Access to care
-Customer Service
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

## Standards/Accreditation

**MCO Standards:**
-BBA Protocols Supplemented with NCQA Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Acumentra (formerly known as OMPRO)
-Qualis Health

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Validation of performance measures

**EQRO Optional Activities:**
-Conduct performance improvement projects

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by beneficiary age

**Rewards Model:**
Withholds as an incentive

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
2004

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-Enrollee Hotlines
-Performance Measures (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance
-Track Health Service provision

**Consumer Self-Report Data:**
None

## Performance Measures

# WASHINGTON
## Healthy Options

**Process Quality:**
None

**Health Status/Outcomes Quality:**
-Percentage of low birth weight infants

**Access/Availability of Care:**
-Average distance to primary care case manager
-Ratio of primary care case managers to beneficiaries

**Use of Services/Utilization:**
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary

**Provider Characteristics:**
-Languages spoken (other than English)

**Beneficiary Characteristics:**
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM

**Performance Measures - Others:**
None

# WASHINGTON
# Washington Medicaid Integration Partnership (WMIP)

## CONTACT INFORMATION

**State Medicaid Contact:**

Shirley Munkberg
Health and Recovery Services Administration
(360) 725-1648

**State Website Address:**

http://www.dshs.wa.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
January 01, 2005

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Disease Management, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Longterm Care, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

# WASHINGTON
## Washington Medicaid Integration Partnership (WMIP)

**Subpopulations Excluded from Otherwise Included Populations:**

-Medicare Dual Eligibles
-Poverty Level Pregnant Woman
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-TANF

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Benzodiazepines
-Nonprescription drugs

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Developmental Disabilities Agency
-Housing Agencies
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Molina Healthcare (WMIP)

## ADDITIONAL INFORMATION

The state contracts with Molina Healthcare of Washington to provide an integrated managed care program that covers a full scope of medical services, long-term care, inpatient, and outpatient mental health and chemical dependency services. The program includes an intensive care management component to assist enrollees with multiple health needs to access needed services.

## QUALITY ACTIVITIES FOR MCO/HIO

# WASHINGTON
## Washington Medicaid Integration Partnership (WMIP)

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Medical Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-CAHPS
Adult Medicaid AFDC Questionnaire with Suplemental Questions

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Required use of Medicaid Provider Identification numbers for service providers
-Use of Provider Identification Numbers for providers

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
None

### Health Status/Outcomes Quality:
None

# WASHINGTON
## Washington Medicaid Integration Partnership (WMIP)

**Access/Availability of Care:**
-Access and Maintenance for Longterm Care
-Access and Maintenance for Mental Health
-Screening, Access and Treatement for Chemical Dependency

**Use of Services/Utilization:**
-Average number of visits to MH/SUD providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

**Clinical Topics:**
-Improvement of compliance with chemical dependency assessment and follow-up
-Increasing depression assessments
-Increasing Influenza vaccine participation

**Non-Clinical Topics:**
-Improve satisfaction with customer service.
-Improve the rate of completion of Documented Care Plans.
-Increasing successful initial contacts between WMIP members and Care Coordination Team
-Referrals for chemical dependency treatment

## Standards/Accreditation

**MCO Standards:**
None

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Acumentra formerly known as OMPRO

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Validation of performance measures

**EQRO Optional Activities:**
-Validation of encounter data

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

# WASHINGTON
## Washington Medicaid Integration Partnership (WMIP)

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# WISCONSIN
## BadgerCare Plus

## CONTACT INFORMATION

**State Medicaid Contact:**

Jason Helgerson
Division of Health Care Access and Accountability
(608) 266-8922

**State Website Address:**

http://dhs.wisconsin.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Automated Health Systems

**For All Areas Phased-In:**
No

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
February 01, 2008

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
Not Applicable

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
Not Applicable

**Guaranteed Eligibility:**
12 months guaranteed eligibility for children

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Obstetricians/Gynecologists
-Pediatricians
-Rural Health Centers (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

# WISCONSIN
## BadgerCare Plus

**Subpopulations Excluded from Otherwise Included Populations:**

-American Indian/Alaskan Native
-Enrolled in Another Managed Care Program
-Foster Care Children
-Medicare Dual Eligibles
-Migrant workers
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Residents residing in FFS counties
-Special Needs Children (BBA defined)

**Lock-In Provision:**

9 month lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Outreach and Access
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses enrollment forms to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Maternal and Child Health Agency (County departments)
-Mental Health Agency (County departments)
-Public Health Agency (County departments)
-Social Services Agency (County departments)
-Substance Abuse Agency (County departments)

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Abri Health Plan -- Medicaid HMO
Children's Community Health Plan - Medicaid HMO
Compcare -- Medicaid HMO
Dean Health Plan -- Medicaid HMO
Group Health Cooperative Of Eau Claire -- Medicaid HMO
Group Health Cooperative Of South Central WI -- Medicaid HMO
Gundersen Lutheran Health Plan - Medicaid HMO
Health Tradition Health Plan -- Medicaid HMO
Independent Care (iCare) - Medicaid HMO
Managed Health Services -- Medicaid HMO
MercyCare Insurance Company -- Medicaid HMO
Network Health Plan -- Medicaid HMO
Physicians Plus Health Plan - Medicaid HMO
Security Health Plan -- Medicaid HMO
UnitedHealthcare of WI -- Medicaid HMO
Unity Health Insurance -- Medicaid HMO

# WISCONSIN
## BadgerCare Plus

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Satisfaction Survey
-External Quality Review
-MCO Standards (see below for details)
-MHO Report Care
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Non-Duplication of mandatory EQR Activities Base on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Quality Improvement Goal Setting

### Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

### Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

## Encounter Data

### Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Admission source
-Admission type
-Days supply
-Modifier codes
-Patient status code
-Place of service codes
-Quantity

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Breast Cancer screening rate
-Cervical cancer screening rate
-Children with at least one comprehensive EPSDT well child visit in the look-back period at age 3-5 years, 6-14 years, and 15-20 years
-Children with at least one non-EPSDT well-child visit in the look-back period at ages birth-1 year, 1-2 years, 3-5 years, 6-14years and 15-20 years
-Comprehensive EPSDT well-child visits for children age birth to two years for those receiving 5, 6 and 7 or more visits
-Dental services
-Diabetes management
-Follow-up after hospitalization for mental illness
-Hearing services for individuals of all ages
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals of all ages

**Health Status/Outcomes Quality:**
-Breast malignancies detected
-Cervix/uterus malignancies detected
-HPV infections detected
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Children's access to primary care practitioners
-Provider network data on geographic distribution
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

**Use of Services/Utilization:**
-Drug Utilization
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percent of beneficiaries with at least one PCP visit
-Percent of beneficiaries with at least one specialist visit
-Percentage of beneficiaries with at least one dental visit

**Health Plan Stability/ Financial/Cost of Care:**
-OCI certification
-Review of medical loss ratios

**Health Plan/ Provider Characteristics:**
-Board Certification
-Languages Spoken (other than English)

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
-Accreditation
-Enrollee Satisfaction Survey

# WISCONSIN
# BadgerCare Plus

## Performance Improvement Projects

### Project Requirements:

-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

### Clinical Topics:

-Adolescent Immunization
-Antibiotic Resistance
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management
-Improving Birth Outcome Project
-Increase Utilization of Preventative Dental Care
-Lead toxicity
-Post-natal Care
-Smoking prevention and cessation
-Well Child Care/EPSDT

### Non-Clinical Topics:

-Health living individual incentive program

## Standards/Accreditation

### MCO Standards:

-State-Developed/Specified Standards

### Accreditation Required for Participation:

None

### Non-Duplication Based on Accreditation:

-AAAHC (Accreditation Association for Ambulatory Health Care)
-NCQA (National Committee for Quality Assurance)
-URAC

### EQRO Name:

-MetaStar, Inc.

### EQRO Organization:

-Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of Tobacco Registries

### EQRO Optional Activities:

-Assessment of MCO information systems
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

### Implementation of P4P:

The State has implemented a Pay-for-Performance program with MCO

### Program Payers:

Medicaid is the only payer

### Population Categories Included:

A subset of MCO members, defined by disease and medical condition
Covers all MCO members

### Rewards Model:

Payment incentives/differentials to reward MCOs

### Clinical Conditions:

Asthma
Blood Lead Testing
Childhood immunizations
Dental
Diabetes

### Measurement of Improved Performance:

Delivery of EPSDT Services
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

# WISCONSIN
## BadgerCare Plus

Perinatal Care
Tobacco Cessation
Well-child visits

**Initial Year of Reward:**
1996

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

**Member Incentives:**
Not Applicable

# WISCONSIN
# Medicaid SSI Managed Care Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Jason Helgerson
Division of Health Care Access and Accountability
(608) 266-8922

**State Website Address:**

http://dhs.wisconsin.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a) - State Plan Option to Use Managed Care

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Automated Health Systems

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 01, 2005

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Coordination With Non-Medicaid Services (Social & Vocational ), Recreational & Wellness Prog, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pediatricians, Personal Care, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Centers (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-American Indians
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

# WISCONSIN
## Medicaid SSI Managed Care Program

**Subpopulations Excluded from Otherwise Included Populations:**

-Beneficiaries Who After Enrollment Are Placed In A Nursing Home For Longer Than 90 Days
-Children Under Age 19
-Enrolled in Another Managed Care Program
-In Family Care
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

No

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Asks advocacy groups to identify members of these groups
-Comprehensive Assessment Required At Time of Enrollment
-Only SSI-Disabled Adult Recipients May Enroll
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
-Local Public Health Agency
-Mental Health Agency
-Substance Abuse Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Abri Health Plan -- SSI
Independent Care Health Plan -- SSI
Network Health Plan - SSI
Group Health Cooperative of Eau Claire County SSI
Managed Health Services -- SSI
UnitedHealthcare of WI -- SSI

## ADDITIONAL INFORMATION

SSI Managed Care Program is for SSI and SSI-related Medicaid recipients, age 19 or older not living in an institution and not

participating in a home and community based waiver. Dually eligible persons and Medicaid Purchase Plan recipients may enroll on a voluntary basis. Targeted Case Management, Community Support Program Services, and Crisis Intervention Services are covered under fee-for-service for enrollees in this program.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:

-CAHPS
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey

### Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data ALL of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

## Encounter Data

### Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, 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
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

### MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Payment
-Provider ID

### State conducts general data completeness assessments:

Yes

-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Admission Source
-Admission Type
-Days Supply
-Modifier Codes
-Patient Status Code
-Place of Service Codes
-Quantity

## Performance Measures

### Process Quality:
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Diabetes management/care
-Follow-up after hospitalization for mental illness and substance abuse at 7 and 30 days
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit

### Health Status/Outcomes Quality:
-Patient satisfaction with care

### Access/Availability of Care:
-Monitoring Disenrollments
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Asthma prevalence, ED care and inpatient care
-Inpatient general and speciality care: surgery, medical, psychiatry, substance abuse
-Mental health/substance abuse evaluations and day and outpatient care
-Outpatient general and specialty care: ED without admit, primary care visits, vision care, audiology, general dental
-Percentage of beneficiaries with at least one dental visit

### Health Plan Stability/ Financial/Cost of Care:
-OCI certification
-Review of medical loss ratios

### Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)

### Beneficiary Characteristics:
-Beneficiary need for interpreter
-MCO/PCP-specific disenrollment rate

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

### Clinical Topics:
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Flu Vaccine Rate
-Lipid Screening

### Non-Clinical Topics:
-Access to and availability of services
-Cultural competency of the HMO and its providers
-Enrollee satisfaction with the HMO customer service
-Grievances, appeals and complaints
-Satisfaction with services for enrollees with special health

care needs

## Standards/Accreditation

**MCO Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-MetaStar

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# CALIFORNIA
## AIDS Healthcare Foundation

## CONTACT INFORMATION

**State Medicaid Contact:**

Tanya Homman
Medi-Cal Managed Care Division
(916) 449-5000

**State Website Address:**

http://www.dhcs.ca.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a) - Voluntary

**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:**
April 01, 1995

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Hospice, Immunization, Laboratory, Long Term Care, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Personal Care, Pharmacy, Physical Therapy, Physician, Skilled Nursing Facility, Specialty Mental Health, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligibility Period Less Than 3 Months
-Medicare Dual Eligibles
-Member approved for a Major Organ Transplant
-Poverty Level Pregnant Woman

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Plan is responsible to identify this group

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Positive Healthcare/AHF Healthcare Centers

## ADDITIONAL INFORMATION

PCPs contract to provide and assume risk for primary care, specialty physician services, and selected outpatient preventive and treatment services. The Program is designed for people living with AIDS. All categories of federally eligible Medi-Cal are eligible to participate.

## QUALITY ACTIVITIES FOR MCO/HIO

# CALIFORNIA
## AIDS Healthcare Foundation

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-Plan-developed Survey

### Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Colorectal Cancer Screening

### Health Status/Outcomes Quality:
None

# CALIFORNIA
## AIDS Healthcare Foundation

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services

**Use of Services/Utilization:**
None

**Health Plan Stability/ Financial/Cost of Care:**
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-MCOs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
-Advance Care Directives, pending
-CD4 and Viral Load Testing, pending

**Non-Clinical Topics:**
None

## Standards/Accreditation

**MCO Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Health Services Advisory Group

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

# CALIFORNIA
## AIDS Healthcare Foundation

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# CALIFORNIA
## Family Mosaic

## CONTACT INFORMATION

**State Medicaid Contact:**

Tanya Homman
Medi-Cal Managed Care Division
(916) 449-5000

**State Website Address:**

http://www.dhcs.ca.gov

## PROGRAM DATA

**Program Service Area:**
City
County

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
January 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

### Emotional and Mental Health Support PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Crisis, Emotional Support, Inpatient Mental Health, Mental Health Rehabilitation, Mental Health Support, Outpatient Mental Health, Pharmacy

**Allowable PCPs:**
-N/A

**Contractor Types:**
None

#### Enrollment

**Populations Voluntarily Enrolled:**
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Children and Related Populations

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

-Populations residing outside plans service area defined by contract
-Reside in Nursing Facility or ICF/MR

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Plan is responsible to identify this group

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

San Francisco City & CO/Family Mosaic

## ADDITIONAL INFORMATION

San Francisco City and County/Family Mosaic only provides emotional and mental support to severely emotionally disturbed children.

## QUALITY ACTIVITIES FOR PIHP

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Ombudsman
-Performance Measures (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance

**Consumer Self-Report Data:**
-Plan-developed survey

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

### Performance Measures

# CALIFORNIA
## Family Mosaic

**Process Quality:**
None

**Health Status/Outcomes Quality:**
-Percentage of out-of-home placements

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
-Out of home placements
-Percentage of inpatient hospitalizations

**Health Plan Stability/ Financial/Cost of Care:**
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Standards/Accreditation

**PIHP Standards:**
None

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Health Services Advisory Group

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Does not collect Mandatory EQRO Activities at this time

**EQRO Optional Activities**
-Calculation of performance measures
-Technical assistance to PIHPs to assist them in conducting quality activities

# CALIFORNIA
## Prepaid Health Plan Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Tanya Homman
Medi-Cal Managed Care Division
(916) 449-5000

**State Website Address:**

http://www.dhcs.ca.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
1915(b)(4)

**Enrollment Broker:**
Health Care Options/Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
January 01, 1972

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Transportation, Tuberculosis, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Physician Assistants
-Psychiatrists

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations

**Populations Mandatorily Enrolled:**
None

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR (after 30 days)

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

## Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

## Dental PAHP - Risk-based Capitation

### Service Delivery

**Included Services:**
Dental

**Allowable PCPs:**
-Dentists

### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Populations residing outside plans service area defined by contract
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
SLMB, QI, and QDWI
QMB

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-DOES NOT coordinate with any other Agency

# CALIFORNIA
## Prepaid Health Plan Program

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan-LA

American Health Guard-Dental Plan-LA

Care 1st Health Plan-Dental-LA

Community Dental Services-LA

Health Net of CA-Dental-LA

KP Cal, LLC

Liberty Dental Plan of CA-LA

Safeguard Dental-LA

Western Dental Services-LA

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:

-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-MCO-developed Survey

### Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

### Encounter Data

### Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved

### Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
None

**Health Plan Stability/ Financial/Cost of Care:**
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-MCOs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
-Cervical cancer screening (Pap Test)
-Smoking prevention and cessation

**Non-Clinical Topics:**
None

## Standards/Accreditation

**MCO Standards:**
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Health Services Advisory Group

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Technical assistance to MCOs to assist them in conducting quality activities

### Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Encounter Data (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Track Health Service provision

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

### Encounter Data

**Collection: Requirements:**
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections - Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing

**Collection: Standardized Forms:**
None

**Validation - Methods:**
-Verify provider data with Provider Master File

**PAHP conducts data accuracy check(s) on specified data elements:**
None
-Provider ID

**State conducts general data completeness assessments:**
No

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
-Number of procedures provided and monthly and yearly unduplicated users

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Standards/Accreditation

**PAHP Standards:**
None

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# CALIFORNIA
## Senior Care Action Network

## CONTACT INFORMATION

**State Medicaid Contact:**

Della Cabrera
Long Term Care Division
(916) 440-7538

**State Website Address:**

http://www.dhcs.ca.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a) - Voluntary

**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, 2008

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Adult Day Health Care, Case Management, Chiropractic, Dental, Durable Medical Equipment, Emergency Care, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Clinical Social Workers
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Addiction Professionals (i.e. Substance Use Disorder counselors, alcohol and drug counselors,
-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants
-Podiatrists
-Psychiatrists
-Psychologists

#### Enrollment

# CALIFORNIA
## Senior Care Action Network

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Poverty Level Pregnant Woman
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Senior Care Action Network (SCAN)

## ADDITIONAL INFORMATION

SCAN Health Plan was formerly a Social HMO operating under an 1115(a)-Demonstration waiver program authority which expired December 31, 2007. Effective January 1, 2008, SCAN Health Plan is now a Medicare Advantage Special Needs Plan that contracts with the Department of Health Care Services to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los Angeles, San Bernardino, and Riverside counties. SCAN is a managed care organization operating under Section 1915(a) of the Social

Security Act. SCAN provides all services in the Medi-Cal State Plan; inlcuding home and community based services to SCAN members who are assessed at the Nursing Facility Level of Care and nursing home custodial care, following the member in the nursing facility. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCANs approved service areas of Los Angeles, Riverside, and San Bernardino counties. SCAN does not enroll individuals with End Stage Renal Disease.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-MCO-developed Surveys

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID

### State conducts general data completeness assessments:
Yes

-Medicaid Eligibility
-Procedure Codes

## Performance Measures

**Process Quality:**
-Beta-blocker treatment after heart attack
-Glaucoma screening in older adults

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
None

**Health Plan Stability/ Financial/Cost of Care:**
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-MCOs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
-Chronic Obstructive Pulmonary Disease
-Stroke and Transient Ischemic Attack prevention

**Non-Clinical Topics:**
None

## Standards/Accreditation

**MCO Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Health Services Advisory Group

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Calculation of performance measures
-Technical assistance to MCOs to assist them in conducting quality activities

# CALIFORNIA
## Senior Care Action Network

### Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# COLORADO
## Managed Care Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Valerie Baker-Easley
Department. of Health Care Policy and Financing
(303) 866-3684

**State Website Address:**

http://www.colorado.gov/hcpf

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
MAXIMUS, INC.

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
May 01, 1983

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Speech Therapy, Telemedicine, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Gerontologists
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

**Populations Mandatorily Enrolled:**
None

-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-American Indian/Alaskan Native
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

SLMB, QI, and QDWI
QMB

## Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

# COLORADO
## Managed Care Program

### Medical-only PIHP (risk or non-risk, non-comprehensive) - Non-risk Capitation

#### Service Delivery

**Included Services:**
Case Management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Telemedicine, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Gerontologist
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-American Indian/Alaskan Native
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
SLMB, QI, and QDWI
QMB

#### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

# COLORADO
## Managed Care Program

**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 groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Developmental Disabilities Agency
-Mental Health Agency
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Colorado Access
Rocky Mountain Health Plan Authority
Denver Health and Hospital Authority

## ADDITIONAL INFORMATION

MCO options and PIHP options are available and varies by county. A payment to the State agency makes to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular recipient receives services during the period covered by the payment.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**

-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**

-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**

-CAHPS
Adult Medicaid SSI Questionnaire
Child Medicaid SSI Questionnaire

**Use of HEDIS:**

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

### Encounter Data

**Collection: Requirements:**

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections: Submission Specifications:**

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

-Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

**Validation - Methods:**
-Medical record validation

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Revenue Codes
-Gender-appropriate diagnosis/procedure

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Adolescent well-care visit rate
-Annual Monitoring for Patients on Persistent Medications
-Childhood Immunization Status
-Chlamdyia screening in women
-Controlling high blood pressure
-Depression management/care
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

**Health Status/Outcomes Quality:**
-CAHPS Health Plan
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Survey 4.0 H -Adult
-Survey 4.0 H -Child

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Prenatal and Postpartum Care

**Use of Services/Utilization:**
-Antibiotic Utilization
-Frequency of Selected Procedures
-Inpatient Utilization - General Hospital/Acute Care Ambulatory Care

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-MCOs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
-Managed Care is performing a focus study

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

**Non-Clinical Topics:**

-Coordination of Care

## Standards/Accreditation

**MCO Standards:**

-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

**Accreditation Required for Participation:**

-NCQA (National Committee for Quality Assurance)

**Non-Duplication Based on Accreditation:**

None

**EQRO Name:**

-Health Services Advisory Group, Inc.

**EQRO Organization:**

-QIO-like entity

**EQRO Mandatory Activities:**

-Site Reviews
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**

-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

## Pay for Performance (P4P)

**Implementation of P4P:**

The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**

Medicaid is the only payer

**Population Categories Included:**

Covers all MCO members

**Rewards Model:**

Payment incentives/differentials to reward MCOs

**Clinical Conditions:**

Not Applicable

**Measurement of Improved Performance:**

Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**

2007

**Evaluation Component:**

The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**

Not Applicable

# QUALITY ACTIVITIES FOR PIHP

**State Quality Assessment and Improvement Activities:**

-Consumer Self-Report Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews

**Use of Collected Data:**

-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal

-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data
-Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:
-CAHPS
Adult Medicaid 4.0 H
Child Medicaid 4.0 H

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Performance Measures

### Process Quality:
-Adolescent well-care visit rate
-Annual Monitoring for Patients on Persistent Medications
-Antidepressant medication management
-Childhood Immunization Status
-Chlamdyia screening in women
-Controlling high blood pressure
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-CAHPS Health Plan
-Survey 4.0 H- Adult
-Survey 4.0 H- Child

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Prenatal and Postpartum Care

### Use of Services/Utilization:
-Ambulatory Care
-Antibiotic Utilization
-Frequency of Selected Procedures
-Inpatient Utilization-General Hospital/Acute Care
-Use of Imaging Studies for lower back pain

### Health Plan Stability/ Financial/Cost of Care:
None

### Health Plan/ Provider Characteristics:
None

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing
-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

### Clinical Topics:
-Improving well care visits for Children and Adolescents

### Non-Clinical Topics:
-Improving coordination of care for members with Behavorial Health Conditions

## Standards/Accreditation

### PIHP Standards:
-CMS's Quality Improvement System for managed Care

### Accreditation Required for Participation:
None

(QISMC) Standards for Medicaid and Medicare
-NCQA (National Committee for Quality Assurance) Standards

**Non-Duplication Based on Accreditation:**
None

**EQRO Organization:**
-QIO-like entity

**EQRO Name:**
-Health Services Advisory Group, Inc.

**EQRO Mandatory Activities:**
-Site Reviews
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities**
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

# DISTRICT OF COLUMBIA
## Health Services for Children with Special Needs

## CONTACT INFORMATION

**State Medicaid Contact:**

Lisa Truitt
Department of Health Care Finance
(202) 442-9109

**State Website Address:**

http://www.dchealth.com

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
February 01, 1996

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Medical-only PIHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

**Allowable PCPs:**
None

#### Enrollment

**Populations Voluntarily Enrolled:**
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**
None

**Populations Mandatorily Enrolled:**
None

**Lock-In Provision:**
None

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
None

**Agencies with which Medicaid Coordinates the Operation of the Program:**
None

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Services For Children with Special Needs

## ADDITIONAL INFORMATION

This is no longer a demonstration program but a cost-base reimbursement program and there is no risk involved for providers. Program provides Emergency Transportation only and Skilled Nursing Facility for first 30 days.

## QUALITY ACTIVITIES FOR PIHP

**State Quality Assessment and Improvement Activities:**
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

**Use of Collected Data:**
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of

the measures

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across PIHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

### PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Diabetes medication management
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants

-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

### Access/Availability of Care:
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries

### Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

### Health Plan Stability/ Financial/Cost of Care:
-Net income
-Net worth
-Total revenue

### Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

## Standards/Accreditation

### PIHP Standards:
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Delmarva Foundation for Medical Care

### EQRO Organization:
-Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance measures

### EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

# ILLINOIS
## Voluntary Managed Care

## CONTACT INFORMATION

**State Medicaid Contact:**

Michelle Maher
Illinois Department of Healthcare and Family Services
(217) 524-7478

**State Website Address:**

http://www.hfs.illinois.gov/

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Illinois Client Enrollment Broker

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Assistive/Augmentative Communication Devices, Audiology, Blood and Blood Components, Case Management, Chiropractic, Clinic, Diagnosis and treatment of medical conditions of the eye, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Psychiatric Care, Inpatient Substance Use Disorders, Laboratory, Medical procedures performed by a dentist, Non-Durable Medical Equipment and Supplies, Nurse Midwives, Occupational Therapy, Orthotic/Prosthetic Devices, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplants, Transportation, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Clinics including certain Hospitals and Cook County Bureau of Health Service Clinics
-Other Provider Types as allowed by the Department
-Pediatricians
-Rural Health Clinics (RHCs)
-Specialist upon approval of Medical Director

#### Enrollment

# ILLINOIS
## Voluntary Managed Care

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-All Kids Premium Levels 2 through 8
-All Kids Rebate and Family Care Rebate
-Blind Disabled Children and Related Population
-Individuals enrolled in presumptive eligible programs
-Individuals enrolled in programs with limited benefits
-Medicare Dual Eligibles
-Non-citizens only receiving emergency services
-Other Insurance - High Level
-Pace Participants
-Participate in HCBS Waiver
-Refugees
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Spenddown Eligibles
-Transitional Assistance, Age 19 and Older
-Veterans Care Program

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Family Health Network
Harmony Health Plan
Meridian Health Plan

## ADDITIONAL INFORMATION

Nursing facility services are provided up to 90 days annually.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**
-Access to Care Standards Monitoring
-Consumer Self-Report Data (see below for details)
-Customer Satisfaction Survey

**Use of Collected Data:**
-Contract Standard Compliance
-Data Mining - HEDIS calculations
-Fraud and Abuse

-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continous enrollment

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, 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
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

### Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

### State conducts general data completeness assessments:
Yes

## Performance Measures

# ILLINOIS
## Voluntary Managed Care

### Process Quality:
-Adolescent well-care visit rates
-adult preventive care
-Asthma care- medication use
-Breast Cancer Screening Rate
-Cervical Cancer Screening Rate
-check ups after delivery - Prenatal and Postpartum care
-childhood immunization status
-Chlamydia screening in women
-Controlling high blood pressure
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Well-child care visit rates in 3, 4, 5 and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of low birth weight infants
-Percentage of very low birth weight infants

### Access/Availability of Care:
-Access and Availability of Care: Prenatal and Postpartum
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Birth and average length of stay - newborns
-chemical dependency utilization
-Discharge and average length of stay - maternity care
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-mental health utilization
-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/SUD facility

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

### Health Plan/ Provider Characteristics:
-Admitting and delivery privileges
-Languages Spoken (other than English)
-Provider license number
-Specialty of providers

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-special needs population

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

### Clinical Topics:
-Asthma management
-EPSDT/Content of care for under age three
-Follow-up After Hospitalization for Mental Illness/ PCP Communication
-Prenatal Depression Screening and referral

### Non-Clinical Topics:
None

# ILLINOIS
## Voluntary Managed Care

### Standards/Accreditation

**MCO Standards:**
-CMS Quality Improvement Systems - for performance improvement
-NCQA for HEDIS
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Health Services Advisory Group

**EQRO Organization:**
-External Quality Review Organization

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Assessment of MCO information systems
-Calculation of performance measures
-Technical Assistance - to state for Readiness Review
-Technical assistance to MCOs to assist them in conducting quality activities

### Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Health Care and Family Services is the only payer

**Population Categories Included:**
Covers all MCO members meeting the P4P criteria

**Rewards Model:**
Bonus as an incentive for meeting percentile and have no more than three measures below minimum performanc level
Payment for well child visits under age 5
Payment of Withold as an incentive for meeting P4P criteria

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Use of services, e.g., immunization rates
well child visits under the age of 5

**Initial Year of Reward:**
2006

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

**Member Incentives:**
Not Applicable

# MINNESOTA
# Minnesota Disability Health Options (MnDHO)

## CONTACT INFORMATION

**State Medicaid Contact:**

Brian Osberg
Minnesota Department of Human Services
(651) 431-2189

**State Website Address:**

http://www.dhs.state.mn.us

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
September 01, 2001

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Dental, Durable Medical Equipment, Family Planning, Hearing, Home and Community-Based Waiver, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
-Blind/disabled adults ages 18 through 64, and related populations
-Medicare Dual Eligibles
-or Eligible for Medicaid Only

**Populations Mandatorily Enrolled:**
None

# MINNESOTA
## Minnesota Disability Health Options (MnDHO)

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligible for Medicare Part A or Part B Only
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-QMB or SLMB, Not Otherwise Eligible for Medicaid
-Reside in Regional Treatment Center
-Residing in a State institution other than a NF

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

No

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

## 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:**

-Mental Health Agency
-Public Health Agency
-Social Services Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

UCARE

## ADDITIONAL INFORMATION

PCP provider types are designated by HMOs rather than State. Health plans have been encouraged to develop networks with professionals with disability experience. Skilled Nursing Facility is covered up to 180 days. All medicare services under parts A, B, and D are included.

## QUALITY ACTIVITIES FOR MCO/HIO

# MINNESOTA
## Minnesota Disability Health Options (MnDHO)

### State Quality Assessment and Improvement Activities:
-Annual HCBS Quality Assurance Plan
-Care Plan Audits
-Care System Reviews
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-HCBS self-assessment QA survey
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:
-Assess program results
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track access and utilization

### Consumer Self-Report Data:
-CAHPS
  Adult Medicaid Questionaire
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
-Disenrollment Survey

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, 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
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

### Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-None

### State conducts general data completeness assessments:
No

## Performance Measures

### Process Quality:
-Adult preventive visits
-Antidepressant medication management
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

-Colorectal Cancer Screening
-COPD-spirometry testing
-Dental services
-Diabetes screening
-Mental health discharges
-Osteoporosis care after fracture
-Percentage of beneficiaries with at least one dental visit

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services
-Average distance to PCP

**Use of Services/Utilization:**
-CD initiating and treatment
-Mental health discharges
-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

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-MCOs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
-Aspirin therapy
-Asthma - Reduction in ED Visits
-Asthma management
-Breast cancer screening (Mammography)
-Calcium/Vitamin D
-Cholesterol screening and management
-Colon cancer screening
-Depression management
-Diabetes management
-Diabetic statin use, 40 to 75 year olds
-Human Papillomavirus
-Hypertension management
-Lead toxicity
-Mental health/chemical dependency dual diagnoses
-Obesity
-Pneumococcal vacine
-Sexually transmitted disease screening

**Non-Clinical Topics:**
-Adults access to preventive/ambulatory health services

## Standards/Accreditation

**MCO Standards:**
-NCQA (National Committee for Quality Assurance) Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
-NCQA (National Committee for Quality Assurance)

**EQRO Name:**
-MetaStar (QIO)
-Michigan Performance Review Organization

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance measures

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Population Categories Included:**
A subset of MCO members, defined by disease and medical condition

**Clinical Conditions:**
Dental

**Initial Year of Reward:**
1999

**Member Incentives:**
Not Applicable

**Program Payers:**
Medicaid has collaborated with a public sector entity to support the P4P program

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Measurement of Improved Performance:**
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

# MINNESOTA
# Minnesota Senior Health Options Program (MSHO)

## CONTACT INFORMATION

**State Medicaid Contact:**

Brian Osberg
Minnesota Department of Human Services
(651) 431-2189

**State Website Address:**

http://www.dhs.state.mn.us

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a) - Voluntary

**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:**
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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Available Under The Home And Community-Based Waiver, Case Management, Chiropractic, Community Based, Dental, Durable Medical Equipment, ESRD, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter, Laboratory, Medication Therapy Management, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care Assistant, Pharmacy, Physician, Prosthetic and Orthotic Devices, Public Health, Reconstructive Surgery, Skilled Nursing Facility, Skilled Nursing Facility, Transplants, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

# MINNESOTA
## Minnesota Senior Health Options Program (MSHO)

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligibility Less Than 3 Months
-Eligible For Medicare Part A or Part B Only
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Poverty Level Pregnant Woman
-QMB or SLMB Not Otherwise Eligible For Medicaid
-Residing in State institution other than NF
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

## 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
-Mental Health Agency
-Social Services Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Health Partners
Itasca Medical Care
Medica
Metropolitan Health Plan
PrimeWest Health System
South Country Health Alliance
UCARE

## ADDITIONAL INFORMATION

# MINNESOTA
## Minnesota Senior Health Options Program (MSHO)

This program only includes Medicare Dual Eligibles age 65 and up.

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. All medicare services under parts A, B, and D are included. Skilled nursing facility services are covered for up to 180 days.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:
-Annual HCBS Quality Assurance Plan
-Care Plan Audits
-Care System Reviews
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-HCBS self-assessment QA survey
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:
-Assess program results
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track access and utilization

### Consumer Self-Report Data:
-CAHPS
  Adult Medicaid Questionaire
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
-Disenrollment Survey

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, 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
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

### Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

### MCO/HIO conducts data accuracy check(s) on specified data elements:
None

### State conducts general data completeness assessments:
No

# MINNESOTA
# Minnesota Senior Health Options Program (MSHO)

## Performance Measures

### Process Quality:
-Adult preventive visits
-Antidepressant medication management
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Colorectal Cancer Screening
-COPD-spirometry testing
-Dental services
-Diabetes screening
-Mental health discharges
-Osteoporosis care after fracture
-Percentage of beneficiaries with at least one dental visit

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP

### Use of Services/Utilization:
-CD initiating and treatment
-Mental health discharges
-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

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

### Clinical Topics:
-Aspirin therapy
-Asthma management
-Asthma-reduction of emergency department visits
-Breast cancer screening (Mammography)
-Calcium/Vitamin D
-Cholesterol screening and management
-Colon cancer screening
-Depression management
-Diabetic statin use, 40 to 75 year olds
-Human Papillomavirus
-Hypertension management
-Mental health/chemical dependency dual diagnoses
-Obesity
-Pneumococcal vaccine

### Non-Clinical Topics:
-Adults access to preventive/ambulatory health services

## Standards/Accreditation

### MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)

### EQRO Name:
-MetaStar (QIO)

-Michigan Performance Review Organization

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance measures

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid has collaborated with a public sector entity to support the P4P program

**Population Categories Included:**
A subset of MCO members, defined by disease and medical condition

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Clinical Conditions:**
Cardiac Care
Dental
Diabetes

**Measurement of Improved Performance:**
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
1999

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

**Member Incentives:**
Not Applicable

# MINNESOTA
## Special Needs Basic Care

## CONTACT INFORMATION

**State Medicaid Contact:**

Brian Osberg
Minnesota Department of Human Services
(651) 431-2189

**State Website Address:**

http://www.dhs.state.mn.us

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a) - Voluntary

**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, 2008

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Child & Teen Check-Up, Chiropractic, Dental, Disease Management, Durable Medical Equipment, Emergency Room, Family Planning, Hearing, Home Health (Skilled Nurse Visit, Home health Aid), Inpatient Hospital, Inpatient Substance Use Disorders, Interpreter, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Preventive Visit, Respiratory Therapy, Skilled Nursing Facility (100 days), Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Not Applicable; Contractors Not Required to Identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations

**Populations Mandatorily Enrolled:**
None

-Medicaid Only
-Medicare Dual Eligibles

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligible for Medicare Part A or Part B Only
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-QMB, SLMB not Otherwise Eligible for Medicaid
-Residing in a State Institution

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

No

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

## 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
-Mental Health Agency
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Medica
Metropolitan Health Plan
PrimeWest Health System
South Country Health Alliance
UCARE

## ADDITIONAL INFORMATION

None

# MINNESOTA
## Special Needs Basic Care

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:
-Assess program results
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track access and utilization

### Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
-Disenrollment Survey

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

### Validation - Methods:
-None

### MCO/HIO conducts data accuracy check(s) on specified data elements:
None

### State conducts general data completeness assessments:
No

## Performance Measures

### Process Quality:
-Adult preventive visits
-Antidepressant medication management
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Colorectal cancer screening
-Dental services

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

-Diabetes screening
-Mental health discharges
-Osteoporosis care after fracture

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services

**Use of Services/Utilization:**
-CD initiating and treatment
-Mental health discharges
-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

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-MCOs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
-Aspirin therapy
-Asthma management
-Asthma-reduction of emergency department visits
-Breast cancer screening (Mammography)
-Calcium/Vitamin D
-Cholesterol screening and management
-Colon cancer screening
-Depression management
-Diabetes management
-Diabetic statin use, 40 to 75 year olds
-Human papillomavirus
-Hypertension management
-Mental health/chemical dependency dual diagnoses
-Obesity
-Pneumococcal vaccine

**Non-Clinical Topics:**
-Adults access to preventive/ambulatory health services

## Standards/Accreditation

**MCO Standards:**
-NCQA (National Committee for Quality Assurance) Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
-NCQA (National Committee for Quality Assurance)

**EQRO Name:**
-MetaStar (QIO)
-Michigan Performance Review Organization

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance measures

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys

## Pay for Performance (P4P)

# MINNESOTA
## Special Needs Basic Care

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Population Categories Included:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Member Incentives:**
Not Applicable

**Program Payers:**
Not Applicable

**Rewards Model:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Evaluation Component:**
Not Applicable

# NEW YORK
## Managed Long Term Care Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Linda Gowdy
Division of Managed Care & Program Evaluation
(518) 474-6965

**State Website Address:**

http://www.nyhealth.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
January 01, 1998

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Long Term Care PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Adult Day Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Meals, Medical Social, Nutrition, Occupational Therapy, Personal Care, Personal Emergency Response System, Physical Therapy, Podiatry, Private Duty Nursing, Respiratory Therapy, Skilled Nursing Facility, Social and Environmental Supports, Speech Pathology, Transportation, Vision

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

# NEW YORK
## Managed Long Term Care Program

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver

**Lock-In Provision:**

1 month lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

SLMB, QI, and QDWI
QMB

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Uses 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:**

-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Community Connections
Fidelis Care at Home
Health Advantage/Elant Choice
HomeFirst
Senior Health Partners
Total Aging in Place
WellCare Advocate
CCM Select
Guildnet
HHH Choices
Independent Care Systems
Senior Network Health
VNS Choice

## ADDITIONAL INFORMATION

To be eligible for this program, a person must be age 18+ and eligible for nursing home placement but able to live in the community upon enrollment. Beneficiaries may receive services at home or in a Nursing Home in the plan network.

## QUALITY ACTIVITIES FOR PIHP

# NEW YORK
## Managed Long Term Care Program

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
-Consumer satfisfaction surbey

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

## Encounter Data

**Collection: Requirements:**
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Specifications for the submission of encounter data to the Medicaid agency

**Collections: Submission Specifications:**
-Deadlines for regular/ongoing encounter data submission(s)
-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)

**PIHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
-Provider networks and updates are collected quarterly and reviewed for accuracy

**Use of Services/Utilization:**
-Drug Utilization
-Number of home health visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

**Health Plan Stability/ Financial/Cost of Care:**
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)

**Health Plan/ Provider Characteristics:**
-Languages Spoken (other than English)

# NEW YORK
## Managed Long Term Care Program

**Beneficiary Characteristics:**
-Upon enrollment and semi-annual assessment

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-PIHPs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
-Diabetes management
-Improve dental utilization
-Reduction of Hosp/ER for CHF
-Standardized pain assessment tool

**Non-Clinical Topics:**
-Advaced Directives
-DME tracking
-Effective use of PERS
-Improving SASM scoring

## Standards/Accreditation

**PIHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-IPRO - Island Peer Review Organization

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Validation of performance improvement projects

**EQRO Optional Activities**
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

# NEW YORK
# Medicaid Advantage Plus (MAP)

## CONTACT INFORMATION

**State Medicaid Contact:**

Linda Gowdy
Division of Managed Care & Program Evaluation
(518) 474-6965

**State Website Address:**

http://www.nyhealth.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
October 01, 2007

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Long Term Care PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Adult Day Health Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Meals, Medical Social, Nutrition, Occupational Therapy, Personal Care, Personal Emergency Response System, Physical Therapy, Podiatry, Private Duty Nursing, Respiratory Therapy, Skilled Nursing Facility, Social and Environmental Supports, Speech Pathology, Transportation, Vision

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

# NEW YORK
## Medicaid Advantage Plus (MAP)

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver

**Lock-In Provision:**
1 month lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
SLMB, QI, and QDWI
QMB

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Uses provider referrals 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

AmeriGroup Advantage Plus/Medicaid Advantage Plus
Elder Plan/Medicaid Advantage Plus
GuildNet/Medicaid Advantage Plus
NYS Catholic Health Plan/Fidelis/Medicaid Advantage Plus
Senior Whole Health/Medicaid Advantage Plus
VNS Choice Plus/Medicaid Advantage Plus
WellCare Advantage Plus/Medicaid Advantage Plus

## ADDITIONAL INFORMATION

To be eligible for this program, a person must be age 18+ and eligible for nursing home placement but able to live in the community upon enrollment. Beneficiaries may receive services at home or in a Nursing Home in the plan network.

## QUALITY ACTIVITIES FOR PIHP

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies

**Use of Collected Data:**
-Contract Standard Compliance
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

-Grievance and Appeal Data
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

**Consumer Self-Report Data:**
-Consumer satisfaction survey

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

## Encounter Data

**Collection: Requirements:**
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Specifications for the submission of encounter data to the Medicaid agency

**Collections: Submission Specifications:**
-Deadlines for regular/ongoing encounter data submission(s)
-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)

**PIHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
-Provider networks and updates are collected quarterly and reviewed for accuracy

**Use of Services/Utilization:**
-Drug Utilization
-Number of home health visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

**Health Plan Stability/ Financial/Cost of Care:**
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)

**Health Plan/ Provider Characteristics:**
-Languages Spoken (other than English)

**Beneficiary Characteristics:**
-Upon enrollment and semi-annual assessment.

**Performance Measures - Others:**
None

## Performance Improvement Projects

# NEW YORK
## Medicaid Advantage Plus (MAP)

**Project Requirements:**

-PIHPs are required to conduct a project(s) of their own choosing

**Clinical Topics:**

-Diabeetes Management
-Improve Dental Utilization
-Pain Management

**Non-Clinical Topics:**

-Advance Directives

## Standards/Accreditation

**PIHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-IPRO - Island Peer Review Organization

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Validation of performance improvement projects

**EQRO Optional Activities**
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

# PENNSYLVANIA
# Living Independence for the Elderly (LIFE) Program (PIHP)

## CONTACT INFORMATION

**State Medicaid Contact:**

Randy Nolen
PA Department of Public Welfare, Bureau of Provider Support,
(717) 772-2543

**State Website Address:**

http://www.state.pa.us

## PROGRAM DATA

**Program Service Area:**
County
Zip Code

**Initial Waiver Approval Date:**
Not Applicable

**Operating Authority:**
1915(a) - Voluntary

**Implementation Date:**
October 01, 1998

**Statutes Utilized:**
Not Applicable

**Waiver Expiration Date:**
Not Applicable

**Enrollment Broker:**
No

**Sections of Title XIX Waived:**
None

**For All Areas Phased-In:**
No

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

**Guaranteed Eligibility:**
None

## SERVICE DELIVERY

### Medical-only PIHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Adult Day Care, Case Management, Chiropractic, Dental, Durable Medical Equipment, Hearing, Hospice, Immunization, In-home Supportive Care, Institutional, Occupational Therapy, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

# PENNSYLVANIA
## Living Independence for the Elderly (LIFE) Program (PIHP)

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Albright LIFE
Senior LIFE York
Viecare Butler
LIFE Northwestern PA
Senior LIFE Washingtown

## ADDITIONAL INFORMATION

The pre-PACE sites listed are identified as Medical-only PIHP. Program provides capitated institutional services not capitated inpatient hospital services.

## QUALITY ACTIVITIES FOR PIHP

**State Quality Assessment and Improvement Activities:**
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)

**Use of Collected Data:**
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

# PENNSYLVANIA
## Living Independence for the Elderly (LIFE) Program (PIHP)

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
-Patient satisfaction with care

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services
-Ratio of PCPs to beneficiaries

**Use of Services/Utilization:**
None

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-PIHPs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
None

**Non-Clinical Topics:**
-Appeals and Grievances
-Falls

## Standards/Accreditation

**PIHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-IPRO

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities**
-Technical assistance to PIHPs to assist them in conducting quality activities

# PENNSYLVANIA
## Voluntary HMO Contracts

## CONTACT INFORMATION

**State Medicaid Contact:**

Joan Morgan
Pennsylvania Department of Welfare
(717) 772-6300

**State Website Address:**

http://www.state.pa.us

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
1915(b)(4)

**Enrollment Broker:**
Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
January 01, 1972

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based 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, Skilled Nursing Facility, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Rural Health Centers (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

**Populations Mandatorily Enrolled:**
None

-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles
-Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-State Only Categorically Needy
-State Only Medically Needy

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Enrolled in Health Insurance Premium Payment (HIPP) with HMO Coverage
-Enrolled in Long Term Care Capitated Program (LTCCP)
-Incarceration
-Medicare Dual Eligibles
-Monthly Spend Downs
-Reside in Nursing Facility or ICF/MR
-Residence in a State Facility
-State Blind Pension Recipients

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only (under age 21)

**Medicare Dual Eligibles Excluded:**

QMB (age 21 and over)
SLMB, QI, and QDWI (age 21 and over)

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-None - managed care entity provides standard prescription drug coverage

## 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 groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Education Agency
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan - VOL

Gateway Health Plan, Inc. -VOL

Unison Health Plan/MedPlus - VOL

UPMC Health Plan, Inc./UPMC for You - VOL

## ADDITIONAL INFORMATION

Included Services: Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, and Outpatient Substance Use Disorders are provided on a Fee-For-Service basis or through Behaviorial Health MCOs where implemented.

Special Needs Children: (state defined) Broadly defined non-categorical to include all children. Skilled Nursing Facility is provided for the first 30 days. Transportation services only includes emergency ambulance services.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
  4.0H Adult
  4.0H Children
-Plan-developed survey

### Use of HEDIS:

-The State uses ALL of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

### Performance Measures

### Process Quality:

-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

### Health Status/Outcomes Quality:

-Patient satisfaction with care

# PENNSYLVANIA
## Voluntary HMO Contracts

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-All use of services in HEDIS measures
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

### Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

### Clinical Topics:
-Adolescent Pregnancy
-Asthma management
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Hypertension management
-Smoking prevention and cessation

### Non-Clinical Topics:
-Adults Access to Dental Care
-Childrens Access to Dental Care

## Standards/Accreditation

### MCO Standards:
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-IPRO

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
Covers all MCO members

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
2006

**Evaluation Component:**
The State has conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

# PUERTO RICO
## Medicare Platino

## CONTACT INFORMATION

**State Medicaid Contact:**

Miguel Negron-Rivera
PR Department of Health - Medicaid Office
(787) 250-0453

**State Website Address:**

http://www.ases.gobierno.pr

## PROGRAM DATA

**Program Service Area:**
Region

**Operating Authority:**
1915(a) - Voluntary

**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, 2006

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Dental, Diagnosis and Treatment of tuberculosis and leprosy, Disease Management, EPSDT, Family Planning, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Maternity, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Exam, Physician, Preventive, Surgery, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians

#### Enrollment

**Populations Voluntarily Enrolled:**
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

# PUERTO RICO
## Medicare Platino

**Subpopulations Excluded from Otherwise Included Populations:**
-All populations who are not dual eligibles

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
-Barbituates
-Benzodiazepines
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

## 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

American Health Medicare
MCS Advantage
PMC Medicare Choice
Humana Puerto Rico
MMM Healthcare Inc.
Triple S

## ADDITIONAL INFORMATION

Medicare Platino is a program contracted with Medicare Advantage Plans to provide coverage to qualified beneficiaries from the Puerto Rico Health Care Program. Medicare Platino provides Medicaid wrap services that are not provided by the Medicare Advantage Plans to ensure the same level of service and coverage as in the Puerto Rico's Health Care Program. Program is strictly for dual eligibles.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**
-Encounter Data (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance

# PUERTO RICO
## Medicare Platino

### Consumer Self-Report Data:
None

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
None

### Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Payment
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Gender-appropriate diagnosis/procedure

### State conducts general data completeness assessments:
No

## Performance Measures

### Process Quality:
-Annual monitoring of patients on persistent medications
-Antidepressant medication management
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cholosterol management for patients with cardiovascular conditions
-Colorectal Cancer Screening
-Comprehensive Diabetes Care
-Controlling high blood pressure
-Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis
-Follow-up after hospitalization for mental illness
-Glaucoma screening in older adults
-Osteoporosis management in women who had a fracture
-Pharmacotherapy Management of COPD Exacerbation
-Potentially Harmful Drug-Disease Interactions in the Elderly
-Use of High-Risk Medications in the Elderly
-Use of spirometry testing in assessment and diagnosis of COPD

### Health Status/Outcomes Quality:
-Effectiveness of care

# PUERTO RICO
## Medicare Platino

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Call abandoment
-Call answer timeliness
-Initiation and engagement of alcohol and other drug dependence treatment

### Use of Services/Utilization:
-Ambulatory care
-Antibiotic utilization
-Drug Utilization
-Frequency of selected procedures
-Identification of Alcohol and Other Drug Services
-Inpatient Utilization - General Hospital / Acute Care
-Inpatient Utilization - Non-Acute Crae
-Mental Health Utilization

### Health Plan Stability/ Financial/Cost of Care:
-Relative resources used for people with cardiac conditions
-Relative resources used for people with COPD
-Relative resources used for people with diabetes
-Relative resources used for people with uncomplicated hypertension

### Health Plan/ Provider Characteristics:
-Board Certification
-Enrollment by Product Line
-Enrollment by State
-Language Diversity of Membership
-Race / Ethnicity Diversity of Membership

### Beneficiary Characteristics:
None

### Performance Measures - Others:
-Effectiveness of care

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

### Clinical Topics:
-Chronic Care Improvement Program (CCIP): Targeting high risk members with Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Bronchial Asthma (BA), High Blodd Pressure (HBP) and Chronic Obstructive Pulmonary Disease (COPD)
-Comprehensive Diabetes Care: Poor HbA1c control
-Improving the Quality of Care of Part D Enrollees Diagnosed with High Blood Pressure Receiving Diuretics Therapy
-Increasing the Number of Enrollees that Received an Influenza Vaccination and Pneumonia Vaccination
-Lowering the Drug-Drug Interaction (DDI) and teh Ptentially Inapproriate Medication (PIM) on Medicare Claims Part D
-Members High Risk / SNP Program Diabetes Special Needs Plans
-Polypharmacy Program in Medicare Members
-Retinopathy Screening and Long Term Control in Diabetic Population

### Non-Clinical Topics:
None

## Standards/Accreditation

### MCO Standards:
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Quality Improvement Professional Research Organization

### EQRO Organization:
-Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Calculation of performance measures

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# PUERTO RICO
## Puerto Rico Health Care Plan

## CONTACT INFORMATION

**State Medicaid Contact:**

Miguel Negron-Rivera
PR Department of Health - Medicaid Office
(787) 250-0453

**State Website Address:**

http://www.ases.gobierno.pr

## PROGRAM DATA

**Program Service Area:**
Region

**Operating Authority:**
1915(a) - Voluntary

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Dental, Disease Management, EPSDT, Family Planning, Immunization, Inpatient Hospital, Laboratory, Maternity, Outpatient Hospital, Pharmacy, Physical Exam, Physician, Preventive, Surgery, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Individual/Families up to 200% of Puerto Rico poverty level
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

-Police
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-No populations are excluded

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

## Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## MH/SUD PIHP - Risk-based Capitation

### Service Delivery

**Included Services:**
Case Management, Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation

**Allowable PCPs:**
-Psychiatrists
-Psychologists

### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Individual/families up to 200% of the Puerto Rico poverty line
-Medicare Dual Eligibles
-Police
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-No populations are excluded

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Public Health Agency

# PUERTO RICO
## Puerto Rico Health Care Plan

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

APS Healthcare
Humana Health Plans of Puerto Rico, Inc.
Triple-S, Inc.
FHC Healthcare
MCS Health Management Options, Inc.

## ADDITIONAL INFORMATION

Puerto Rico's Health Care Program is not a voluntary program. It is a mandatory managed care program which requires no waiver authority because Puerto Rico is statutory exempt from Freedom of Choice requirements. PRHIA main duty is to obtain health insurance coverage for the medically indigent. Vision and hearing services are only included under physician services and other ancillary services. Mental Health and Abuse program is separated and handled by MBHOs. There are no QMBs dual eligibles in Puerto Rico.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**
-Encounter Data (see below for details)
-Monitoring of MCO Standards
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State uses 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 to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

### Encounter Data

**Collection: Requirements:**
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

**Collections: Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
None

**Validation - Methods:**
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Payment
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Gender-appropriate diagnosis/procedure

**State conducts general data completeness assessments:**
No

### Performance Measures

### Process Quality:
-Ambulatory Care
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Call Abandonment
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Frequency of Selected Procedures
-Immunizations for two year olds
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care

### Access/Availability of Care:
-Adolescent Well-Care Visits
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

### Use of Services/Utilization:
-Inpatient Utilization - General Hospital / Acute Care
-Inpatient Utilization - Non-Acute Care
-Relative Resource Use for People with Asthma
-Relative Resource Use for People with Cardiovascular Conditions
-Relative Resource Use for People with Diabetes

### Health Plan Stability/ Financial/Cost of Care:
None

### Health Plan/ Provider Characteristics:
-Board Certification

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

### Clinical Topics:
-Asthma management
-Diabetes management
-Retinopathy Screening and Long Term Control in Diabetic Population

### Non-Clinical Topics:
-Clinical Edits Improvement Project
-Teleconsulta and Extended Hour Care Program

## Standards/Accreditation

### MCO Standards:
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Island Peer Review Organization
-Quality Improvement Professional Research Organization

### EQRO Organization:
-Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational

standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Assessment of education and prevention programs

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# QUALITY ACTIVITIES FOR PIHP

**State Quality Assessment and Improvement Activities:**
-Monitoring of PIHP Standards
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Performance Measures

**Process Quality:**
-Antidepressant medication management
-Follow-up after hospitalization for mental illness
-Follow-up Care for Children Prescribed ADHD Medication
-Identification of Alcohol and Other Drug Services
-Initiation and engagement of SUD treatment

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services
-Children's access to primary care practitioners

**Use of Services/Utilization:**
-Mental Health Utilization

# PUERTO RICO
## Puerto Rico Health Care Plan

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**

-PIHPs are required to conduct a project(s) of their own choosing

**Clinical Topics:**

-Ambulatory Follow-up and Readmissions within 30 days
-Depression and Diabetes Disease Management Pilot
-Vida Sana - Clinical Project that targets the Mediciad Enrollee with Major Depression and Diabetes

**Non-Clinical Topics:**

-Patients Telephone Access / Telephone Skills Surveillance Project

## Standards/Accreditation

**PIHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Island Peer Review Organization
-Quality Improvement Professional Research Organization

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities**
-Assessment of education and prevention programs
-Technical assistance to PIHPs to assist them in conducting quality activities

# TEXAS
# STAR Health

## CONTACT INFORMATION

**State Medicaid Contact:**

Joe Vesowate
Texas Health and Human Services Commission
(512) 491-1379

**State Website Address:**

http://www.hhs.state.tx.us/medicaid/StarHealth.shtml

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Maximus

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 01, 2008

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Service Management, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Children and young adults in DFPS conservatorship

**Populations Mandatorily Enrolled:**
None

-Emancipated minors or members age 18-22 who voluntarily agree to continue in foster placement
-Young adults age 21 through the month of their 23rd birthday who are participating in the Former Fos
-Young adults who have exited care and are participating in the foster care youth transitional progra

**Subpopulations Excluded from Otherwise Included Populations:**

-Medicare Dual Eligibles
-Placed with TYC or TJPC
-Reside in a state school or other 24 hour facility
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Department of Aging and Disability Services(DADS)
-Department of Family and Protective Service(DFPS)
-Department of State Health Services(DSHS)

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Superior HealthPlan (STAR Health)

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**

-Consumer Self-Report Data (see below for details)

**Use of Collected Data:**

-Contract Standard Compliance

-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Consumer Self-Report Data:
-CAHPS
  Child Medicaid Questionnaire
-State-developed Survey

-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-837 transaction format
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-837 transaction format
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-Behavioral health layout
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO
-State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills)

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Preparing HEDIS and risk adjustment software

### State conducts general data completeness assessments:
Yes

# TEXAS
# STAR Health

## Performance Measures

### Process Quality:
-Access to behavioral health treatment
-Access to Dental care
-Access to emergent care
-Access to routine care
-Access to specialist care
-Access to urgent care
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Depression management/care
-Diabetes care and control
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in adolescents

### 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
-Children's access to primary care practitioners
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

### Health Plan Stability/ Financial/Cost of Care:
-None

### Health Plan/ Provider Characteristics:
-Languages Spoken (other than English)

### Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Provider Turnover
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

### Performance Measures - Others:
-Health Status/Outcomes Process

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

### Clinical Topics:
-Diabetes care and management
-Influenza Immunizations

-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

**Non-Clinical Topics:**

None

## Standards/Accreditation

**MCO Standards:**
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Institute for Child Health Policy

**EQRO Organization:**
-Institute for Child Health Policy, University of Florida

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of encounter data
-Validation of performance improvement projects

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# UTAH
# Healthy Outcomes Medical Excellence (HOME)

## CONTACT INFORMATION

**State Medicaid Contact:**

Emma Chacon
Division of Medicaid and Health Financing
(801) 538-6577

**State Website Address:**

http://www.health.utah.gov/medicaid

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
March 01, 2001

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Non-risk PIHP that covers medical and mental health services. - Non-risk Capitation

#### Service Delivery

**Included Services:**
Case Management, Diabetes Self-management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Personal Care, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility if less than 30 days, Speech Therapy, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Pediatricians

**Contractor Types:**
None

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

**Populations Mandatorily Enrolled:**
None

-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**

-Eligible only for TB-related Services
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-All clients enrolled with HOME are people with special needs.

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Developmental Disabilities Agency
-Education Agency
-Housing Agencies
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Outcomes Medical Excellence (HOME)

## ADDITIONAL INFORMATION

Enrollees with special health care needs are enollees who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require services of a type or amount beyond that required by adults and children in general.

The Medicaid agency pays HOME a monthly prepayment for each HOME client. Total prepayments made to HOME are reconciled against its covered encounter records total costs.

## QUALITY ACTIVITIES FOR PIHP

# UTAH
# Healthy Outcomes Medical Excellence (HOME)

### State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)

### Use of Collected Data:
-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:
None

### Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Duplicate encounters

### PIHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Dulplicate Encounters

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
None

### Health Status/Outcomes Quality:
None

### Access/Availability of Care:
None

### Use of Services/Utilization:
None

### Health Plan Stability/ Financial/Cost of Care:
-Medical loss ratio
-Net worth
-Total revenue

### Health Plan/ Provider Characteristics:
None

# UTAH
# Healthy Outcomes Medical Excellence (HOME)

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-PIHPs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
-Measuring the impact of physical activity on BMI.

**Non-Clinical Topics:**
Not Applicable - PIHPs are not required to conduct common project(s)

## Standards/Accreditation

**PIHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-HCE Quality Quest

**EQRO Organization:**
-QIO-like entity

**EQRO Mandatory Activities:**
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities**
-Technical assistance to PIHPs to assist them in conducting quality activities

# WISCONSIN
# Children Come First (CCF)

## CONTACT INFORMATION

**State Medicaid Contact:**

Jason Helgerson
Division of Health Care Access and Accountability
(608) 266-8922

**State Website Address:**

http://dhs.wisconsin.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 01, 1993

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### MH/SUD PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Community Support Program (CSP), Crisis, Emergency, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Medical Day Treatment, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders, Targeted Case Management

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Populations Mandatorily Enrolled:**
None

# WISCONSIN
## Children Come First (CCF)

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver

**Lock-In Provision:**

Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Community Partnerships
-Dane County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
-Mental Health Agency
-Other Public And Private Agencies Are On The Statewide Children Come First Advisory Committee.
-Social Services Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Dane County Human Services Department -- CCF

## ADDITIONAL INFORMATION

Program goal is to keep children with severe emotional disturbances out of institutions and to serve these children and their families in the community. The state reallocates previous funding for institutional placement into community based care. It uses a "wraparound," integrated services approach with multi-agency and multi-disciplinary collaboration. Key components include intensive case management, crisis intervention, and a flexible array of services and supports (including some not traditionally covered under Medicaid) based on highly individualized plans of care. This mental health and substance abuse carve-out program does not designate a primary care provider for physical health care. All enrollees must have a special needs to be eligible for enrollment.

## QUALITY ACTIVITIES FOR PIHP

# WISCONSIN
# Children Come First (CCF)

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)

### Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-State-developed Survey

### Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

## Performance Measures

### Process Quality:
-Collaboration and teamwork
-Family-based and community-based sevice delivery
-Follow-up after hospitalization for mental illness
-Identification and process=service/care coordinators (case managers)
-Membership and process=child and family reams (plan of care teams)
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Process and content=plans of care
-Process and content=service authorization plans

### Health Status/Outcomes Quality:
-Cost-effectiveness comparison of this managed care program to non-managed care program
-Criminal offenses and juvenile justice contracts of enrollees, pretest and post-test
-Functional impairment of enrollees, pre-test, post-test
-Patient satisfaction with care
-Restrictiveness of living arrangements for enrollees, pre-test, and post-test
-School attendance and performance of enrollees, pre-test, and post-test

### Access/Availability of Care:
-Internal and external quality assurance audits of access and of monitoring plans of care

### Use of Services/Utilization:
-Internal and external quality assurance audits of monitoring plans of care and tracking actual service utilization

### Health Plan Stability/ Financial/Cost of Care:
None

### Health Plan/ Provider Characteristics:
-Internal quality assurance review of sub-contracted providers

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Other demographic, clinical, and service system characteristics of enrollees
-PIHP/PCP-specific disenrollment rate

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing

### Clinical Topics:
None

### Non-Clinical Topics:
-Program Transition

## Standards/Accreditation

### PIHP Standards:
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

# WISCONSIN
## Children Come First (CCF)

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-MetaStar

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

**EQRO Optional Activities**
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

# WISCONSIN
## Wraparound Milwaukee

## CONTACT INFORMATION

**State Medicaid Contact:**

Jason Helgerson
Division of Health Care Access and Accountability
(608) 266.8922

**State Website Address:**

http://dhs.wisconsin.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a) - Voluntary

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
March 01, 1997

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### MH/SUD PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Community Support Program (CSP), Crisis, Emergency, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Medical Day Treatment, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders, Targeted Case Management

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
-American Indian/Alaska Native
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Populations Mandatorily Enrolled:**
None

# WISCONSIN
## Wraparound Milwaukee

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver

**Lock-In Provision:**

Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

Not Applicable

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Mental Health Agency
-Milwaukee County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
-Other Public And Private Agencies Are On The Statewide Children Come First Advisory Committee
-Social Services Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Milwaukee County Human Services Department --
Wraparound Milwaukee

## ADDITIONAL INFORMATION

Program goal is to keep children with severe emotional disturbances out of institutions and to serve these children and their families in the community. The state reallocates previous funding for institutional placement into community based care. It uses a "wraparound," integrated services approach with multi-agency and multi-disciplinary collaboration. Key components include intensive case management, crisis intervention, and a flexible array of services and supports (including some not traditionally covered under Medicaid) based on highly individualized plans of care. This mental health and substance abuse carve-out program does not designate a primary care provider for physical health care. All enrollees must have a special needs to be eligible for enrollment.

## QUALITY ACTIVITIES FOR PIHP

# WISCONSIN
## Wraparound Milwaukee

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)

### Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-Annual family satisfaction survey through Families United Inc. (advocacy agency)
-State-developed Survey

### Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

## Performance Measures

### Process Quality:
-Collaboration And Teamwork
-Family-Based And Community-Based Service Delivery
-Follow-up after hospitalization for mental illness
-Identification And Process= Service/Care Coordinators (Case Managers)
-Membership And Process= Child And Family Teams (Plan Of Care Teams)
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Process And Content= Plans Of Care
-Process And Content= Service Authorization Plans

### Health Status/Outcomes Quality:
-Cost-Effectiveness Comparison Of This Managed Care Program To Non-Managed Care
-Criminal Offenses And Juvenile Justice Contracts Of Enrollees, Pre-Test And Post-Test
-Functional Impairment Of Enrollees, Pre-Test And Post-Test
-Patient satisfaction with care
-Restrictiveness Of Living Arrangements For Enrollees, Pre-Test And Post-Test
-School Attendance And Performance Of Enrollees, Pre-Test And Post-Test

### Access/Availability of Care:
-Internal And External Quality Assurance Audits Of Access And Of Monitoring Plans Of Care

### Use of Services/Utilization:
-Internal And External Quality Assurance Audits Of Monitoring Plans Of Care And Tracking Actual Service Utilization

### Health Plan Stability/ Financial/Cost of Care:
None

### Health Plan/ Provider Characteristics:
-Internal Quality Assurance Review Of Sub-Contracted Providers

### Beneficiary Characteristics:
-Information of beneficiary ethnicity/race
-Other Demographic, Clinical, And Service System Characteristics Of Enrollees.
-PIHP/PCP-specific disenrollment rate

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing

### Clinical Topics:
-Transition to Adulthood

### Non-Clinical Topics:
-Transitional Plan

## Standards/Accreditation

### PIHP Standards:
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

# WISCONSIN
## Wraparound Milwaukee

**Non-Duplication Based on Accreditation:**
None

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Name:**
-MetaStar

**EQRO Mandatory Activities:**
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

**EQRO Optional Activities**
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

# FLORIDA
# Florida Comprehensive Adult Day Health Care Program

## CONTACT INFORMATION

**State Medicaid Contact:**

GP Mendie
Florida Agency for Health Care Administration
(850) 412-4252

**State Website Address:**

http://ahca.myflorida.com

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(b)/1915(c)

**Statutes Utilized:**
1915(b)(4)

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
March 24, 2003

**Implementation Date:**
April 01, 2004

**Waiver Expiration Date:**
June 30, 2012

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Adult Day Health Care - Fee-for-Service

#### Service Delivery

**Included Services:**
Adult Day Health Care, Case Management, Medical Direction, Nutrition, Personal Care, Rehabilitation Therapy, Skilled Nursing Facility, Social, Transportation

**Allowable PCPs:**
-Sunrise Community Inc

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged 60 or older

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

**Lock-In Provision:**
No lock-in

-Other Insurance
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Public Health Agency
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HealthEase (Reform)
NetPass (Reform)
Preferred Medical Plan (Reform)
Sunrise Community, Inc.

## ADDITIONAL INFORMATION

The Adult Day Health Care facilities are not managed care entities, as defined by the State statutues. They are licensed pursuant to chapter 400 Part 5 of the Florida Statutes.

## Concurrent Operating 1915(c) Program

## CONTACT INFORMATION

**State Medicaid Agency Contact:**


Debra Scott
Analyst
Florida Department of Elder Affairs
(850) 414-2334

# FLORIDA
## Florida Comprehensive Adult Day Health Care Program

**State Operating Agency Contact:** Not Applicable

## PROGRAM DATA

**Program Service Area:**
County

**Initial Waiver Effective Date:**
April 01, 2005

**Statutes Waived:**
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

**Waiver Expiration Date:**
June 30, 2012

## Service Delivery

**Target Group:**
Aged

**Level of Care:**
Nursing Home

## ADDITIONAL INFORMATION

The 1915(b) waiver allows Florida to selectively contract vendors for selected counties to provide the 1915(c) service

# KANSAS
## Mental Health and Substance Abuse Services

## CONTACT INFORMATION

**State Medicaid Contact:**

Elizabeth Phelps
Department of Social and Rehabilitation Services
(785) 296-4552

**State Website Address:**

http://www.srskansas.org

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b)/1915(c)

**Statutes Utilized:**
1915(b)(1)
1915(b)(3)
1915(b)(4)

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
September 24, 2006

**Implementation Date:**
July 01, 2007

**Waiver Expiration Date:**
June 30, 2013

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Substance Use Disorders (SUD) PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Detoxification, Inpatient Substance Use Disorders, Outpatient Substance Use Disorders, Residential Substance Use Disorders Treatment Programs, Substance Use Disorders Support

**Contractor Types:**
-Behavioral Health MCO (Private)

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Adoption Support
-Aged and Related Populations

-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Breast/Cervical Cancer
-Foster Care Children
-Medically Impoved
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Presumptive XIX
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Working Disables

**Subpopulations Excluded from Otherwise Included Populations:**

-No State Payment Adult Care Home Resident
-Nursing Facility Head Injury
-Nursing Facility Mental Health
-Nursing Facilty Swing Bed
-PACE
-Reside in Nursing Facility or ICF/MR
-State Hospital Developmentally Disabled
-State Hospital Mental Health

**Lock-In Provision:**

Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**

Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**

None

## Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## Mental Health (MH) PAHP - Non-risk Capitation

### Service Delivery

**Included Services:**
Case Conferencing, Crisis, Evidence-based Mental Health Practices, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Peer Support for Mental Health, Personal Care, SED Waiver, Targeted Case Management

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

**Contractor Types:**
-Behavioral Health MCO (Private)

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Adoption Support
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Breast/Cervical Cancer
-Foster Care Children
-Medically Improved
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Presumptive XIX
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Working Disables

**Subpopulations Excluded from Otherwise Included Populations:**
-No State Payment Audit Care Home Resident
-Nursing Facility Head Injury
-Nursing Facility Mental Heatlh
-Nursing Facility Swing Bed
-PACE
-Reside in Nursing Facility or ICF/MR
-State Hospital Developmentally Disabled
-State Hospital Mental Health

**Lock-In Provision:**
Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

**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
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Adult Corrections Systems
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Employment Agencies
-Housing Agencies
-Juvenile Justice Agencies
-Maternal and Child Health Agency
-Mental Health Agency
-Physical Health MCOs and Providers
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Kansas Health Solutions

ValueOptions-Kansas

## ADDITIONAL INFORMATION

The Value Options (Substance Use Disorders PIHP) is connected to the 1915(b) portion and the Kansas Health Solutions (Mental Health PAHP) is connected to the 1915(c) portion of the 1915(b)/(c) Mental Health and Substance Abuse Services program. Both plans include the same number of eligible members.

## Concurrent Operating 1915(c) Program

## CONTACT INFORMATION

**State Medicaid Agency Contact:**

Roxie Namey
Program Integrity Manager
Kansas Health Policy Authority
(785) 296-8906

**State Operating Agency Contact:**

Elizabeth Phelps
Director, Medicaid and Program Oversight
State Medicaid Agency
SRS/Disability and Behavioral Health Services
(785) 296-4552

## PROGRAM DATA

**Program Service Area:**
Statewide

**Initial Waiver Effective Date:**
July 01, 2007

# KANSAS
## Mental Health and Substance Abuse Services

**Statutes Waived:**
1902(a)(10)(B) Comparability of Services
1902(a)(10)(C)(i)(III) Income and Resource Rules

**Waiver Expiration Date:**
June 30, 2011

## Service Delivery

**Target Group:**
Seriously Mentally Ill or Substance Use Disorders
Seriously Emotional Disturbance for Youth

**Level of Care:**
Hospital

## ADDITIONAL INFORMATION

The administration and oversight of both the 1915(b) and 1915(c) program is conducted by the same program unit; the service array and provider/member services activities are conducted by the same PAHP contractor. The 1915(c) program infrastructure was transferred, with very little modification visible to beneficiaries and providers to the PAHP program contractors.

## QUALITY ACTIVITIES FOR PIHP

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PIHP Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

### Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:
-Member Satisfaction Survey
-State-developed Survey

### Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

### 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

**PIHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
-Access to Services
-Adult's access to preventive/ambulatory health services
-Network capacity to serve members
-Ratio of addictions professionals to number of beneficiaries

**Use of Services/Utilization:**
-Over and Under Utilization of intensive services
-Over and Under Utilization of lower levels of care

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
-Annual assessment of provider network
-Geoaccess

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

**Clinical Topics:**
-HEDIS Based Initiation and Engagement

**Non-Clinical Topics:**
-Accuracy of encounter data

## Standards/Accreditation

**PIHP Standards:**
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

-URAC Standards

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Kansas Foundation for Medical Care

**EQRO Organization:**
-Kansas Foundation for Medical Care

**EQRO Mandatory Activities:**
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of Performance Measures
-Validation of state/contractor data systems

**EQRO Optional Activities**
-Validation of encounter data

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Cross-agency MCO Oversight Group
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Fraud and Abuse Monitoring and Collaboration with MFCU
-Georgraphic Mapping
-Monitoring of PAHP Standards
-Network Data
-Ombudsman
-On-Site Reviews
-PAHP Standards (see below for details)
-Performance Measures (see below for details)
-Provider Data
-State Quality Committee
-Utilitzation Review and Corporate Compliance Plan

**Use of Collected Data:**
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
-Consumer/Beneficiary Focus Groups
-Member Satisfaction Survey
-State-developed Survey

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

### Encounter Data

**Collection: Requirements:**
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections - Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

**Validation - Methods:**
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

**PAHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Decreased utilization of institutional care
-Rates of competitive employment for adults
-Rates of school attendance for youth
-Rates of youth residing in permanent family home

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percentage of beneficiaries satisfied with their ability to obtain care

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services
-Ratio of mental health providers to number of beneficiaries

**Use of Services/Utilization:**
-Average number of visits to MH/SUD providers per beneficiary
-Service penetration rates
-Service utilization post-inpatient care

**Health Plan Stability/ Financial/Cost of Care:**
-Business continuity plan
-Corporate Compliance Plan, including Fraud and Abuse
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (ER, pharmacy, lab, x-ray, dental, vision, etc.)
-IBNR claims report (lag report)
-Key Personnel Changes
-Net income
-Net worth
-Subcontractor terms and conditions
-TPL/COB information

**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 PAHPs

**Performance Measures - Others:**
None

## Standards/Accreditation

# KANSAS
## Mental Health and Substance Abuse Services

**PAHP Standards:**
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# MARYLAND
## Living at Home Case Management Waiver

## CONTACT INFORMATION

**State Medicaid Contact:**

Sandra Brownell
DHMH Long Term Care and Waiver Services
(410) 767-5342

**State Website Address:**

http://www.dhmh.state.md.us/

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b)/1915(c)

**Statutes Utilized:**
1915(b)(4)

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
November 01, 2009

**Implementation Date:**
November 01, 2009

**Waiver Expiration Date:**
September 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(23) Freedom of Choice

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Selective Contract - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management

**Allowable PCPs:**
-Case Managers

#### Enrollment

**Populations Voluntarily Enrolled:**
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

The Coordinating Center

## ADDITIONAL INFORMATION

The Department of Health and Mental Hygiene, Office of Health Services has full administrative authority over the Living at Home Waiver program, located within the Living at Home Waiver Division. Historically, the Living at Home Waiver program was responsible for procuring, maintaining, and monitoring contracts for two administrative services available for waiver participants. Fiscal intermediary and case management contractors are selected through a competitive bid process and are available statewide. On October 31, 2009, the contract for case management services ended; the program moved from the administrative case management model to providing administrative, transitional, and ongoing case management as billable services to eligible applicants and participants effective November 1, 2009.

Reimbursement for case management waiver services in the amendment to the 1915(c) Living at Home Waiver (MD 0353) will be based on a rate defined in COMAR. Maryland used a competitive solicitation process to select its case management provider that will be providing case management as an administrative and waiver service.

## Concurrent Operating 1915(c) Program

## CONTACT INFORMATION

**State Medicaid Agency Contact:**


Sandra Brownell
Policy Analyst
DHMH Long Term Care and Waiver Services
(410) 767-5342


**State Operating Agency Contact:**

# MARYLAND
## Living at Home Case Management Waiver

## PROGRAM DATA

**Program Service Area:**
Statewide

**Initial Waiver Effective Date:**
July 01, 2009

**Statutes Waived:**
1902(a)(10)(B) Comparability of Services

**Waiver Expiration Date:**
June 30, 2014

## Service Delivery

**Target Group:**
Disabled

**Level of Care:**
Nursing Home

## ADDITIONAL INFORMATION

Case management is a covered service under the 1915(c) waiver. However, in order to restrict freedom of choice under the 1915(c) waiver, a 1915(b) waiver has to be in place for a selective provider or providers.

The Living at Home Case Management Waiver is a 1915(b)(4) waiver that operates concurrently with the 1915(c) Living at Home Waiver. The Living at Home Case Management Waivers allows MD to selectively contract with a case management contractor to provide case management services to the Living at Home waiver enrollees.

## QUALITY ACTIVITIES FOR OTHER

**Quality Oversight Activities:**
None

**Use of Collected Data:**
None

**Consumer Self-Report Data:**
None

# MICHIGAN
## Specialty Prepaid Inpatient Health Plans

## CONTACT INFORMATION

**State Medicaid Contact:**

Irene Kazieczko
MDCH, Bureau of Community Mental Health Services
(517) 335-0252

**State Website Address:**

http://www.michigan.gov/mdch

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b)/1915(c)

**Statutes Utilized:**
1915(b)(1)
1915(b)(3)
1915(b)(4)

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
June 26, 1998

**Implementation Date:**
October 01, 1998

**Waiver Expiration Date:**
April 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Mental Health (MH) PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Assertive Community Treatment, Assessments, Assistive Technology *, Behavior Management Review, Child Therapy, Clubhouse, Community Living Supports *, Crisis Interventions, Crisis Residential, Enhanced Pharmacy *, Environmental Modifications *, Extended Observation Beds *, Family Support and Training *, Health, Home-based, Housing Assistance *, ICF/MR, Inpatient Psychiatric, Intensive Crisis Stabilization, Medication admin/review, MH Therapies, Nursing Facility Monitoring, Occupational, Physical and Speech Therapies, Outpatient Partial Hospitalization, Peer-delivered Support *, Personal care in specialized residential, Prevention-Direct Models *, Respite Care *, Skill-building Assistance *, Substance Abuse, Support and Service Coordination *, Supported Employment *, Targetted Case Management, Transportation, Treatment Planning, Wrap-around for Children and Adolescents *

**Allowable PCPs:**
-Addictionologists
-Clinical Social Workers
-Other Specialists Approved on a Case-by-Case Basis
-Psychiatrists
-Psychologists

# MICHIGAN
## Specialty Prepaid Inpatient Health Plans

**Contractor Types:**
-County Community Mental Health Services

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Children Enrolled in Childrens Waiver (Section 1915(c))
-Medicare Dual Eligibles
-Residing in ICF/MR

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
-Agents when used for anorexia, weight loss, weight gain

## 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
-Department of Corrections
-Education Agency
-Housing Agencies
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Specialty Employment Agency (Supported Employment)
-Substance Abuse Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Alliance of Michigan
CMH for Central Michigan
CMH Affiliation of Mid-Michigan
CMH Partnership of Southeast Michigan

# MICHIGAN
## Specialty Prepaid Inpatient Health Plans

Detroit-Wayne County CMH Agency
Genesee County CMH Services
Lakeshore Behavioral Health Alliance
LifeWays
Macomb County CMH Services
Network 180
Northcare
Northern Affiliation
Northwest CMH Affiliation
Oakland County CMH Authority
Saginaw County CMH Authority
Southwest Michigan Urban & Rural Consortium
Thumb Alliance PIHP
Venture Behavioral Health

## ADDITIONAL INFORMATION

Michigan remains one of the very few, if not the only, state to have incorporated services to persons with Developmental Disabilities into a 1915(b) Freedom of Choice "managed care" waiver. Also, all persons adjudicated Medicaid eligible are deemed enrolled in this Specialty Community Mental Health Services and Supports managed care program. Included services are offered under the authority of 1915(b)(3). Included services with an "asterisk" next to it are state plan services.

## Concurrent Operating 1915(c) Program

## CONTACT INFORMATION

**State Medicaid Agency Contact:**

Irene Kazieczko
Director
MDCH, Bureau of Community Mental Health Services
(517) 335-0252

**State Operating Agency Contact:**

Debra Ziegler
HSW Specialist
Bureau of Community Health Services
Michigan Department of Community Health
(517) 373-5322

## PROGRAM DATA

**Program Service Area:**
Statewide

**Initial Waiver Effective Date:**
December 12, 2002

**Statutes Waived:**
1902(a)(10)(B) Comparability of Services

**Waiver Expiration Date:**
September 30, 2015

## Service Delivery

**Target Group:**
Developmental Disabled

**Level of Care:**
ICFMR

## ADDITIONAL INFORMATION

Under the Michigan Managed Specialty Support and Services Program, PIHPs administer state plans, 1915(b)(3) and 1915(c) waiver services. This managed mental health services program provides support and services to person with serious mental illness,

developmental disability and substance use disorders, and children with serious emotional disturbance. Persons served through the 1915(b) waiver use a combination of state plan and 1915 (b)(3) services. Persons enrolled in the C waiver, called the Habilitation Supports Waiver (HSW) use a combination of C waiver services, state plan and 1915 (b)(3) service.

## QUALITY ACTIVITIES FOR PIHP

### State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-External Quality Review
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)

### Use of Collected Data:

-Actuarial analysis
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:

-MHSIP Consumer Survey

### Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

## Encounter Data

### Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of electronic file formats
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

### Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

### PIHP conducts data accuracy check(s) on specified data elements:

None
-Provider ID
-Type of Service
-Medicaid Eligibility
-Diagnosis Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Age
-Gender
-Race/Ethnicity
-Social Security

### State conducts general data completeness assessments:

Yes

# MICHIGAN
## Specialty Prepaid Inpatient Health Plans

### Performance Measures

**Process Quality:**
-Follow-up after hospitalization for mental illness

**Health Status/Outcomes Quality:**
-Patient satisfaction with care
-Percent readmitted to inpatient care within 30 days of discharge
-Rates of rights complaints/1000 served
-Rates of sentinel events/1000 served

**Access/Availability of Care:**
-Penetration rates for special populations
-Timelines and screening for inpatient
-Wait time for commencement of service(s)
-Wait time for first appointment with PCP

**Use of Services/Utilization:**
None

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

### Performance Improvement Projects

**Project Requirements:**
-PIHPs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
None

**Non-Clinical Topics:**
-Each PIHP performs two PIP within the 2-year cycle

### Standards/Accreditation

**PIHP Standards:**
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

**Accreditation Required for Participation:**
-CARF
-COA
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-The Council

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Health Service Advisory Group, Phoenix, AZ

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities**
-None

# MINNESOTA
## Minnesota Senior Care/Minnesota Senior Care Plus

## CONTACT INFORMATION

**State Medicaid Contact:**

Brian Osberg
Minnesota Department of Human Services
(651) 431-2189

**State Website Address:**

http://www.dhs.state.mn.us

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(b)/1915(c)

**Statutes Utilized:**
1915(b)(1)

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
March 21, 2005

**Implementation Date:**
June 01, 2005

**Waiver Expiration Date:**
June 30, 2011

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Community Based, Dental, Disease Management, Durable Medical Equipment, Emergency Room, ESRD, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter Service, Laboratory, Medication Therapy Management, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care Assistant, Pharmacy, Physical Therapy, Physician, Podiatry, Preventive Visite, Prosthetic and Orthotic Devices, Public Health, Reconstructive Surgery, Respiratory Therapy, Skilled Nursing Facility, Speech Therapy, Transplants, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Not Applicable. Contractors Not Required to Identify PCPs

# MINNESOTA
## Minnesota Senior Care/Minnesota Senior Care Plus

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles
-Populations Aged 65+

**Subpopulations Excluded from Otherwise Included Populations:**
-CHIP Title XXI Children
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Poverty Level Pregnant Woman
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
SLMB, QI, and QDWI
QMB

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Itasca Medical Care
Metropolitan Health Plan
South Country Health Alliance
Health Partners
Medica
PrimeWest Health System
UCARE

## ADDITIONAL INFORMATION

# MINNESOTA
## Minnesota Senior Care/Minnesota Senior Care Plus

None

## Concurrent Operating 1915(c) Program

## CONTACT INFORMATION

**State Medicaid Agency Contact:**

Ann Berg
Deputy Medicaid Director
Minnesota Department of Human Services
(651) 431-2183

**State Operating Agency Contact:**

Brian Osberg
Medicaid Director

Minnesota Department of Human Services
(651) 431-2193

## PROGRAM DATA

**Program Service Area:**
County

**Initial Waiver Effective Date:**
April 01, 2005

**Statutes Waived:**
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

**Waiver Expiration Date:**
June 30, 2013

## Service Delivery

**Target Group:**
Aged

**Level of Care:**
Nursing Home

## ADDITIONAL INFORMATION

1915(c) services must be part of the MCOs provider network. The 1915(c) Elderly Waiver services are included in MCO contracts in some counties. In the remaining counties, person eligible for EW services receive them through their county or tribe.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**

-Annual HCBS quality assurance plan
-Care plan audits
-Care system reviews
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-HCBS self-assessment QA survey
-MCO Standards (see below for details)

**Use of Collected Data:**

-Assess program results
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
-Disenrollment Survey

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

### Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Payment

### State conducts general data completeness assessments:
No

## Performance Measures

### Process Quality:
-Adult preventive visits
-Antidepressant medication management
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Chlamdyia screening in women
-Colorectal Cancer Screening
-COPD-spirometry testing
-Dental services
-Diabetes screening
-Number of Mental Health Inpatient Discharges
-Osteoporosis care after fracture
-Percentage of beneficiaries with at least one dental visit

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

# MINNESOTA
## Minnesota Senior Care/Minnesota Senior Care Plus

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services
-Average distance to PCP

**Use of Services/Utilization:**
-CD initiating and treatment
-Mental health discharges
-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

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-MCOs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
-Aspirin therapy
-Asthma management
-Asthma-reduction of emergency department visits
-Breast cancer screening (Mammography)
-Calcium/Vitamin D
-Cholesterol screening and management
-Colon cancer screening
-Depression management
-Diabetes management
-Diabetic statin use, 40 to 75 year olds
-Human Papillimavirus
-Hypertension management
-Mental health/chemical dependency dual diagnoses
-Obesity
-Pneumococcal vaccine

**Non-Clinical Topics:**
-Adults access to preventive/ambulatory health services

## Standards/Accreditation

**MCO Standards:**
-NCQA (National Committee for Quality Assurance) Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
-NCQA (National Committee for Quality Assurance)

**EQRO Name:**
-MetaStar
-Michigan Performance Reiview Organization

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance measures

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid has collaborated with a public sector entity to support the P4P program

# MINNESOTA
## Minnesota Senior Care/Minnesota Senior Care Plus

**Population Categories Included:**
A subset of MCO members, defined by disease and medical condition

**Clinical Conditions:**
Dental

**Initial Year of Reward:**
1999

**Member Incentives:**
Not Applicable

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Measurement of Improved Performance:**
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Evaluation Component:**
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

# NEW MEXICO
## Coordination of Long-Term Services

## CONTACT INFORMATION

**State Medicaid Contact:**

Paula McGee
NM HSD/Medical Assistance Division
(505) 827-6234

**State Website Address:**

http://www.hsd.state.nm.us/mad/CCoLTSDetail.html

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(b)/1915(c)

**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:**
August 01, 2008

**Implementation Date:**
August 01, 2008

**Waiver Expiration Date:**
July 31, 2010

**Sections of Title XIX Waived:**
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants

#### Enrollment

# NEW MEXICO
## Coordination of Long-Term Services

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman

**Lock-In Provision:**
12 month lock-in

**Medicare Dual Eligibles Included:**
Medicaid Only

**Medicare Dual Eligibles Excluded:**
SLMB, QI, and QDWI
QMB
QMB Plus
SLMB Plus

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Basic Alternative Coverage

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Department of Health
-Indian Health Services
-Mental Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

# NEW MEXICO
## Coordination of Long-Term Services

AMERIGROUP Community Care of New Mexico, Inc. Evercare of New Mexico

## ADDITIONAL INFORMATION

Individuals with Special Health Care Needs (ISHCN) are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition and who require health and related services of a type or amount beyond that required by other individuals. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO/SE can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

## Concurrent Operating 1915(c) Program

## CONTACT INFORMATION

**State Medicaid Agency Contact:**

Paula McGee
Healthcare Operations Manager
HSD Medicaid
(505) 827-6234

**State Operating Agency Contact:**

## PROGRAM DATA

**Program Service Area:**
Statewide

**Initial Waiver Effective Date:**
August 01, 2008

**Statutes Waived:**
1902(a)(10)(B) Comparability of Services

**Waiver Expiration Date:**
July 31, 2010

## Service Delivery

**Target Group:**
Aged
Disabled
Aged and Disabled

**Level of Care:**
Nursing Home

## ADDITIONAL INFORMATION

Coordinated Long-Term Services is a managed care program designed to provide and coordinate services to specific Medicaid recipients. Services include doctor visits, hospital services, home and community-based services and long term care services. The intent of the program is to improve the quality of life for enrollees by offering long-term services to meet the individuals needs, allowing the individual to decide whether to received services in their home, community, or in a nursing or assisted living facility. 1915(b) allows New Mexico to implement the Coordinated Long-Term Services program under a managed care model. 1915(c) Home and Community-Based Waiver allows New Mexico to have long-term care services delivered in community settings, an alternative to providing comprehensive long-term services in institutional settings.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-CAHPS
Adult Medicaid AFDC Questionnaire
Adult with Special Needs Questionnaire
Child Medicaid AFDC Questionnaire
Child with Special Needs Questionnaire

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Medical record validation
-Per member per month analysis and comparisons across MCO

### MCO/HIO 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

-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

## Performance Measures

### Process Quality:
-Asthma care - medication use
-Diabetes medication management
-Influenza vaccination
-Influenza vaccination rate
-Pneumonia vaccination

### Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of home health visits per beneficiary

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

### Health Plan/ Provider Characteristics:
-Board Certification
-Provider turnover

### Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCO

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

### Clinical Topics:
-State allows MCO to self select area of focus.

### Non-Clinical Topics:
-State allows MCO to self select area of focus.

## Standards/Accreditation

### MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-New Mexico Medical Review Association (NMMRA)

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Technical assistance to MCOs to assist them in conducting quality activities

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# NORTH CAROLINA
## Mental Health Developmental Disabilities & Substance Abuse Waiver

## CONTACT INFORMATION

**State Medicaid Contact:**

Judy Walton
Division of Medical Assistance
(919) 855-4265

**State Website Address:**

http://www.ncdhhs.gov/dma

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(b)/1915(c)

**Statutes Utilized:**
1915(b)(3)
1915(b)(4)

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
October 06, 2004

**Implementation Date:**
April 01, 2005

**Waiver Expiration Date:**
March 31, 2013

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### MH/SUD PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Augmentative Communication, Care Giver Training, Case Management, Community Transitions Support, Crisis, Detoxification, Financial Management, Habilitation, Home Modifications, ICF/MR, IMD, Individual Directed Goods and, Individual Training, Inpatient Mental Health, Inpatient Substance Use Disorders, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Opioid Treatment Programs, Outpatient Substance Use Disorders, Personal Assistance, Residential Substance Use Disorders Treatment Programs, Respite, Specialized Consultation, Specialized Equipment and Supplies, Supports Brokerage, Vehicle Adaptations

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-Adoption Assistance
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**
-Family Planning Waiver Participants
-Medicare Dual Eligibles
-Refugees

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
SLMB, QI, and QDWI
QMB

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Developmental Disabilities Agency
-Mental Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Piedmont Cardinal Health Plan

## ADDITIONAL INFORMATION

None

# NORTH CAROLINA
## Mental Health Developmental Disabilities & Substance Abuse Waiver

## Concurrent Operating 1915(c) Program

## CONTACT INFORMATION

**State Medicaid Agency Contact:**

Judy Walton
Program Administrator
Division of Medical Assistance
(919) 855-4265

**State Operating Agency Contact:**

## PROGRAM DATA

**Program Service Area:**
Region

**Initial Waiver Effective Date:**
April 01, 2005

**Statutes Waived:**
1902(a)(10)(B) Comparability of Services
1902(a)(10)(C)(i)(III) Income and Resource Rules
1902(a)(1) Statewideness

**Waiver Expiration Date:**
March 31, 2013

## Service Delivery

**Target Group:**
Disabled
Aged and Disabled
Mentally Retarded
Developmental Disabled
Mentally Retarded and Developmentally Disabled
Seriously Mentally Ill or Substance Use Disorders

**Level of Care:**
Hospital
ICFMR

## ADDITIONAL INFORMATION

The Piedmont Cardinal Health Plan (PCHP), which is a 1915(b) waiver, and the Innovations waiver operate concurrently and are restriced to a five-county area of North Carolina. The PCHP waiver enables the State to mandate beneficiaries into a single Prepaid Inpatient Health Plan (PIHP). The PIHP is the states mental regional health, developmental disabilities, and substance abuse (MH/DD/SA) authority that serves the five county area covered by the waivers. Thus, Innovations home and community based services are administered by the MD/DD/SA authority in a capitated, managed care environment along with Medicaid State Plan mental health and substance abuse services.

## QUALITY ACTIVITIES FOR PIHP

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Monitoring of PIHP Standards
-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

### Use of Collected Data:
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

### Consumer Self-Report Data:
-Plan developed and state approved consumer survey

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Performance Measures

### Process Quality:
-Ambulatory follow up within 7 days after discharge from mental health facility
-Ambulatory follow up within 7 days after discharge from substance abuse facility
-Follow-up after hospitalization for mental illness
-Number of Consumers moved from institutional care to community care
-Readmission rates for mental health
-Readmission rates for substance abuse

### Health Status/Outcomes Quality:
-Patient satisfaction with care

### Access/Availability of Care:
-Call Abandonment
-Call Answer Timeliness
-Initiation and Engagement of Alcohol and other drug dependence treatment
-Out of Network Services
-Service Availability/Accessibility
-Timeliness of initial service delivery

### Use of Services/Utilization:
-Chemical dependency services utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-MH Utilization percentage of members receiving inpatient, day/night, ambulatory and other support services
-Percentage of members receiving inpatient, day/night, ambulatory and support services for chemical dependency
-Utilization management of the provision of high use services

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements

### Health Plan/ Provider Characteristics:
-Network Capacity

### Beneficiary Characteristics:
-Diversity of Medicaid Membership

### Performance Measures - Others:
None

## Performance Improvement Projects

# NORTH CAROLINA
## Mental Health Developmental Disabilities & Substance Abuse Waiver

**Project Requirements:**

-PIHPs are required to conduct a project(s) of their own choosing
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

**Clinical Topics:**

-Prone Restraints as a Restrictive Intervention
-Reduction in Recidivism Rates in State Hospitals

**Non-Clinical Topics:**

-Complaints processing

## Standards/Accreditation

**PIHP Standards:**

-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

**Accreditation Required for Participation:**

None

**Non-Duplication Based on Accreditation:**

None

**EQRO Name:**

-Michigan Peer Review Organization (MPRO)

**EQRO Organization:**

-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**

-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities**

-Technical assistance to PIHPs to assist them in conducting quality activities

# TEXAS
# STAR+PLUS

## CONTACT INFORMATION

**State Medicaid Contact:**

Joe Vesowate
Texas Health and Human Services Commission
(512) 491-1379

**State Website Address:**

http://www.hhsc.state.tx.us/starplus/starplus.html

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(b)/1915(c)

**Statutes Utilized:**
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

**Enrollment Broker:**
Maximus

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
January 30, 1998

**Implementation Date:**
January 01, 1998

**Waiver Expiration Date:**
August 31, 2012

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

# TEXAS
# STAR+PLUS

## Enrollment

**Populations Voluntarily Enrolled:**
-Blind/Disabled Children and Related Populations

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles
-Reside in a Nursing Facility or ISF/MR, Reside in a state school or other 24 hour facility, Participating in a HCBS waiver other than the 1915 (c) Nursing Facility Waiver

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

## Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

# SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Dept. of Aging and Disability Services (DADS)

# PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup (STAR+PLUS)
Molina (STAR+Plus)
Evercare
Superior HealthPlan (STAR+Plus)

# ADDITIONAL INFORMATION

Blind/disabled/aged adults who are SSI or deemed SSI by CMS are mandatory to participate in the MCO model. Blind/disabled children who are SSI or deemed SSI by CMS have the choice of participating in the MCO model or the PCCM model.

# Concurrent Operating 1915(c) Program

# TEXAS
# STAR+PLUS

## CONTACT INFORMATION

**State Medicaid Agency Contact:**

DJ Johnson
STAR+Plus Project Specialist
Health & Human Services Commission
(512) 491-1301

**State Operating Agency Contact:**

## PROGRAM DATA

**Program Service Area:**
County

**Initial Waiver Effective Date:**
February 01, 1998

**Statutes Waived:**
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

**Waiver Expiration Date:**
August 31, 2012

## Service Delivery

**Target Group:**
Aged and Disabled

**Level of Care:**
Nursing Home

## ADDITIONAL INFORMATION

Both b&c waivers are operating through the STAR+PLUS program which integrates acute and long term care services for SSI enrollees in Harris County. In February 2007, the STAR+Plus 1915(b) and 1915(c) waivers expanded to the Harris contiguous, Bexar, Nueces and Travis SDA. In February 2011, the STAR+Plus 1915(b) and 1915(c) waivers will expand to the Dallas and Tarrant SDA.

## QUALITY ACTIVITIES FOR MCO/HIO

### State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO Standards (see below for details)
-On-Site Reviews
-Performance Improvement 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
-Track Health Service provision

### Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
-State-developed Survey

### Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of

the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

### Collections: Submission Specifications:

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, 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:

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

### Validation - Methods:

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills)
-Medical record validation
-Per member per month analysis and comparisons across MCOs

### MCO/HIO conducts data accuracy check(s) on specified data elements:

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Medicaid Eligibility
-Plan Enrollment
-Preparing HEDIS and risk adjustment software

### State conducts general data completeness assessments:

Yes

## Performance Measures

### Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Depression management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries with at least one dental visit

### Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of low birth weight infants

-Pregnancy Prevention
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in adolescents

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to LTSS providers
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

### Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

### Health Plan Stability/ Financial/Cost of Care:
-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
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

### Clinical Topics:
-Diabetes care and management
-Influenza Immunizations

### Non-Clinical Topics:
None

## Standards/Accreditation

### MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-Standards for Medicaid and Medicare
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Institute for Child Health Policy

### EQRO Organization:
-Institute for Child Health Policy, University of Florida

### EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State

-Validation of performance improvement projects

**EQRO Optional Activities:**
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of encounter data
-Validation of performance improvement projects

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# WISCONSIN
## Family Care

## CONTACT INFORMATION

**State Medicaid Contact:**

Charles Jones
Wisconsin Department of Health and Family Services
(608) 266-0991

**State Website Address:**

http://dhs.wisconsin.gov/LTCare/INDEX.HTM

## PROGRAM DATA

**Program Service Area:**
Region by MCO Contract

**Operating Authority:**
1915(b)/1915(c)

**Statutes Utilized:**
1915(b)(2)
1915(b)(4)

**Enrollment Broker:**
Aging and Disability Resource Centers

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
January 01, 2001

**Implementation Date:**
January 01, 2001

**Waiver Expiration Date:**
December 31, 2014

**Sections of Title XIX Waived:**
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Family Care PIHPs - Risk-based Capitation

#### Service Delivery

**Included Services:**
1915(c) Waiver, Case Management, Disposable Medical Supplies, Durable Medical Equipment, Duty Nursing, Home Health, ICF-MR, In-home Psychotherapy, Language Pathology, Mental Health Comminity Support Program, Occupational Therapy, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Physical Therapy, Respiratory Therapy, Skilled Nursing, Skilled Nursing Facility, Speech Therapy, Transportation

**Allowable PCPs:**
-Not applicable, primary care is carved out

#### Enrollment

# WISCONSIN
## Family Care

**Populations Voluntarily Enrolled:**
-Adults with Developmental Disability or Mental Retardation
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Have an Eligibility Period that Is Only Retroactive

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-All Target Groups Are Persons with Special Needs

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Mental Health Agency
-Physicians & Clinics
-Protective Services Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Care Wisconsin First, Inc.
Community Care of Central Wisconsin
Lakeland Care District
Northern Bridges
Western Wisconsin Cares
CHP-LTS, Inc.
Community Care, Inc.
Milwaukee County Department of Family Care
Southwest Family Care Alliance

## ADDITIONAL INFORMATION

None

# WISCONSIN
## Family Care

## Concurrent Operating 1915(c) Program

## CONTACT INFORMATION

**State Medicaid Agency Contact:**

Charles Jones
Family Care Program Manager
WI Department of Health & Social Services
(608) 266-0991

**State Operating Agency Contact:**

## PROGRAM DATA

**Program Service Area:**
Region by PIHP Contract

**Initial Waiver Effective Date:**
January 01, 2001

**Statutes Waived:**
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

**Waiver Expiration Date:**
December 31, 2014

## Service Delivery

**Target Group:**
Aged and Disabled
Mentally Retarded
Developmental Disabled

**Level of Care:**
Nursing Home
ICFMR

## ADDITIONAL INFORMATION

The 1915(b) waiver allows for restriction of freedom of choice of providers under the Family Care risk-based prepaid inpatient health plan contract, which allows Family Care MCOs to deliver through a managed care model. The 1915(c) waiver services and the longterm care Medicaid State Plan services - nursing home and ICF-MR, home health, personal care, therapies, mental health services, AODA services, durable medical equipment, medical supplies and transportation services (except ambulance).

## QUALITY ACTIVITIES FOR PIHP

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Individualized Service Plan Reviews
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation

-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data
-Structured Member Outcome Interviews

**Consumer Self-Report Data:**
-Structured Member Outcome Interviews

**Use of HEDIS:**
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires PIHPs to modify some or all NCQA specifications in ways other than continous enrollment

## Encounter Data

**Collection: Requirements:**
-Certification
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections: Submission Specifications:**
-Certification of Data Submissions
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
None

**Validation - Methods:**
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

**PIHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Procedure Codes
-Revenue Codes

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Member LTC outcomes present
-Support for member LTC outcomes provided

**Health Status/Outcomes Quality:**
-Member health and safety outcomes present
-Support for member health and safety outcomes provided

**Access/Availability of Care:**
-State assessment of adequate network capacity

**Use of Services/Utilization:**
-NF and ICF-MR utilization

**Health Plan Stability/ Financial/Cost of Care:**
-Actual reserves held by plan
-State minimum reserve requirements

**Health Plan/ Provider Characteristics:**
-Board Certification
-State review for cultural competency

# WISCONSIN
## Family Care

**Beneficiary Characteristics:**
-Information of beneficiary ethnicity/race
-PIHP/PCP-specific disenrollment rate

**Performance Measures - Others:**
-Structured Member Outcome Interviews

## Performance Improvement Projects

**Project Requirements:**

-PIHPs are required to conduct a project(s) of their own choosing
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

**Clinical Topics:**

-Dementia Assessment
-Diebetes Disease Management
-Fall Prevention
-Substance Use Disorders treatment after detoxification service

**Non-Clinical Topics:**

Not Applicable - PIHPs are not required to conduct common project(s)

## Standards/Accreditation

**PIHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-MetaStar, Inc.

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Review of PIHP compliance with structural and operational standards established by the State

**EQRO Optional Activities**
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities

# FLORIDA
## Nursing Home Diversion Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Keith Young
Florida Agency for Health Care Administration
(850) 412-4257

**State Website Address:**

http://ahca.myflorida.com

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1915(a)/1915(c)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
December 01, 1998

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
1902(a)(1) Statewideness
1902(a)(10)(b) Comparability of Services

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Long Term Care PIHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Dental, Emergency, Escort, Family Training, Financial Assessment and Risk Reduction, Hearing, Home Health, Hospice, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physicians, Respite Care, Skilled Nursing Facility, Speech Therapy, Vision, X-ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged 65 or older
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

# FLORIDA
## Nursing Home Diversion Program

**Subpopulations Excluded from Otherwise Included Populations:**

-Adults age 64 or younger
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title CHIP XXI

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**

None

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Department of Children and Family Services
-Department of Elder Affairs

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

American Eldercare
Amerigroup (NHD)
Citrus (NHD)
Humana Medical Plan
Humana Senior's Choice
Life Hope Care
Little Havana Activities and Nutrition Centers
Neighborly Care Network
Project Independence at Home
Sunrise Home Health
United Health Care (NHD)
United Home Care Services
Universal Health Care (NHD)
Urban Jacksonville
Vista Independence Plan
World Net, Inc.
YourCare Brevard

## ADDITIONAL INFORMATION

None

## Concurrent Operating 1915(c) Program

# FLORIDA
## Nursing Home Diversion Program

## CONTACT INFORMATION

**State Medicaid Agency Contact:**

Keith Young
Medical/Health Care Program Analyst
Agency for HealthCare Administration
(850) 412-4257

**State Operating Agency Contact:**

Not Applicable

## PROGRAM DATA

**Program Service Area:**
Statewide

**Initial Waiver Effective Date:**
July 01, 1998

**Waiver Expiration Date:**
September 28, 2011

## Service Delivery

**Target Group:**
65 or older
Medicare Dual Eligibles

**Level of Care:**
Nursing Home

## ADDITIONAL INFORMATION

The 1915 (a) authority permits managed care organizations to offer home and community care services to program recipients through their provider networks. The Nursing Home Diversion waiver coordinates acute and long-term care services for dual eligible beneficiaries through managed care organizations under the 1915(a) waiver authority. Under the 1915(c) authority, the waiver provides home and community-based services to recipients in order to prevent or delay nursing home placement.

## QUALITY ACTIVITIES FOR PIHP

### State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Focused Studies
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

### Use of Collected Data:

-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation

### Consumer Self-Report Data:

None

### Use of HEDIS:

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

# FLORIDA
## Nursing Home Diversion Program

### Encounter Data

**Collection: Requirements:**
-Requirements for data validation
-Requirements for PIHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections: Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for initial encounter data submission

**Collection: Standardized Forms:**
None

**Validation - Methods:**
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

**PIHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure

**State conducts general data completeness assessments:**
Yes

### Performance Measures

**Process Quality:**
-Controlling high blood pressure
-Diabetes medication management
-Influenza vaccination rate
-Pneumonia vaccination

**Health Status/Outcomes Quality:**
-Patient satisfaction with care

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
None

**Health Plan Stability/ Financial/Cost of Care:**
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

**Health Plan/ Provider Characteristics:**
-Languages Spoken (other than English)
-Verify Provider compliance with State surplus account and reserve requirements

**Beneficiary Characteristics:**
-Information on primary languages spoken by beneficiaries
-PIHP/PCP-specific disenrollment rate

**Performance Measures - Others:**
-Contractual Compliance

### Performance Improvement Projects

# FLORIDA
## Nursing Home Diversion Program

### Project Requirements:
-PIHPs are required to conduct a project(s) of their own choosing
-Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

### Clinical Topics:
None

### Non-Clinical Topics:
-Availability of language interpretation services

## Standards/Accreditation

### PIHP Standards:
None

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
-Health Services Advisory Group (HSAG)

### EQRO Organization:
-Health Services Advisory Group (HSAG)

### EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

### EQRO Optional Activities
-Assessment of MCO Organizations

# MASSACHUSETTS
# Senior Care Options (SCO)

## CONTACT INFORMATION

**State Medicaid Contact:**

Rachel Richards
Office of Medicaid
(617) 222-7508

**State Website Address:**

http://www.mass.gov/masshealth

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1915(a)/1915(c)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
January 01, 2004

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
1902(a)(1) Statewideness
1902(a)(10)(b) Comparability of Services

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Adult Day Health, All Medicare and Medicaid Covered, Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-General Practitioners
-Geriatricians
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations

**Populations Mandatorily Enrolled:**
None

-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

**Subpopulations Excluded from Otherwise Included Populations:**

-A Medicare dual eligible who is excluded would be buy in only.
-Diagnosed with End Stage Renal Disease (ESRD)
-Enrolled in Another Managed Care Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Reside in ICF/MR
-Special Needs Children (BBA defined)
-Under 65 years old

**Lock-In Provision:**

1 month lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

SLMB, QI, and QDWI
A member must have full MassHealth benefits in order to enroll. All buy in only categories are excluded

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Developmental Disabilities Agency
-Housing Agencies
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Commonwealth Care Alliance
NaviCare
Evercare SCO
Senior Whole Health

# MASSACHUSETTS
## Senior Care Options (SCO)

## ADDITIONAL INFORMATION

All four of the Senior Care Organizations are also Medicare Advantage Special Needs Plans, serving MassHealth Standard members aged 65 or older. If an enrollee has Medicare A and B (in addition to MassHealth Standard), that enrollee must be enrolled in the SNP and the SCO. Enrollment is voluntary. There are no carve out or wrap services.

## Concurrent Operating 1915(c) Program

## CONTACT INFORMATION

**State Medicaid Agency Contact:**

Rachel Richards
Director, Office of Long Term Care
Office of Medicaid
(617) 222-7508

**State Operating Agency Contact:**

Not Applicable

## PROGRAM DATA

**Program Service Area:**
County

**Initial Waiver Effective Date:**
January 01, 2004

**Waiver Expiration Date:**
June 30, 2011

## Service Delivery

**Target Group:**
Aged
Disabled individuals age 65 and older
Mentally Retarded age 65 and older
Developmental Disabled age 65 and older
Seriously Mentally Ill age 65 and older
Serious Emotional Disturbance age 65 and older

**Level of Care:**
Nursing Home
Hospital
ICFMR
PRTF

## ADDITIONAL INFORMATION

The commonwealth offers a variety of services to consumers under a home and community-based services waiver program and the number of services that can be provided is not limited. These programs may provide a combination of both traditional medical services (i.e. dental services, skilled nursing) as well as non-medical services (i.e. respite, case management, environmental modifications).

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**
-Focused Studies

**Use of Collected Data:**
-Contract Standard Compliance

-MCO Standards (see below for details)
-Monitoring of MCO Standards
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:
None

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Performance Measures

### Process Quality:
-Ace Inhibitor/ARB Therapy
-Antidepressant medication management
-Beta-blocker treatment after heart attack
-Diabetes medication management
-Heart Failure care
-Influenza vaccination rate
-Pneumonia vaccination

### Health Status/Outcomes Quality:
-Mortality rates
-Patient satisfaction with care

### Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP

### Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-MH/SUD facility
-Number of days in ICF or SNF per beneficiary over 64 years
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

### Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

### Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

### Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate

### Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
-MCOs are required to conduct a project(s) of their own choosing

### Clinical Topics:
-Adult hearing and vision screening
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Breast cancer treatment
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment

-Cholesterol screening and management
-Coordination of care for persons with physical disabilities
-Coronary artery disease prevention
-Coronary artery disease treatment
-Depression management
-Diabetes management
-Domestic violence
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment
-Hepatitis B screening and treatment
-Hip fractures
-HIV Status/Screening
-HIV/AIDS Prevention and/or Management
-Hospital Discharge Planning
-Hypertension management
-Hysterectomy
-Medical problems of the frail elderly
-Motor vehicle accidents
-Otitis Media management
-Pharmacy management
-Prescription drug abuse
-Prevention of Influenza
-Sexually transmitted disease screening
-Sexually transmitted disease treatment
-Sickle cell anemia management
-Smoking prevention and cessation
-Substance Use Disorders treatment after detoxification service
-Treatment of myocardial infraction
-Tuberculosis screening and treatment

**Non-Clinical Topics:**

None

## Standards/Accreditation

**MCO Standards:**

-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

**Accreditation Required for Participation:**

None

**Non-Duplication Based on Accreditation:**

None

**EQRO Name:**

-APS Healthcare

**EQRO Organization:**

-QIO-like entity

**EQRO Mandatory Activities:**

-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects

**EQRO Optional Activities:**

-Administration or validation of consumer or provider surveys
-Assessment of MCO information systems
-Calculation of performance measures

## Pay for Performance (P4P)

**Implementation of P4P:**

The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**

Not Applicable

**Population Categories Included:**

Not Applicable

**Rewards Model:**

Not Applicable

# MASSACHUSETTS
## Senior Care Options (SCO)

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# WISCONSIN
## Wisconsin Partnership Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Charles Jones
DHS/DLTC/OFCE/MCS
(608) 266-0991

**State Website Address:**

http://dhs.wisconsin.gov/wipartnership

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1932(a)/1915(c)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
Yes

**Guaranteed Eligibility:**
No guaranteed eligibility

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
January 01, 1999

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
1902(a)(1) Statewideness
1902(a)(10)(b) Comparability of Services

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### MCO (Comprehensive Benefits) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Clinic, Dental, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Internists

#### Enrollment

**Populations Voluntarily Enrolled:**
-Adults with Developmental Disability or Mental Retardation
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

# WISCONSIN
## Wisconsin Partnership Program

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles - Have an eligibility period there is only retroactive.

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-None - managed care entity provides standard prescription drug coverage

## 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 groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Mental Health Agency
-Protective Services Agency
-Social Services Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Care Wisconsin Health Plan, Inc. (Partnership)
Independent Care Health Plan (SNP)
Community Care Health Plan, Inc.
Partnership Health Plan, Inc.

## ADDITIONAL INFORMATION

The Wisconsin Partnership Program began operating under a dual Medicaid--Medicare waiver in January 1999. This program provides comprehensive Medicaid and Medicare services for older adults (ages 65+) and people with disabilities (ages 18-64). The Partnership Program integrates health and long-term support services and includes home- and community-based care, physician services, and all other medical care. Services are delivered in the participants home or a setting of his or her choice. Team-based care management is a key component of the program. Enrollees must meet nursing home level-of-care to state, enrollees must meet either a nursing home or an ICF/MR level of care. The Partnership Program goals are to: improve quality of health care and service delivery while containing costs; reduce fragmentation and inefficiency in the existing health care delivery system; increase the ability of people to live in the community and participate in decisions regarding their own health care. Other special characteristics: same goals as PACE Program; nurse practitioners play a key role in linking services; recipients can bring their own provider as PCP; external committee evaluation

data techniques.

## Concurrent Operating 1915(c) Program

## CONTACT INFORMATION

**State Medicaid Agency Contact:**

Charles Jones
Program Manager
DHS/DLTC/OFCE/MCS
(608) 266-0991

**State Operating Agency Contact:**

Not Applicable

## PROGRAM DATA

**Program Service Area:**
Region by MCO Contract

**Initial Waiver Effective Date:**
January 01, 2001

**Waiver Expiration Date:**
December 31, 2010

## Service Delivery

**Target Group:**
Aged and Disabled
Mentally Retarded and Developmentally Disabled

**Level of Care:**
Nursing Home
ICFMR

## ADDITIONAL INFORMATION

The 1932(a) program incorporates all state plan services including the services available under the 1915(c) waiver program.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**
-Encounter Data (see below for details)
-Monitoring of MCO Standards
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance
-Monitor Quality Improvement

**Consumer Self-Report Data:**
-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 modifies/requires MCOs to modify some or all NCQA

specifications in ways other than continous enrollment

## Encounter Data

### Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

### Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

### Validation - Methods:
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
None

### Health Status/Outcomes Quality:
-Patient satisfaction with care

### Access/Availability of Care:
None

### Use of Services/Utilization:
-Emergency room visits/1,000 beneficiary
-Number of hospital admissions per member per year
-Number of hospital days per member per year
-Percentage of beneficiaries with at least one dental visit
-Percentage of people living at home, CBRF/group home, nursing home

# WISCONSIN
## Wisconsin Partnership Program

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
-Board Certification

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**
-MCOs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
-Breast cancer screening (Mammography)
-Diabetes management
-Emergency Room service utilization
-Medical problems of the frail elderly

**Non-Clinical Topics:**
-Personal Living Assistant Scheduling Management

## Standards/Accreditation

**MCO Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-MetaStar

**EQRO Organization:**
-Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
-Calculation of performance measures

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# DISTRICT OF COLUMBIA
## Non-Emergency Medical Transportation Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Colleen Sonosky
Department of Health Care Finance
(202) 442-5913

**State Website Address:**

http://www.mtm.inc.net

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1902(a)(70)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
October 19, 2008

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Transportation PAHP - Non-risk Capitation

#### Service Delivery

**Included Services:**
Non-Emergency Transportation

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

# DISTRICT OF COLUMBIA
## Non-Emergency Medical Transportation Program

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Uses enrollment forms to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Developmental Disabilities Agency
-Mental Health Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medical Transportation Management

## ADDITIONAL INFORMATION

This program serves the FFS population only.

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Network Data
-Ombudsman
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

**Use of Collected Data:**
-Program Evaluation
-Program Modification, Expansion, or Renewal

**Consumer Self-Report Data:**
-State-developed Survey

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures

# DISTRICT OF COLUMBIA
## Non-Emergency Medical Transportation Program

### Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
-Transportation to PCP

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

### Performance Improvement Projects

**Project Requirements:**
-Individual PAHPs are required to conduct a project prescribed by the State Medicaid agency

**Clinical Topics:**
None

**Non-Clinical Topics:**
-Transportation service to PCP

### Standards/Accreditation

**PAHP Standards:**
None

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# GEORGIA
## Non-Emergency Transportation Brokerage Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Barbara Lowe
GA Department of Community Health
(404) 656-4451

**State Website Address:**

http://www.dch.ga.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1902(a)(70)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
January 01, 2007

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Transportation PAHP - Risk-based 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:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

# GEORGIA
## Non-Emergency Transportation Brokerage Program

**Subpopulations Excluded from Otherwise Included Populations:**
-Emergency Medical Assistance Members
-Medicare Dual Eligibles
-Title XXI CHIP (PeachCare)

**Lock-In Provision:**
Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation Brokerage

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Encounter Data (see below for details)
-Enrollee Hotlines
-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

**Use of Collected Data:**
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the

HEDIS measure listed for Medicaid

## Encounter Data

**Collection: Requirements:**
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections - Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
None

**Validation - Methods:**
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

**PAHP conducts data accuracy check(s) on specified data elements:**
None

**State conducts general data completeness assessments:**
No

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
-Provider Network must have sufficent providers to cover regional service area

**Use of Services/Utilization:**
-Collect the total number of medical related or necessary encounters

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Standards/Accreditation

**PAHP Standards:**
None

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# KANSAS
# Non-Emergency Medical Transportation (NEMT)

## CONTACT INFORMATION

**State Medicaid Contact:**

Tracy Conklin
Kansas Health Policy Authority
(785) 296-7788

**State Website Address:**

http://www.khpa.ks.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1902(a)(70)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
November 01, 2009

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Transportation PAHP - Risk-based 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:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-American Indian/Alaskan Native
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Developmental Disabilities Agency
-Mental Health Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medical Transportation Management Inc. (MTM)

## ADDITIONAL INFORMATION

The Broker handles scheduling of NEMT transportation statewide and authorizes the least expensive and most appropriate ancillary services based on confirmed eligibility. The Broker enlists a network of transportation providers acorss the state to provide service utilizing sedan, lift van, and public transportation when appropriate. The Broker has internal controls, policies and procedures in place to prevent, detect, and review and report to the Medicaid state agency instances of suspected fraud and abuse by providers, subcontractors and recipients.

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)

**Use of Collected Data:**
-Beneficiary Plan Selection

-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Network Data
-On-Site Reviews
-PAHP Standards (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

**Consumer Self-Report Data:**
-State-developed Survey

-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

## Encounter Data

**Collection: Requirements:**
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections - Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
-Not Applicable

**Validation - Methods:**
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

**PAHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes

**State conducts general data completeness assessments:**
Yes

## Performance Measures

**Process Quality:**
-Not Applicable

**Health Status/Outcomes Quality:**
-Not Applicable

**Access/Availability of Care:**
-Adult's access to preventive/ambulatory health services

**Use of Services/Utilization:**
-Not Applicable

**Health Plan Stability/ Financial/Cost of Care:**
-Total revenue

**Health Plan/ Provider Characteristics:**
-Board Certification
-Languages Spoken (other than English)

**Beneficiary Characteristics:**
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

**Performance Measures - Others:**
None

-Percentage of beneficiaries who are auto-assigned to PAHPs

## Performance Improvement Projects

**Project Requirements:**

-PAHPs are required to conduct a project(s) of their own choosing

**Clinical Topics:**

None

**Non-Clinical Topics:**

-Adults access to preventive/ambulatory health services

## Standards/Accreditation

**PAHP Standards:**

-State-Developed/Specified Standards

**Accreditation Required for Participation:**

None

**Non-Duplication Based on Accreditation:**

None

# KENTUCKY
## Human Service Transportation

## CONTACT INFORMATION

**State Medicaid Contact:**

Kerry Conlee
Division of Provider Operations
(502) 564-6890

**State Website Address:**

http://www.chfs.ky.gov/dms

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1902(a)(70)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
June 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

### Transportation PAHP - Risk-based 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:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

# KENTUCKY
## Human Service Transportation

**Subpopulations Excluded from Otherwise Included Populations:**
-CHIP Above 150%
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only
SLMB, QI, and QDWI

**Medicare Dual Eligibles Excluded:**
QMB

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Human Service Transportation

## ADDITIONAL INFORMATION

TITLE XXI CHIP is included up to 150% of FPL

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines

**Use of Collected Data:**
-Contract Standard Compliance
-Fraud and Abuse
-Track Health Service provision

-Ombudsman

-Utilization Review

### Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

### Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

## Encounter Data

### Collection: Requirements:
-State DID NOT provide any requirements for encounter data collection

### 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 PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-Comparison to plan claims payment data
-Per member per month analysis and comparisons across PAHPs

### PAHP conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

### State conducts general data completeness assessments:
Yes

## Standards/Accreditation

### PAHP Standards:
None

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

# MISSISSIPPI
## Non-Emergency Transportation Broker Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Alicia Crowder
Division of Medicaid
(601) 359-5243

**State Website Address:**

http://www.medicaid.ms.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1902(a)(70)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
November 01, 2006

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Transportation PAHP - Risk-based 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:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LogistiCare Solutions, LLC

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-On-Site Reviews

**Use of Collected Data:**
-Contract Standard Compliance
-Fraud and Abuse
-Program Evaluation
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
-Broker-developed Survey approved by State

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures

# MISSISSIPPI
## Non-Emergency Transportation Broker Program

### Encounter Data

**Collection: Requirements:**
-Requirements for PAHPs to collect and maintain encounter data

**Collections - Submission Specifications:**
None

**Collection: Standardized Forms:**
None

**Validation - Methods:**
-Per member per month analysis and comparisons across PAHPs

**PAHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment

**State conducts general data completeness assessments:**
Yes

### Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# MISSOURI
## Non-Emergency Medical Transportation Program (NEMT)

## CONTACT INFORMATION

**State Medicaid Contact:**

Theresa Valdes
Department of Social Services, MO HealthNet Division
(573) 526-4274

**State Website Address:**

http://www.dss.mo.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1902(a)(70)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
October 01, 2006

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Transportation PAHP - Risk-based 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:**
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

# MISSOURI
## Non-Emergency Medical Transportation Program (NEMT)

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participants enrolled in the Hospice Program
-Participants in HCBS Waiver
-Participants who have access to transportation at no cost to the participant
-Participants who have access to transportation through a public entity

**Lock-In Provision:**

Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LogistiCare Solutions, LLC

## ADDITIONAL INFORMATION

Statewide broker services are provided through the Medicaid State Plan.

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**

-Encounter Data (see below for details)
-Provider Data

**Use of Collected Data:**

-Contract Standard Compliance
-Program Evaluation

# MISSOURI
## Non-Emergency Medical Transportation Program (NEMT)

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures

## Encounter Data

**Collection: Requirements:**
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections - Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

**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

**PAHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Procedure Codes
-Amount Paid
-Capitation Indicator
-Charges
-Place of Service
-Statement from Date
-Statement through Date
-Units of Service

**State conducts general data completeness assessments:**
Yes

## Standards/Accreditation

**PAHP Standards:**
None

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# NEVADA
# Mandatory Non-Emergency Transportation Broker Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Greg W. Tanner
Division of Health Care Financing and Policy, Managed Care
(775) 684-3708

**State Website Address:**

http://www.nv.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1902(a)(70)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 01, 2006

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Transportation PAHP - Risk-based 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:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles

**Lock-In Provision:**
Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Uses provider referrals 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

Logisticare

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Encounter Data (see below for details)
-Monitoring of PAHP Standards
-PAHP Standards (see below for details)
-Provider Data

**Use of Collected Data:**
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

## Encounter Data

**Collection: Requirements:**
-Requirements for PAHPs to collect and maintain encounter data

**Collections - Submission Specifications:**
None

**Collection: Standardized Forms:**
None

**Validation - Methods:**
-Historical Analysis

**PAHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility

**State conducts general data completeness assessments:**
Yes

## Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# NEW JERSEY
## Non-Emergency Transportation Broker Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Richard Hurd
Office of Managed Health Care
(609) 588-2550

**State Website Address:**

http://www.state.nj.us/humanservices/dmahs/index.html

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1902(a)(70)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
July 01, 2009

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Transportation PAHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Non-Emergency Transportation

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP

**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

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LogistiCare

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Monitoring of PAHP Standards

**Use of Collected Data:**
-Plan Reimbursement
-Program Evaluation

**Consumer Self-Report Data:**
-State-developed Survey

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures

### Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# OKLAHOMA
## SoonerRide

## CONTACT INFORMATION

**State Medicaid Contact:**

Rebecca Pasternik-Ikard
Oklahoma Health Care Authority
(405) 522-7300

**State Website Address:**

http://www.okhca.org

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1902(a)(70)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
June 01, 2009

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Transportation PAHP - Risk-based 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:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles
-Participate in HCBS Waiver

**Lock-In Provision:**
Does not apply because State only contracts with one managed care entity

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Employment Agencies
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

SoonerRide

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PAHP

# OKLAHOMA
## SoonerRide

### State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-On-Site Reviews
-Provider Data

### Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal

### Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire
  Child with Special Needs Questionnaire
-Consumer Oriented Mental Health Report Card
-Disenrollment Survey

### Use of HEDIS:
-The State DOES NOT use any of the HEDIS measures

## Standards/Accreditation

### PAHP Standards:
-State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

# PENNSYLVANIA
## Medical Assistance Transportation Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Tyrone Williams
Managed Care Operations
(717) 772-6300

**State Website Address:**

http://www.state.pa.us

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1902(a)(70)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
November 01, 2005

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Transportation PAHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Non-Emergency Transportation

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Populations Mandatorily Enrolled:**
None

# PENNSYLVANIA
## Medical Assistance Transportation Program

**Subpopulations Excluded from Otherwise Included Populations:**
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-DOES NOT coordinate with any other Agency

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Logisticare Solutions, LLC

## ADDITIONAL INFORMATION

The Medical Assistance Transportation Program only provides non-emergency transportation to medical assistance consumers.

Special Needs Children: (state defined) Broadly defined non-categorical to include all children. Skilled Nursing Facility is provided for the first 30 days. Transportation services only includes emergency ambulance services.

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-On-Site Reviews
-Performance Measures (see below for details)
-Trip Summary Detail File

**Use of Collected Data:**
-Contract Standard Compliance
-Monitor Quality Improvement

**Consumer Self-Report Data:**
-Third Party Phone Survey

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures

## Performance Measures

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
None

**Use of Services/Utilization:**
None

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
-Call Center Performance Measures
-Compliant Standards
-Timeliness of Trips

## Standards/Accreditation

**PAHP Standards:**
None

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# SOUTH CAROLINA
## Non-Emergency Transportation Program

## CONTACT INFORMATION

**State Medicaid Contact:**

Sheila Platts
Division of Medical Support Services
(803) 898-2655

**State Website Address:**

http://www.scdhhs.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1902(a)(70)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Logisticare
MTM

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
May 01, 2007

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Transportation PAHP - Risk-based 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:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)

-Special Needs Children (State defined)
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Healthy Connections Kids (HCK) - standalone Title XXI CHIP

**Lock-In Provision:**
Does not apply

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Family Connections
-Mental Health Agency
-Palmetto Project
-Social Services Agencies

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Logisticare

Medical Transportation Management (MTM)

## ADDITIONAL INFORMATION

The state contracts with two transportation brokers. The Transportation brokerage services is divided into six regions: Logisticare covers 2/3 of the state and MTM covers 1/3 of the state.

Children with special health care needs are those who have a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

## QUALITY ACTIVITIES FOR PAHP

# SOUTH CAROLINA
## Non-Emergency Transportation Program

**State Quality Assessment and Improvement Activities:**
-Advisory Committee
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-On-Site Reviews
-Performance Measures (see below for details)

**Use of Collected Data:**
-Track Health Service provision

**Consumer Self-Report Data:**
-State-developed Survey

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

## Encounter Data

**Collection: Requirements:**
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections - Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing

**Collection: Standardized Forms:**
None

**Validation - Methods:**
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

**PAHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Processing
-Date of Payment
-Type of Service
-Medicaid Eligibility

**State conducts general data completeness assessments:**
Yes

## 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

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Standards/Accreditation

# SOUTH CAROLINA
## Non-Emergency Transportation Program

**PAHP Standards:**
None

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# VIRGINIA
## Virginia Non-Emergency Transportation Services

## CONTACT INFORMATION

**State Medicaid Contact:**

Robert Knox
Department of Medical Assistance Services
(804) 371-8854

**State Website Address:**

http://www.dmas.virginia.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1902(a)(70)

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 01, 2007

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Transportation PAHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Non-Emergency Transportation

**Allowable PCPs:**
-Not applicable

#### Enrollment

**Populations Voluntarily Enrolled:**
-Foster Care Children
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Home and Community Based Waivers
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Enrolled in a Managed Care Program
-Medicare Dual Eligibles

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Not applicable

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Not applicable

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LogistiCare Solutions

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-None

**Use of Collected Data:**
-Not Applicable

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures

# VIRGINIA
## Virginia Non-Emergency Transportation Services

### Standards/Accreditation

**PAHP Standards:**
None

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# IDAHO
## Healthy Connections

## CONTACT INFORMATION

**State Medicaid Contact:**

Robin Pewtress
Idaho Medicaid
(208) 364-1892

**State Website Address:**

http://www.healthandwelfare.idaho.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1937

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
Continuous eligibility for children under age 19

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
May 25, 2006

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

#### Service Delivery

**Included Services:**
Case Management, Disease Management, Durable Medical Equipment, EPSDT, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Speech Therapy, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

#### Enrollment

# IDAHO
## Healthy Connections

**Populations Voluntarily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

**Populations Mandatorily Enrolled:**
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Eligibility Period Less Than 3 Months
-Enrolled in Another Managed Care Program
-Have Existing Relationship With a Non-participating PCP
-If travel > 30 Minutes or 30 Miles
-Live in a Non-participating County
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-QMB only
-Reside in Nursing Facility or ICF/MR
-Retro-Eligibility Only

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
No

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
-Initial screening upon eligibility and enrollment in PCCM program; also during annual redetermination; or via physician request
-Reviews complaints and grievances to identify members of these groups
-Screen for participation in certain programs

**Agencies with which Medicaid Coordinates the Operation of the Program:**
-Aging Agency
-Child Welfare Agency
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Substance Abuse Agency

# IDAHO
## Healthy Connections

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Connections

## ADDITIONAL INFORMATION

Enrollment is mandatory in 42 counties out of 44 counties. Clark and Custer Counties are voluntary.

## QUALITY ACTIVITIES FOR PCCM

**Quality Oversight Activities:**
-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Performance Measures (see below for details)
-Provider Data

**Use of Collected Data:**
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation

**Consumer Self-Report Data:**
-State-developed Survey

### Performance Measures

**Process Quality:**
-Diabetes management/care
-Immunizations for two year olds

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
-24/7 access to live Health Care Professional
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

**Use of Services/Utilization:**
None

**Provider Characteristics:**
None

**Beneficiary Characteristics:**
-Disenrollment rate
-Disenrollment reasons

**Performance Measures - Others:**
None

# IDAHO
## Idaho Smiles

## CONTACT INFORMATION

**State Medicaid Contact:**

Matt Wimmer
Bureau of Medical Care
(208) 364-1989

**State Website Address:**

http://www.healthandwelfare.idaho.gov

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1937

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 19, 2007

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Dental PAHP - Risk-based Capitation

#### Service Delivery

**Included Services:**
Dental

**Allowable PCPs:**
-Not applicable, contractors not required to identify PCPs

#### Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
-American Indian/Alaska Native
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
-Medicare Dual Eligibles
-Participate in HCBS Waiver

**Lock-In Provision:**
Does not apply because State only contracts with one managed care entity

-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

**Medicare Dual Eligibles Included:**
None

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross of Idaho

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-On-Site Reviews
-PAHP Standards (see below for details)

**Use of Collected Data:**
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
-The State DOES NOT use any of the HEDIS measures

### Encounter Data

**Collection: Requirements:**
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

**Collections - Submission Specifications:**
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, 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
-ADA approved or other forms approved in advance by Idaho Smiles

**Validation - Methods:**
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

**PAHP conducts data accuracy check(s) on specified data elements:**
-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Procedure Codes
-Age-appropriate diagnosis/procedure

**State conducts general data completeness assessments:**
No

## Standards/Accreditation

**PAHP Standards:**
-State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None

# IDAHO
# Medicare-Medicaid Coordinated Plan

## CONTACT INFORMATION

**State Medicaid Contact:**

Sheila Pugatch
Idaho Medicaid
(208) 364-1817

**State Website Address:**

http://www.healthandwelfare.idaho.gov

## PROGRAM DATA

**Program Service Area:**
County

**Operating Authority:**
1937

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
No

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
None

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
April 01, 2007

**Waiver Expiration Date:**
Not Applicable

**Sections of Title XIX Waived:**
None

**Sections of Title XIX Costs Not Otherwise Matchable Granted:**
None

## SERVICE DELIVERY

### Medical-only PAHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Case Management, Dental, Durable Medical Equipment, Family Planning, Federally Qualified Health Center, Hearing, Home Health, Immunization, Indian Health Clinic, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medicare part D Excluded Drugs Covered by Medicaid, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Rural Health Clinic, Speech Therapy, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Physician Assistants
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
None

**Subpopulations Excluded from Otherwise Included Populations:**

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR

**Lock-In Provision:**

No lock-in

**Medicare Dual Eligibles Included:**

QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**

Yes

**Provides Part D Benefits:**

Yes

**Scope of Part D Coverage:**

Basic Alternative Coverage

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

-None - managed care entity provides standard prescription drug coverage

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medicare-Medicaid Coordinated Plan

## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PAHP

**State Quality Assessment and Improvement Activities:**

-Consumer Self-Report Data (see below for details)

**Use of Collected Data:**

-Program Modification, Expansion, or Renewal

**Consumer Self-Report Data:**

-Perceived problems with program participation

**Use of HEDIS:**

-The State DOES NOT use any of the HEDIS measures

### Standards/Accreditation

**PAHP Standards:**

None

**Accreditation Required for Participation:**

None

**Non-Duplication Based on Accreditation:**

None

# WEST VIRGINIA
## Mountain Health Choices

## CONTACT INFORMATION

**State Medicaid Contact:**

Brandy Pierce
Office of Managed Care, Bureau for Medical Service
(304) 356-4912

**State Website Address:**

http://www.wvdhhr.org/bms

## PROGRAM DATA

**Program Service Area:**
Statewide

**Operating Authority:**
1937

**Statutes Utilized:**
Not Applicable

**Enrollment Broker:**
Automated Health Systems, Inc

**For All Areas Phased-In:**
No

**Guaranteed Eligibility:**
12 months of guaranteed eligibility for children

**Initial Waiver Approval Date:**
Not Applicable

**Implementation Date:**
March 01, 2007

**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) - Risk-based Capitation

#### Service Delivery

**Included Services:**
Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

**Allowable PCPs:**
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

#### Enrollment

**Populations Voluntarily Enrolled:**
-Categorically Needy Caretaker under Section 1931

**Populations Mandatorily Enrolled:**
-Poverty Level Infants and Children
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

**Subpopulations Excluded from Otherwise Included Populations:**

-Foster Care Children
-Medically Needy
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Subsidized Adoptions under Titles IV-B and IV-E

**Lock-In Provision:**

12 month lock-in

**Medicare Dual Eligibles Included:**

None

**Medicare Dual Eligibles Excluded:**

Exclude all categories of Medicare Dual Eligibles

### Part D Benefit

**MCE has Medicare Contract:**

No

**Provides Part D Benefits:**

Not Applicable

**Scope of Part D Coverage:**

Not Applicable

**Part D - Enhanced Alternative Coverage:**

Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

None

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carelink Health Plan
Health Plan of the Upper Ohio Valley
Unicare Health Plan of WV

## ADDITIONAL INFORMATION

Under this program, if the member signs the "Member Agreement" and enrolls into Enhanced services, they will receive additional benefits. The enhanced benefits include: cardiac and pulmonary rehabilitation, nutritional counseling, tobacco cessation, and weight management services. If the member chooses not to sign the "Member Agreement" they will remain in Basic for one year.

Poverty Level Infants and Children are mandatorily enrolled under Sections 1902(a)(10)(A)(i)(V)-(VII) and under Section 1902(a)(10)(A)(ii)(IX) and (XIV).

Children are guaranteed one year eligibility. Adults do not have guaranteed eligibility.

Caretaker/relatives have voluntary enrollment choices.

## QUALITY ACTIVITIES FOR MCO/HIO

**State Quality Assessment and Improvement Activities:**

-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards

**Use of Collected Data:**

-Data Mining
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

-Network Data
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

### Consumer Self-Report Data:
-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire
Child with Special Needs Questionnaire

### Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

## Encounter Data

### Collection: Requirements:
-Requirements for MCOs to collect and maintain encounter data

### 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.)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

### MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

### State conducts general data completeness assessments:
Yes

## Performance Measures

### Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Controlling high blood pressure
-Diabetes medication management
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of
-Smoking prevention and cessation
-Well-child care visit rates in 3,4,5, and 6 years of life

### Health Status/Outcomes Quality:
-Patient satisfaction with care

-Well-child care visit rates in first 15 months of life

**Access/Availability of Care:**
-Average distance to PCP

**Use of Services/Utilization:**
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

**Health Plan Stability/ Financial/Cost of Care:**
None

**Health Plan/ Provider Characteristics:**
None

**Beneficiary Characteristics:**
None

**Performance Measures - Others:**
None

## Performance Improvement Projects

**Project Requirements:**

-All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

**Clinical Topics:**

-Adolescent Immunization
-Asthma management
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-Well Child Care/EPSDT

**Non-Clinical Topics:**

-Adults access to preventive/ambulatory health services

## Standards/Accreditation

**MCO Standards:**
-NCQA (National Committee for Quality Assurance) Standards

**Accreditation Required for Participation:**
-NCQA (National Committee for Quality Assurance)

**Non-Duplication Based on Accreditation:**
None

**EQRO Name:**
-Delmarva Foundation

**EQRO Organization:**
-Private accreditation organization

**EQRO Mandatory Activities:**
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities:**
None

## Pay for Performance (P4P)

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable

# ARKANSAS
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Stephanie Blocker
Director of Aging and Adult Services
Arkansas Department of Human Services
(501) 683-7962

**State Website Address:**

http://www.daas.ar.gov

## PACE Organization

**Approved PACE Organization Name:**

Total Life Healthcare

**Program Agreement Effective Date:**

June 01, 2008

**PACE Contact:**

Becky McDaniels, CEO
225 East Jackson #92
Jonesboro, AR 72401
(870) 207-6703

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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# CALIFORNIA
## Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Della Cabrera
Chief, PACE/SCAN Unit
DHCS Long Term Care Division
(916) 440-7538

**State Website Address:**

http://www.dhcs.ca.gov

## PACE Organization

**Approved PACE Organization Name:**

On Lok Senior Health Services dba On Lok Lifeways

**Program Agreement Effective Date:**

November 01, 2003

**PACE Contact:**

Robert Edmondson
1333 Bush Street
San Francisco, CA 94109
(415) 292-8888

**Approved PACE Organization Name:**

AltaMed Health Services Corporation dba Altamed Senior BuenaCare

**Program Agreement Effective Date:**

November 01, 2002

**PACE Contact:**

Castulo de la Rocha
500 Citadel Drive, Suite 490
Los Angeles, CA 90040
(323) 889-7310

**Approved PACE Organization Name:**

Sutter Health Sacramento Sierra Region dba Sutter SeniorCare

**Program Agreement Effective Date:**

November 01, 2003

**PACE Contact:**

John Boyd
7700 Folson Blvd
Sacramento, CA 95823
(916) 386-3000

# CALIFORNIA
## Program of All-inclusive Care for the Elderly (PACE)

**Approved PACE Organization Name:** Coalition Center of Elders Independence dba Center for Elders Independence

**Program Agreement Effective Date:** November 01, 2003

**PACE Contact:** Peter Szutu
510 17th Street, Suite 400
Oakland, CA 94612
(510) 433-1160 x8821

**Approved PACE Organization Name:** Community Eldercare of San Diego dba St. Pauls PACE

**Program Agreement Effective Date:** February 01, 2008

**PACE Contact:** Cheryl Wilson
328 Maple Street
San Diego, CA 92103
(619) 239-6900

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# COLORADO
# Program of All-Inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Matthew Wrich
Contract Manager
Department of Health Care Policy and Financing
(303)866-2148

**State Website Address:**

http://www.colorado.gov/hcpf

## PACE Organization

**Approved PACE Organization Name:**

Total Long Term Care

**Program Agreement Effective Date:**

April 01, 2003

**PACE Contact:**

Maureen Hewitt
8950 E. Lowry Boulevard
Denver, CO 802030
(303) 869-4664

**Approved PACE Organization Name:**

VOANS PACE, Inc

**Program Agreement Effective Date:**

August 01, 2008

**PACE Contact:**

Craig Ammermann
2377 Robins Way
Montrose, CO 81401
(970) 252-0522

**Approved PACE Organization Name:**

Rocky Mountain PACE

**Program Agreement Effective Date:**

December 01, 2008

**PACE Contact:**

Laurie Tebo
2335 Robinson Street
Colorado Springs, CO 80904
(719) 457-0660 ext 1

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# FLORIDA
## Program of All-Inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Kym Holcomb
Medical Health Care Program Analyst
Florida Agency for Health Care Administration
(850) 412-4251

**State Website Address:**

http://ahca.myflorida.com

## PACE Organization

**Approved PACE Organization Name:** Florida PACE Centers

**Program Agreement Effective Date:** January 01, 2003

**PACE Contact:**

Daniel Brady
5200 Northeast 2nd Avenue
Miami, FL 33137
(305) 762-1380

**Approved PACE Organization Name:** Hope Select Care

**Program Agreement Effective Date:** February 01, 2008

**PACE Contact:**

Mary Curtis
2668 Winkler Avenue
Fort Myers, FL 33901
(239) 985-6400

**Approved PACE Organization Name:** Neighborly PACE

**Program Agreement Effective Date:** September 01, 2009

**PACE Contact:**

Debra Shade
12425 28 Street North, Suite 200
St. Petersburg, Fl 33716
(727) 573-9444

## ADDITIONAL INFORMATION

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# HAWAII
# Program of All-Inclusive Care for the Eldelry (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Madi Silverman
Program Specialist
Hawaii Department of Human Services
(808) 692-8070

**State Website Address:**

http://hawaii.gov/dhs

## PACE Organization

**Approved PACE Organization Name:**

Maui PACE

**Program Agreement Effective Date:**

October 01, 2008

**PACE Contact:**

Connie Miller
472 Kaulana Street
Kahului, HI 96709
(808) 442-4552

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# IOWA
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Lin Christensen
Medicaid Program Manager
Iowa Medicaid Enterprise
(515) 256-4639

**State Website Address:**

http://www.ime.state.ia.us/

## PACE Organization

**Approved PACE Organization Name:**

Siouxland PACE

**Program Agreement Effective Date:**

August 01, 2008

**PACE Contact:**

Linda Todd
4300 Hamilton Blvd
Sioux City, IA 51104
(712) 233-4144

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# KANSAS
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Tracy Conklin
Manager
Kansas Health Policy Authority
(785) 296-7788

**State Website Address:**

http://www.khpa.ks.gov

## PACE Organization

**Approved PACE Organization Name:**

Via Christi Healthcare Outreach Program for the Elders

**Program Agreement Effective Date:**

September 01, 2002

**PACE Contact:**

Justin Loewen
2622 W Central Ave, Suite 101
Wichita, KS 67203
(316) 946-5110

**Approved PACE Organization Name:**

Midland Care Services

**Program Agreement Effective Date:**

January 01, 2007

**PACE Contact:**

Karren Weichert
200 SW Frazier Circle
Topeka, KS 66606
(785) 232-2044

## ADDITIONAL INFORMATION

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# LOUISIANA
## Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Allison Vuljoin
Acting Director
Office of Aging and Adult Services
(225) 219-0229

**State Website Address:**

http://www.LA.Gov

## PACE Organization

**Approved PACE Organization Name:**

Greater New Orleans

**Program Agreement Effective Date:**

September 01, 2007

**PACE Contact:**

Stephanie Smith
4201 N. Rampart
New Orlean, LA 70117
(504) 945-1531

**Approved PACE Organization Name:**

Franciscan PACE Baton Rouge

**Program Agreement Effective Date:**

July 01, 2008

**PACE Contact:**

Karen Allen
7436 Bishop Ott Dr.
Baton Rouge, LA 70806
(225) 490-0322

## ADDITIONAL INFORMATION

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# MARYLAND
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Susan, P Panek
Deputy Director, Long Term Care Financing
Department of Health and Mental Hygiene
(410) 767-6764

**State Website Address:**

http://www.dhmh.state.md.us

## PACE Organization

**Approved PACE Organization Name:**

Hopkins Elder Plus

**Program Agreement Effective Date:**

November 01, 2002

**PACE Contact:**

Karen Armacost
4940 Eastern Ave.
Baltimore, MD 21224
410-550-7044

## ADDITIONAL INFORMATION

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# MASSACHUSETTS
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Robert Holmes
Program Manager
Office of Medicaid
(617) 222-7413

**State Website Address:**

http://www.mass.gov/masshealth

## PACE Organization

**Approved PACE Organization Name:** Summit Elder Care

**Program Agreement Effective Date:** November 01, 2002

**PACE Contact:**

Karen Longo
10 Chestnut Street
Worchester, MA 01608
(508) 368-9437

**Approved PACE Organization Name:** Elder Service Plan of Cambridge Health Alliance

**Program Agreement Effective Date:** November 01, 2002

**PACE Contact:**

Tom Reiter, Director of Operations
270 Green Street
Cambridge, MA 02139
(617) 499-8366

**Approved PACE Organization Name:** Elder Service Plan of Harbor Health Services Inc

**Program Agreement Effective Date:** November 01, 2002

**PACE Contact:**

Carol Crawford
1135 Morton Street
Mattapan, MA 02126
(617) 533-2400

# MASSACHUSETTS
## Program of All-inclusive Care for the Elderly (PACE)

**Approved PACE Organization Name:** Uphams Elder Service Plan

**Program Agreement Effective Date:** November 01, 2002

**PACE Contact:**
Jay Trivedi
1140 Dorchester Avenue
Dorchester, MA 02125
(617) 288-0970

**Approved PACE Organization Name:** Elder Service Plan of East Boston

**Program Agreement Effective Date:** November 01, 2003

**PACE Contact:**
Laura Wagner
10 Gove Street
East Boston, MA 02128
(617) 568-4570

**Approved PACE Organization Name:** Elder Service Plan of the North Shore, Inc.

**Program Agreement Effective Date:** November 01, 2003

**PACE Contact:**
Robert Wakefield, Jr.
37 Friend Street
Lynn, MA 01902
(781) 715-6608

## ADDITIONAL INFORMATION

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# MICHIGAN
## Program of All-Inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Peggy Peckham
Medical Services Administrator
Department of Community Health
(517) 335-5202

**State Website Address:**

http://www.michigan.gov/mdch

## PACE Organization

**Approved PACE Organization Name:**

Henry Ford Health System Center for Senior Independence

**Program Agreement Effective Date:**

November 01, 2003

**PACE Contact:**

Lori Crow
7800 W. Outer Drive, Suite 240
Detroit, MI 48255
(313) 653-2256

**Approved PACE Organization Name:**

Care Resources

**Program Agreement Effective Date:**

September 01, 2006

**PACE Contact:**

Tom Muszynski, Executive Director
1471 Grace Street, SE
Grand Rapids, MI 49506
(616) 913-2006

**Approved PACE Organization Name:**

Life Circles

**Program Agreement Effective Date:**

February 01, 2009

**PACE Contact:**

Robert Mills, Executive Director
560 Seminole Road
Muskegon, MI 49444
(231) 733-8686

# MICHIGAN
## Program of All-Inclusive Care for the Elderly (PACE)

**Approved PACE Organization Name:** Centra Care

**Program Agreement Effective Date:** April 01, 2009

**PACE Contact:** Rod Auton, Executive Director
200 W. Michigan Ave Ste 103
Battle Creek, MI 49017
(269) 441-9300

## ADDITIONAL INFORMATION

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# MISSOURI
## Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Shelley Farris
Operations Manager - MO HealthNet Managed Care
Department of Social Services, MO HealthNet Division
(573) 526-4274

**State Website Address:**

http://www.dss.mo.gov

## PACE Organization

**Approved PACE Organization Name:**

Alexian Brothers Community Services

**Program Agreement Effective Date:**

November 01, 2001

**PACE Contact:**

Mel Causey
3900 South Grand
St. Louis, MO 63118
(314) 771-5800 x127

## ADDITIONAL INFORMATION

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# MONTANA
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Kelly Williams
Administrator
SLTC
(406) 444-4147

**State Website Address:**

http://www.DPHHS.mt.gov/sltc/services/communityservi

## PACE Organization

**Approved PACE Organization Name:**

Billings Clinic

**Program Agreement Effective Date:**

October 01, 2008

**PACE Contact:**

Anne Gonzalez
3155 Avenue C
Billings, MT 59102
(406) 247-6315

## ADDITIONAL INFORMATION

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# NEW JERSEY
# Program of All-inclusive Care for the Eldelry (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Paul Sullivan
County Liaison
NJ Department of Health and Senior Services
(609) 292-0217

**State Website Address:**

http://www.state.nj.us/health/senior/pace.shtml

## PACE Organization

**Approved PACE Organization Name:**

LIFE at Lourdes

**Program Agreement Effective Date:**

May 01, 2009

**PACE Contact:**

Margaret Sullivan
2475 McClellan Avenue
Pennsauken, NJ 08109
(856) 675-3663

**Approved PACE Organization Name:**

LIFE St. Francis

**Program Agreement Effective Date:**

April 01, 2009

**PACE Contact:**

Jill Viggiano
1435 Liberty Street
Hamilton, NJ 08629
(609) 475-4701

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# NEW MEXICO
# Program of All-Inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Ellen Costillo
Long Term Services Bureau
NM HSD/Medical Assistance Division
(505) 827-2297

**State Website Address:**

http://www.state.nm.us/hsd/mad/Index.html

## PACE Organization

**Approved PACE Organization Name:**

Total Community Care

**Program Agreement Effective Date:**

July 01, 2004

**PACE Contact:**

Gina DeBlassie
904 A Los Lomas NE
Albuquerque, NM 87102
(505) 924-2606

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# NEW YORK
## Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Linda Gowdy
Director, Bureau of Continuing Care Initiatives
Division of Managed Care & Program Evaluation
(518) 474-6965

**State Website Address:**

http://www.nyhealth.gov

## PACE Organization

**Approved PACE Organization Name:**

Independent Living for Seniors, Inc.

**Program Agreement Effective Date:**

November 01, 2003

**PACE Contact:**

Deborah Metz
2066 Hudson Ave.
Rochester, NY 14617
(585) 922-2800

**Approved PACE Organization Name:**

PACE CNY

**Program Agreement Effective Date:**

November 01, 2002

**PACE Contact:**

Penny Abulencia
100 Malta Lane
North Syracuse, NY 13212
(315) 452-5800

**Approved PACE Organization Name:**

Eddy Senior Care

**Program Agreement Effective Date:**

November 01, 2002

**PACE Contact:**

Bernadette Hallam
504 State Street
Schenectady, NY 12305
(518) 382-3290

# NEW YORK
## Program of All-inclusive Care for the Elderly (PACE)

**Approved PACE Organization Name:** Comprehensive Care Management (CCM)

**Program Agreement Effective Date:** November 01, 2003

**PACE Contact:** Joseph Healy, Jr
1250 Waters Place, 6th floor
Bronx, NY 10467
(347) 640-6020

**Approved PACE Organization Name:** Total Senior Care

**Program Agreement Effective Date:** October 01, 2008

**PACE Contact:** Carol Mahoney
1225 West State St.
Olean, NY 14760
(716) 372-2106

**Approved PACE Organization Name:** ArchCare Senior Life

**Program Agreement Effective Date:** September 01, 2009

**PACE Contact:** Marcia Konrad
1432 Fifth Avenue
New York, NY 10026
(646) 289-7722

**Approved PACE Organization Name:** Catholic Health - LIFE

**Program Agreement Effective Date:** September 01, 2009

**PACE Contact:** Thomas Schhifferli
55 Melroy Avenue
Lackawanna, NY 14218
(716) 819-5102

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# NORTH CAROLINA
## Program of All-inclusive Care for the Eldelry (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Michael Howard
Manager for PACE
Noth Carolina Department of Health and Human Services
(919) 855-4344

**State Website Address:**

http://www.ncdhhs.gov/aging

## PACE Organization

**Approved PACE Organization Name:**

Piedmont Health SeniorCare

**Program Agreement Effective Date:**

February 01, 2008

**PACE Contact:**

Marianne Ratcliff
1214 Vaughn Road, P.O. Box 1033
Burlington, NC 27217
(336) 532-0000

**Approved PACE Organization Name:**

Elderhaus

**Program Agreement Effective Date:**

February 01, 2008

**PACE Contact:**

Larry Reinhart
2222 South 17th Street
Wilmington, NC 28401
(910) 343-8209

## ADDITIONAL INFORMATION

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# NORTH DAKOTA
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Tania Hellman
Administrator, Managed Care
Department of Human Services Medical Services Division
(701) 328-3598

**State Website Address:**

http://www.nd.gov/dhs/

## PACE Organization

**Approved PACE Organization Name:**

Northland PACE

**Program Agreement Effective Date:**

August 01, 2008

**PACE Contact:**

Tim Cox
3811 Lockport Street, Suite 3
Bismarck, ND 58501
(701) 250-0709

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# OHIO
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Gayle Lee, Ohio PACE Manager
Bureau of Long Term Care Services and Supports
Ohio Department of Job and Family Services
(614) 752-3553

**State Website Address:**

http://jfs.ohio.gov/OHP/index.stm

## PACE Organization

**Approved PACE Organization Name:**

TriHealth Senior Link

**Program Agreement Effective Date:**

November 01, 2002

**PACE Contact:**

Brett Kirkpatrick, Director
619 Oak Street
Cincinnati, OH 45206
(513) 569-6673

**Approved PACE Organization Name:**

McGregor PACE

**Program Agreement Effective Date:**

November 01, 2002

**PACE Contact:**

Tangi McCoy, President/CEO
2373 Euclid Heights Blvd.
Cleveland Heights, OH 44106
(216) 791-3580

## ADDITIONAL INFORMATION

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# OKLAHOMA
## Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Ashley Herron
Pace Research Analyst
Oklahoma Health Care Authority
(405) 522-7902

**State Website Address:**

http://www.ok.gov/health

## PACE Organization

**Approved PACE Organization Name:**

Cherokee Elder Care

**Program Agreement Effective Date:**

August 01, 2008

**PACE Contact:**

David James
1387 W. 4th Street
Tahlequah, OK 74464
(918) 453-5599

## ADDITIONAL INFORMATION

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# OREGON
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Julie Strauss
Acting PACE Contact
Department of Human Services
(800) 232-3020

**State Website Address:**

http://www.dhs.state.or.us

## PACE Organization

**Approved PACE Organization Name:**

Providence Elder Place

**Program Agreement Effective Date:**

November 01, 2003

**PACE Contact:**

Ellen Garcia
4531 SE Belmont, Suite 100
Portland, OR 97215
(503) 215-3612

## ADDITIONAL INFORMATION

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# PENNSYLVANIA
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Randy Nolen
Director, Division of Field Operations
PA Department of Public Welfare, Bureau of Provider Support, Office of Long Term Living
(717) 772-2543

**State Website Address:**

http://www.state.pa.us

## PACE Organization

**Approved PACE Organization Name:** LIFE - University of Pennsylvania

**Program Agreement Effective Date:** January 01, 2002

**PACE Contact:**

Daniel J. Drake
4508 Chestnut Street
Philadelphia, PA 19139
(215) 573-7200

**Approved PACE Organization Name:** Community - LIFE

**Program Agreement Effective Date:** March 01, 2004

**PACE Contact:**

Richard DiTommaso
2400 Ardmore Boulevard, Suite 700
Pittsburgh, PA 15221
(412) 664-1448

**Approved PACE Organization Name:** LIFE - Pittsburgh

**Program Agreement Effective Date:** May 01, 2005

**PACE Contact:**

Joann Gago
875 Greentree Road, Suite 200, One Parkway Center
Pittsburgh, PA 15220
(412) 388-8042

# PENNSYLVANIA
## Program of All-inclusive Care for the Elderly (PACE)

**Approved PACE Organization Name:** LIFE Geisinger

**Program Agreement Effective Date:** October 01, 2007

**PACE Contact:** Amy Minnich
100 North Academy Avenue
Danville, PA 17822-2412
(570) 271-5531

**Approved PACE Organization Name:** LIFE at Home

**Program Agreement Effective Date:** July 01, 2009

**PACE Contact:** Nancy Morrison
101 East State Street
Kennett Square, PA 19348
(610) 925-2225

**Approved PACE Organization Name:** LIFE Lutheran Services

**Program Agreement Effective Date:** September 01, 2008

**PACE Contact:** Mary Fredette
840 5th Avenue
Chambersburg, PA 17201
(717) 264-5433

**Approved PACE Organization Name:** LIFE Beaver County

**Program Agreement Effective Date:** November 01, 2008

**PACE Contact:** Toni Hirely
131 Pleasant Drive, Suite 1
Aliquippa, PA 15001
(724) 302-2066

# PENNSYLVANIA
## Program of All-inclusive Care for the Elderly (PACE)

**Approved PACE Organization Name:** Everyday LIFE

**Program Agreement Effective Date:** February 01, 2009

**PACE Contact:**
Cyndi Walters
One Trinity Drive, East Suite 201
Dillsburgh, PA 19019
(717) 802-8877

**Approved PACE Organization Name:** Mercy LIFE

**Program Agreement Effective Date:** October 01, 2005

**PACE Contact:**
Carol Quinn
1001 Baltimore Pike
Springfield, PA 19064
(610) 690-2526

**Approved PACE Organization Name:** Senior LIFE Johnstown

**Program Agreement Effective Date:** October 01, 2005

**PACE Contact:**
Mark Irwin
401 South Broad Street, Suite 100
Johnstown, PA 15905
(814) 535-6000

**Approved PACE Organization Name:** NewCourtland LIFE

**Program Agreement Effective Date:** October 01, 2010

**PACE Contact:**
Beth Cwiklinski
5457 Wayne Avenue
Philadelphia, PA 19144
(269) 335-1500

## ADDITIONAL INFORMATION

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# RHODE ISLAND
## Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Ellen Mauro
Chief, Family Health Systems/Center for Adult Heal
RI Department of Human Services
(401) 462-0140

**State Website Address:**

http://www.pace-Ri.org

## PACE Organization

**Approved PACE Organization Name:**

PACE Organization of Rhode Island

**Program Agreement Effective Date:**

December 01, 2005

**PACE Contact:**

Joan Kwiakowski
225 Chapman Street
Providence, RI 02905
(401) 490-7610

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# SOUTH CAROLINA
## Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

George Maky
Director, Division of Community Options
South Carolina Dept of Health and Human Services
(803) 898-2711

**State Website Address:**

http://www.scdhhs.gov

## PACE Organization

**Approved PACE Organization Name:**

Palmetto SeniorCare

**Program Agreement Effective Date:**

November 01, 2003

**PACE Contact:**

Judy Baskins
Palmetto SeniorCare, 5 Richland Medical Park
Columbia, SC 29203
(803) 434-3770

**Approved PACE Organization Name:**

The OAKS PACE

**Program Agreement Effective Date:**

March 01, 2008

**PACE Contact:**

Elaine Till
153 Founders Ct
Orangeburg, SC 29118
(803) 535-1561

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# TENNESSEE
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Carolyn Fulghum
Director of Quality and Administration
TennCare
(615) 507-6671

**State Website Address:**

http://www.tn.gov/tenncare

## PACE Organization

**Approved PACE Organization Name:**

Alexian Brothers Community Services

**Program Agreement Effective Date:**

November 01, 2002

**PACE Contact:**

Viston Taylor
425 Cumberland Street Suite 110
Chattanooga, TN 37404
(423) 698-0802

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# TEXAS
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Lori Roberts
Acting PACE Contact
Department of Aging and Disability Services
(512) 438-5301

**State Website Address:**

http://www.dads.state.tx.us/business/pace/index.html

## PACE Organization

**Approved PACE Organization Name:** Bienvivir Senior Health Services

**Program Agreement Effective Date:** November 01, 2003

**PACE Contact:**

Rosemary Castillo
2300 Mckinley Ave.
El Paso, TX 78751
(915) 562-3492

**Approved PACE Organization Name:** Jan Werner Adult Day Care Center

**Program Agreement Effective Date:** March 01, 2004

**PACE Contact:**

Alana Chilcote
3108 South Fillmore
Amarillo, TX 79110
(806) 374-5516

**Approved PACE Organization Name:** La Paloma

**Program Agreement Effective Date:** May 01, 2010

**PACE Contact:**

Cathy Pope
4010 22nd Street
Lubbock, TX 79410
(806) 766-0201

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be

able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on a rate similar to the rate paid to Medicare Advantage and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. PACE organizations may charge a premium to individuals who do not have Medicaid eligibility.

The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

# VERMONT
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Megan Tierney-Ward
Medicaid Waiver Supervisor
Department of Disabilities, Aging, and Independent Living
(802) 241-2426

**State Website Address:**

http://dail.vermont.gov

## PACE Organization

**Approved PACE Organization Name:**

PACE Vermont

**Program Agreement Effective Date:**

March 01, 2007

**PACE Contact:**

Denise Zoeterman
786 College Parkway
Colchester, VT 05446
(802) 655-6700

## ADDITIONAL INFORMATION

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# VIRGINIA
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Yvonne Goodman
Program Supervisor
Department of Medical Assistance Services
(804) 786-0503

**State Website Address:**

http://www.dmas.virginia.gov/

## PACE Organization

**Approved PACE Organization Name:**

Sentara Senior Community Care

**Program Agreement Effective Date:**

November 01, 2007

**PACE Contact:**

Alverta Robertson
665 Newtown Road, Suite 121
Virginia Beach, VA 23462
(757) 502-7800

**Approved PACE Organization Name:**

Riverside Peninsula

**Program Agreement Effective Date:**

February 01, 2008

**PACE Contact:**

Doris Mosocco
4107 West Mercury Blvd
Hampton, VA 23666
(757) 251-7977

**Approved PACE Organization Name:**

Mountain Empire

**Program Agreement Effective Date:**

March 01, 2008

**PACE Contact:**

Tony Lawson
P.O. Box 888
Big Stone Gap, VA 24219
(276) 523-0599

# VIRGINIA
## Program of All-inclusive Care for the Elderly (PACE)

**Approved PACE Organization Name:** AllCare for Seniors

**Program Agreement Effective Date:** May 01, 2008

**PACE Contact:** Dana Collins
P.O. Box 765
Cedar Bluff, VA 24609
(276) 964-4915

**Approved PACE Organization Name:** Centra

**Program Agreement Effective Date:** February 01, 2009

**PACE Contact:** Debra Maddox
407 Federal Street
Lynchburg, VA 24501
(434) 200-6516

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# WASHINGTON
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Kristi Knudsen
Program Manager
ADSA
(360) 725-3213

**State Website Address:**

http://www.dshs.wa.gov

## PACE Organization

**Approved PACE Organization Name:**

Providence Elderplace - Seattle

**Program Agreement Effective Date:**

November 01, 2002

**PACE Contact:**

Susan Tuller
4515 Martin Luther King Jr. Way So., Suite 100
Seattle, WA 98108
(206) 320-5325

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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# WISCONSIN
# Program of All-inclusive Care for the Elderly (PACE)

## CONTACT INFORMATION

**State Medicaid Contact:**

Cecilia Chathas
Contract Administrator
Wisconsin Department of Health and Family Services
(608) 267-2923

**State Website Address:**

http://dhs.wisconsin.gov

## PACE Organization

**Approved PACE Organization Name:**

Community Care Organization

**Program Agreement Effective Date:**

November 01, 2003

**PACE Contact:**

Kirby Shoaf
1555 South Layton Boulevard
Milwaukee, WI 53215
(414) 385-6600

## ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age and older, certified by the State administering agency as needing a nursing facility level of care, and reside in the approved service area of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

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Alabama
- The Partnership Hospital Program, 1915(a) voluntary program was terminated.

California
- California previously reported the following three waiver programs: CalOPTIMA, Central Coast Alliance for Health (now known as Central California Alliance for Health) and Partnership Health Plan of California. In 2003, these three entities were consolidated under one 1915(b) waiver known as the Health Insuring Organizations (HIO) of California but reporting in the National Summary remained separate. In an effort to improve the accuracy of reporting, California has appropriately reported the HIO of California waiver and identified CalOPTIMA, Central California Alliance for Health and Partnership Health Plan as the participating managed care entities in the program.

Florida
- The Florida Medicaid Alzheimer's Waiver Program, 1915(b)/(c) was terminated.

Georgia
- Georgia Preadmission Screening and Annual Resident Review (PASARR) program was terminated.

Kansas
- Kansas has implemented a 1902(a)(70) Non-Emergency Medical Transportation (NEMT) program.

Maryland
- Living at Home Case Management Waiver, "other managed care entity type – selective contract", is a new 1915(b)(c) program.

Massachusetts
- Senior Care Options (SCO) program, 1915(a)/(c), is not a new program but is listed for the first time in this report.

Minnesota

- The Minnesota Prepaid Medical Assistance Program-1115 and MinnesotaCare Program for Families and Children are now combined into one program.

Montana
- MT – Nurse First Disease Management PAHP is no longer operating. MT implemented Nurse First – Selective Contracting and Enhanced PCCM sub-programs under the Passport to Health program.

New Hampshire
- The Medicaid Health Management Program, 1915(b) was terminated.

New Jersey
- NJ has implemented a 1902(a)(70) Non-Emergency Transportation Broker program.

New Mexico
- The New Mexico State Coverage Insurance Section 1115 Demonstration program is a new 1115 program.
- The mental health carve-out is no longer under the New Mexico SALUD! program. It's operating as a separate mental health program, Salud!Behavioral Health.

New York
- The PCCM Provider-FFS model is no longer operational under the Federal-State Health Reform Partnership (F-SHRP) Medicaid Managed Care and Partnership Plan Medicaid Managed Care, 1115 programs.
- NY implemented a 1915(b)(4), Selective Contracting – Bariatric Surgery program.

North Carolina
- Piedmont Cardinal Health Plan (Innovations) 1915 b/c program name changed to NC Mental Health Development Disabilities and Substance Abuse Services Waiver.

Oregon

- Oregon has terminated the P4P program under the Oregon Health Plan Plus program due to the legislature appropriated funds for those preventive services/PCP access grants just the one time

Rhode Island

- Connect Care Choice is a PCCM program formerly under 1932(a) SPA but was rolled into 1115 waiver.

South Carolina

- The Health Maintenance Organization (HMO) program was converted from 1915(a) voluntary to 1932(a).
- The Medically Fragile Children Program (MFCP), 1915(a) voluntary program was terminated.

Tennessee

- The Pharmacy Benefit Manager was previously reported as "Other" managed care entity under the TennCare II program. It is now reported as a Pharmacy Benefit Manager PAHP.
- The Dental Benefit Manager was previously reported as "Other" managed care entity under the TennCare II program. It is now reported as a Dental Benefit Manager PAHP.

Texas

- The 1915(b) Texas Disease Management Program was renamed Texas Medicaid Enhanced Care Program

Utah

- Healthy Outcomes Medical Excellence (HOME) program, 1915(a) voluntary is not a new program but is listed for the first time in this report.

***Section: Program Data--Operating Authority Terms***

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| *1915(b)* | **Mandatory managed care program** which has restrictions on beneficiaries' freedom of choice provider. |
| *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. |
| 1915(a) | **Voluntary managed care program** in which enrollment is voluntary and therefore does not require a waiver. |
| 1915(b)/1915(c) | Concurrent waiver programs, or portions thereof, operating under both 1915(b) managed care and 1915c) home and community-based services waivers. |
| 1915(a)/1915(c) | Concurrent waiver programs, or portions thereof, operating under both 1915(a) voluntary managed care and 1915(c) home and community-based services waivers. |

1905(t) **Voluntary PCCM managed care program** in which enrollment is voluntary and therefore does not require a waiver.

1937 **Alternative Benefit Package Benchmark Program** – Managed care program operates under this authority through a State plan amendment.

1902(a)(70) Option for States to amend their Medicaid state plans to establish **Non-Emergency Medical Transportation Brokerage program** without regard to the statutory requirements for comparability, statewideness, and freedom of choice.

*1902(a)(1)* ***Statewideness***. This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. Waiving 1902(a)(1) indicates that this waiver program is not available throughout the State.

*1902(a)(10)(B)* ***Comparability of Services***. This section of the Act requires State Medicaid plans to permit all individuals eligible for Medicaid to obtain medical assistance. Waiving 1902(a)(10)(B) indicates that the scope of services offered to beneficiaries enrolled in this program are broader than those offered to beneficiaries not enrolled in the program.

*1902(a)(23)* ***Freedom of Choice***. This section of the Act requires State Medicaid plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted.

***Section: Service Delivery--Managed Care Entity Terms***

*PCCM* ***Primary Care Case Management (PCCM) Provider*** is usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants who contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category include PCCMs and those PIHPs which act as PCCMs.

*PIHP* **Prepaid Inpatient Health Plan (PIHP)** – A PIHP is a prepaid **inpatient** health plan that provides less than comprehensive services on an at-risk or other than state plan reimbursement basis; and provides,

arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are define in 42 CFR 438.2} There are several types of PIHPs that States use to deliver a range of services (i.e. Mental Health (MH) PIHP is a managed care entity provides only mental health services**.**

*PAHP* **Prepaid Ambulatory Health Plan (PAHP)** – A PAHP is a prepaid **ambulatory** health plan that provides less than comprehensive services on an at-risk or other than state plan reimbursement basis, and does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are defined in 42 CFR 438.2} There are several types of PAHPs that States use to deliver a range of services. For example, a Dental PAHP is a managed care entity that provides only dental services.

*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 managed care entity is paid for providing services to enrollees solely through fee-for-service payments, plus in a PCCM, a case management fee.

*Risk-based Capitation* The managed care entity is paid for providing services to enrollees primarily through capitation. (There may be other payments under the contract such as incentive arrangements or risk-sharing.)

*Non-risk Capitation* The managed care entity is paid for providing services to enrollees through capitation, but payments are settled at the end of the year at amounts that do not exceed the FFS cost for services actually provided, plus an amount for administration.

***Section: Quality Activity Terms***

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| *Accreditation for Deeming* | Some States use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as "deemed compliance" with a standard. |
| *Accreditation for Participation* | State requirement that plans must be accredited to participate in the Medicaid managed care program. |
| *Consumer Self-Report Data* | Data collected through survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a MCO, PIHP, or PAHP. The survey may be conducted by the State or a contractor to the State. |
| *Encounter Data* | Detailed data about individual services provided to individual beneficiaries at the point of the beneficiary's interaction with a MCO, PIHP, PAHP institutional or practitioner provider. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims". |
| *Enrollee Hotlines* | Toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their MCO, PIHP, PAHP. The people who staff hotlines are knowledgeable about program policies and may play an "intake and triage" role or may assist in resolving the problem. |
| *Focused Studies* | State required studies that examine a specific aspect of health care (such as prenatal care) for a defined point in time. These projects are usually based on information extracted from medical records or MCO, PIHP, PAHP administrative data such as enrollment files and encounter /claims data. State staff, EQRO staff, MCO, PIHP, PAHP staff or more than one of these entities may perform such studies at the discretion of the State. |

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| *MCO/PIHP/PAHP* | These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each MCO/PIHP/PAHP must have in order to participate in the Medicaid program. |
| *Monitoring of Standards* | Activities related to the monitoring of standards that have been set for plan structure, operations, and quality improvement/assurance to determine that standards have been established, implemented, adhered to, etc. |
| *Ombudsman* | An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PIHP/PAHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PIHP/PAHP, and the provider (as appropriate) to resolve individual enrollee problems. |
| *On-Site Reviews* | Reviews performed on-site at the MCO/PIHP/PAHP health care delivery system sites to assess the physical resources and operational practices in place to deliver health care. |
| *Performance Improvement Projects* | Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MCO/PIHP/PAHPs choosing or prescribed by the State. |
| *Performance Measures* | Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PIHP/PAHP. |

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| *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. |
| *Pay for Performance (P4P)* | P4P programs are designed to improve patients' quality of care by recognizing and rewarding high standards of care. This section identifies the States' implementation of a P4P program with any MCOs participating in the State's managed care program. |