NATIONAL SUMMARY of STATE MEDICAID MANAGED CARE PROGRAMS

PROGRAM DESCRIPTIONS
AS OF JULY 1, 2012

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2012 NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS

PROGRAM DESCRIPTIONS AS OF JULY 1, 2012

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, 2012. The data was collected from State Medicaid Agencies and CMS Regional Offices, and submitted for final review to DSG, The Children and Adults Health Programs Group (CAHPG), and Disabled and Elderly Health Program Group (DEHPG) and CMS Regional Offices.

Please contact Loan Swisher at 410-786-4650; e-mail: loan.swisher@cms.hhs.gov or Arun Natarajan at 410-786-7455; e-mail arun.natarajan@cms.hhs.gov if you have any questions concerning this report.

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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), Sharing of Cost Savings
1915(b)(4), Selective Contracting

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:
August 31, 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

Medical-only PAHP (risk or non-risk, non-comprehensive) - Non-Risk 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

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

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

Maternity Care Program

ADDITIONAL INFORMATION

The reimbursement methodology for the maternity program is capitated to a health entity assigned in each district throguhout the State. State contracts with a primary contractor that enters into a contractual agreement with each maternity subcontractor serving the district. The providers are paid a fee once the woman delivers. The primary contractor is responsible for submitting a claim for payment. Upon receipt of payment from Medicaid, the primary contractor pays all subcontractors involved in the womans care.

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

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
-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

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

Performance Improvement Projects

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

Clinical Topics:
-Less than 39 week deliveries for Non-Medically indicated reasons
-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), Freedom of Choice
1915(b)(3), Sharing of Cost Savings

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:
August 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

Traditional PCCM Provider - Primary Care Case Management Payments

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:

Populations Mandatorily Enrolled:

None

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

Subpopulations Excluded from Otherwise Included Populations:

-Foster Care Children
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman
-Recipient is a lock-in
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

Lock-In Provision:

1 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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

None

Agencies with which Medicaid Coordinates the Operation of the Program:

None

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.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:

-CAHPS Surveys
-Consumer Self-Report Data (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
-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:

ANDREW ALLISON
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), Freedom of Choice
1915(b)(4), Selective Contracting

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, 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
-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

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

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

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
Medi-Cal Specialty Mental Health Services Consolidation

CONTACT INFORMATION

State Medicaid Contact:

Dina Kokkos-Gonzales
Department of Health Care Services
(916) 552-9055

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
March 17, 1995

Implementation Date:
March 17, 1995

Waiver Expiration Date:
June 30, 2015

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 Plans - Fee-for-Service

Service Delivery

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

Contractor Types:
-None

Allowable PCPs:
None

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
-Targeted Low Income Childrens Program

Subpopulations Excluded from Otherwise Included Populations:
None

Lock-In Provision:
None

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

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:

Matthew Ullrich
Department of Health Care and Financing
(303) 866-6232

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), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

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, 2015

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

Populations Voluntarily Enrolled:
-Foster Care Children

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:
-Individual Granted an Exemption
-Inpatient at an Institute (ages 21-64)
-Medicare Dual Eligibles
-PACE Member
-Undocumented Aliens

Lock-In Provision:
No lock-in

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

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

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

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research

-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
-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

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

EQR Data included in State's annual EQR technical report:
None

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

FLORIDA
Florida Coordinated Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Susan Hamrick
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), Selective Contracting

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, 2014

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

Populations Mandatorily Enrolled:
None

-Section 1931 Children and Related Populations
-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

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

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:
-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)
-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

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), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

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:
January 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
-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 - FFS/Administrative fee

Service Delivery

Included Services:
Advanced Registered Nurse Practitioner Service, Ambulatory Surgical Centers, Birth Centers, Child Health Check-up, Chiropratic, Community Mental Health, County Health Department Services, Dental Services-Adults, Dental Services-Children, Dialysis, Durable Medical Equipment, Emergency room, Family Planning, Federally Qualified Health Centers, Freestanding Dialysis Centers, Hearing, Home Health, Immunization, Independent Lab, Inpatient Hospital, Licensed Midwive, Occupational Therapy, Optometric Services, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Physician Assistant Services, Podiatry, Rural Health Clinic Services, Speech Therapy, Targeted Case Management, Therapy Services-Respiratory, Transplant (Organ and Bone Marrow), Vision, X-Ray

Allowable PCPs:
-Not Applicable

Contractor Types:

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

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 Recipients
-Hospice
-Medically Complex Children in CMS Program
-Medically Needy
-Medicare Dual Eligibles
-Mediciad Eligibles in Residential Commitment Facilities
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman (SOBRA)
-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

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:
-Blind/Disabled Children and Related Populations
-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 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

PCCM Provider - Primary Care Case Management Payments

Service Delivery

Included Services:

Adult Health Screenings, Advanced Registered Nurse Practioner, Ambulatory Surgical, Birth Center, Child Health Check-Up (EPSDT), Chiropractic, County Health Department, Durable Medical Equipment, 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:

-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Children and Related Populations

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

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

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Advanced Registered Nurse Practitioner Services, Ambulatory Surgical Centers, Birth Center Services, Child Health Check-Up (EPSDT), Chiropractic Services, Community Mental Health, County Health Department Services, Dental Services-Adult, Dental Services-Children, Dialysis Services, Durable Medical Equipment, Emergency Services, Family Planning, Federally Qualified Health Centers, Free Standing Dialysis Centers, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Hospital Services, Laboratory, Licensed Midwife Services, Mental Health Targeted Case Management, Occupational Therapy, Optometric Services, Outpatient Hospital, Physical Therapy, Physician Assistant Services, Physician Services, Podiatry, Prescribed Drugs, Respiratory Therapy, Rural Health Clinic, Speech Therapy, Visual Services, 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:

-American Indian/Alaskan Native
-Childrens Medical Services Network Enrollees
-Enrolled in Another Managed Care Program
-Other Insurance
-Poverty Level Pregnant Woman (SOBRA)
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

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:
-Blind/Disabled Adults abd Related Populations (18-20 years old)
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare dual eligibles aged 18-20 yrs.
-Residents in nursing home facility under 21 years of age
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Children in a 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 Commitment Facilities
-Medically Complex Children in CMS Program
-Medically Needy
-Medicare Dual Eligibles
-Other Insurance
-Over 21 years of age
-Poverty Level Pregnant Woman (SOBRA)
-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 Hospice Services

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

Medical-only PAHP (risk or non-risk, non-comprehensive) - FFS/Administrative fee

Service Delivery

Included Services:

Advanced Registered Nurse Practitioner Service, Ambulatory Surgical Centers, Birth Centers, Child Health Check-up, Chiropratic, Community Mental Health, County Health Department Services, Dental Services-Adults, Dental Services-Children, Dialysis, Durable Medical Equipment, Emergency room, Family Planning, Federally Qualified Health Centers, Freestanding Dialysis Centers, Hearing, Home Health, Immunization, Independent Lab, Inpatient Hospital, Licensed Midwive, Occupational Therapy, Optometric Services, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Physician Assistant Services, Podiatry, Rural Health Clinic Services, Speech Therapy, Targeted Case Management, Therapy Services-Respiratory, 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:

-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:

-American Indian/Alaskan Native
-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 commitment facilities
-Medically Complex Children in CMS program
-Medically Needy
-Other Insurance
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Residents in ADM residential treatment facilities
-Retroactive Eligibility
-Share of Cost (Medically Needy Beneficiaries)
-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

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

Service Delivery

Included Services:

Advanced Registered Nurse Practitioner, Ambulatory Surgical Centers, Birth Center, Case Management, Child Health Check-up, Chiropractic, County Health Department, Durable Medical Equipment, Emergency Room, EPSDT, Family Planning, FQHCs, Freestanding Dialysis Centers, Hearing, Home Health, Immunization, Independent Lab, Inpatient Hospital, Licensed Mid-wive, Obstetrical, Occupational Therapy, Optometric Services, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Physician Assistant, Podiatry, Respiratory Therapy, Rurak Health Clinic Services, Speech Therapy, Targeted Case Management, Therapy Services- Respiratory, 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:

-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
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-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 Commitment Facilities
-Medically Complex Children in CMS Program
-Medically Needy
-Medicare Dual Eligibles
-Other Insurance
-Poverty Level Pregnant Woman (SOBRA)
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Share of Cost (Medically Needy Beneficiaries
-Special Needs Children (State defined)
-State Health Services

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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

None

Agencies with which Medicaid Coordinates the Operation of the Program:

None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AIDS Healthcare Foundation, Inc.

Amerigroup of Florida, Inc.

Better Health, LLC

Caremark

Community Based Care Partnership, Ltd.

Coventry Health Care of Florida, Inc. d/b/a Buena Vista

Coventry Health Care of Florida, Inc. d/b/a Vista

DentaQuest of Florida, Inc d/b/a DentaQuest

First Coast Advantage Cental, LLC

Florida Health Partners, Inc.

Freedom Health Plan, Inc.

HealthEase of Florida, Inc.

Hemophilia of the Sunshine State (Lynnfield Drug, Inc.)

Humana Medical Plan, Inc.

Integral Health Plan

Lakeview Center, Inc. d/b/a Access Behavioral Health

Magellan Behavioral Health of Florida

Managed Care of North America d/b/a MCNA Dental Plans

Medica Health Plans of Florida, Inc.

MediPass

Molina Healthcare of Florida, Inc.

North Florida Behavioral Health Partnership

Personal Health Plan d/b/a Healthy Palm Beaches, Inc

Preferred Care Partners Inc. d/b/a Care Florida

Preferred Medical Plan, Inc.

Prestige Health Choice

Public Health Trust of Dade County

Simply Healthcare Plans, Inc.

South Florida Community Care Network

Sunshine State Health Plan

United Healthcare of Florida, Inc.

Universal Health Care, Inc.

WeCareHealth Plans, Inc.

WellCare of Florida, Inc. d/b/a Staywell Health Plan of Florida

ADDITIONAL INFORMATION

The Disease Management PAHP is specifically for persons with one or more of the following diseases: HIV/AIDS and Hemophilia. The Disease Management program reimbursement arrangement is per member per month.

PCCM enrollees receive mental health services through a capitated arrangement.

The Shared Savings Model is mostly Fee-for-Service but administrative costs 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 and others are paid on a capitated basis.

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.

FFS/Administrative Fee

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)

Use of Collected Data:

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

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

Consumer Self-Report Data:

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire
-MCO Member Satisfaction Surveys
-State-developed Survey

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires 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
-Adults Access to Preventive/Ambulatory Health Services (AAP)
-Ambulatory Care
-Annual Dental Visits

Health Status/Outcomes Quality:

-Controlling High Blood Pressure (CBP)
-Patient satisfaction with care

-Antidepressant Medication Management (AMM)
-Appropriate Testing for Pharyngitis
-BMI Assessment (ABA)
-Breast Cancer Screening (BCS)
-Call Abandonment
-Call Answer Timeliness
-Cervical Cancer Screening Rate
-Childhood Immunization Status (CIS) - Combo 2 and 3
-Children and Adolescents Acess to Primary Care Practitioners
-Chlamydia Screening for Women
-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)
-Prenatal and Postpartum Care
-Prenatal Care Frequency (PCF)
-Transportation Availability
-Transportation Timeliness
-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

Access/Availability of Care:

-Adult's access to preventive/ambulatory health services
-Annual Dental Visits (ADV)
-Call Answer Timeliness
-Children's access to primary care practitioners
-Prenatal and Postpartum Care

Use of Services/Utilization:

-Adolescent well-care visit (AWC)
-Emergency Room visits/10,000 beneficiary
-Inpatient Admission/10,000 beneficiary
-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:

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
-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

EQR Data included in State's annual EQR technical report:

-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans

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
-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:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire
-MCO Member Satisfaction Survey
-State-approved 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 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)
-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

State conducts general data completeness assessments:
Yes

-Revenue Codes
-Age-appropriate diagnosis/procedure

Performance Measures

Process Quality:

-Adolescent well-care visit rate
-Adults access to Preventative/Ambulatory Health Services
-Ambulatory Care
-Annual Dental Visits
-Antidepressant medication management
-Appropriate Testing for Children with Paryngitis
-BMI Assessment
-Breast Cancer screening rate
-Cervical cancer screening rate
-Childhood Immunization Status (CIS) - Combo 2 and 3
-Chlamdyia screening in women
-Controlling high blood pressure
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of HIV Disease Monitoring Lab Tests (CD4 and VL)
-Highly Active Antiretroviral Treatment (HAART)
-HIV-Related Medical Visits (HIVV)
-Immunizations for adolescents
-Inhibitors/Angiotensin Receptor Blocker (ARB) Therapy (ACE)
-Lead screening rate
-Lipid Profile Annually (LPA)
-Mental Health Readmission Rate
-Mental Helath Readmission Rate
-Prenatal and Postpartum Care
-Prenatal Care Frequency
-Transportation Availability
-Transportation Timeliness
-Use of angiotensin-converting Enzyme
-Use of Appropriate Medications for people with asthma (ASM)
-Well-child care visit rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:

-Controlling High Blood Pressure
-Patient satisfaction with Care

Access/Availability of Care:

-Adult's access to preventive/ambulatory health services
-Annual Dental Visit
-Call Answer Timeliness
-Children's access to primary care practitioners
-Prenatal and Postpartum Care

Use of Services/Utilization:

-Adolescent well-care visit (AWC)
-Emergency Room visits/10,000 beneficiary
-Well-child care visit rates in 3,4,5, and 6 yrs of life
-Well-Child care visit rates in forst 15months 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:

-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

Clinical Topics:

-Breast cancer screening (Mammography)
-Child Health Checkups
-Clinical Health care disparities - Blood lead screening African American Children

project(s) prescribed by State Medicaid agency

-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:

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

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:

-Health Services Advisory Group

EQRO Mandatory Activities:

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

EQR Data included in State's annual EQR technical report:

-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans

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
-Technical Assistance to MCOs to assist them in conducting quality activities

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

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
None

Use of Collected Data:
None

Consumer Self-Report Data:
None

FLORIDA
Statewide Inpatient Psychiatric Program

CONTACT INFORMATION

State Medicaid Contact:

Devona Pickle
Florida Agency for Health Care Administration
(850) 412-4646

State Website Address:

http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4), Selective Contracting

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
March 23, 1998

Implementation Date:
April 01, 1999

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

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

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), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

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
-1915(i) Behavioral Health

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

Contractor Types:
-Behavioral Health MCO (Private)

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

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

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.)
-Medical record validation

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

EQR Data included in State's annual EQR technical report:
None

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

KENTUCKY
Human Service Transportation Delivery Program

CONTACT INFORMATION

State Medicaid Contact:

Stephanie Mack
Division of Provider Operations
(502) 564-6890

State Website Address:

http://www.chfs.ky.gov/dms

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
November 01, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
September 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 Adults and Related Populations
-Section 1931 Children and Related Populations

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

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

Human Service
Transportation

ADDITIONAL INFORMATION

TITLE XXI CHIP is included up to 150% of FPL. Program converted from 1902(a)(70) to 1915(b).

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:

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

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Track Health Service provision

Consumer Self-Report Data:

-CAHPS
Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire

Use of HEDIS:

-The State 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

KENTUCKY
Kentucky Managed Care Organization Program

CONTACT INFORMATION

State Medicaid Contact:

Thomas McMahan
Kentucky Department for Medicaid Services
(502) 564-4321

State Website Address:

http://www.chfs.ky.gov/dms

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 01, 2011

Implementation Date:
November 01, 2011

Waiver Expiration Date:
October 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

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, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, 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:
None

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

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Eligibility Less Than 3 Months
-Foster Care Children
-Medicare Dual Eligible
-Medicare Dual Eligibles
-Other Insurance
-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:

-Eligible only for TB-related Services
-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:

No lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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

None

Agencies with which Medicaid Coordinates the Operation of the Program:

None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coventry Cares of Kentucky

Kentucky Spirit

WellCare of Kentucky, Inc

ADDITIONAL INFORMATION

The Kentucky Department of Medicaid Services within the Cabinet for Health and Family Services is charged with the administration of the Kentucky Plan for Medical Assistance in accordance with the requirements of Title XIX of the Social Security Act of 1935, as amended (the "Act"), and the statutes, laws, and regulations of Kentucky; and the Kentucky Children's Health Insurance Program (KCHIP) in accordance with the requirements of the Title XXI of the Social Security Act, as amended.
The Contractor is eligible to enter into a risk contract in accordance with Section 1903(m) of the Act and 42 CFR 438.6, is engaged in the business of providing prepaid comprehensive health care services as defined in 42 C.F.R. 438.2, and the Contractor is an insurer under Subtitle 3 of the Kentucky Insurance Code with a health line of authority.

Kentucky Medicaid defines Special Needs Children, as a child with a special health care need. This includes a child in or receiving

foster care or adoption assistance and a blind or disabled child. The MCO shall have a process to target children for the purpose of screening and identifying those with special health care needs. The MCO shall assess each enrollee identified as having a special health care need to determine if the enrollee needs case management or regular care monitoring.

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
-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
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Reporting to CMS on Medicaid/CHIP quality of care measures
-Track Health Service provision

Consumer Self-Report Data:

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

Use of HEDIS:

-The State uses ALL of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs 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
-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
-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 rate
-Antidepressant medication management
-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
-Colorectal Cancer Screening
-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
-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:

-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 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
-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
-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.)
-Net income
-Net worth

Health Plan/ Provider Characteristics:

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

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

Clinical Topics:
-Cervical cancer screening (Pap Test)
-Dental Care Children with SHCN
-Depression management
-Emergency Room service utilization
-Pharmacy management (including psychotropic)
-Reduction of Inapproate Prescribed Antibotics in Children
-Smoking prevention and cessation

Non-Clinical Topics:
-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
-URAC Standards

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

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer 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
-Validation of performance measures

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans
-Specific Health Plan Data only

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
-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

Initial Year of Reward:
Not Applicable

Member Incentives:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

MICHIGAN
Comprehensive Health Plan

CONTACT INFORMATION

State Medicaid Contact:

Kathleen Stiffler
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), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

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:
October 31, 2015

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:
Ambulance, Blood Lead Testing, Case Management, Certified Mid-wife Services, Certified Pediatric and Family Nurse Practitioner, Chiropractic, Diagnostic Lab, X-Ray, and other imaging services, Disease Management, Durable Medical Equipment and Supplies, Emergency, End Stage Renal Disease Services, Family Planning, Health Education, Hearing, Hearing Aid for enrollee under 21 years of age, Home Health, Hospice, Immunization, Inpatient Hospital, Intermittent or Short-term Restorative or Rehab Skilled Nursing Care, Medically Necessary Weight Reduction Services, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outreach, Parenting and Birthing Classes, Pharmacy, Physical Therapy, Physician/Practitioner, Podiatry, Prosthetics and Orthotics, Speech/Language Therapy, Tobacco Cessation Treatment, Transplant, Transportation, Treatment for STDs, Vision, Well Child/EPSDT

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

Populations Voluntarily Enrolled:

-Medicare Dual Eligibles

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 child care institutions
-Enrolled in Another Managed Care Program
-Other insurance (HMO or PPO only)
-Participate in HCBS Waiver
-Persons disenrolled due to special disenrollment or medical exception
-Persons enrolled in CSHCS
-Persons in PACE
-Persons in Repatriate Assistance Program
-Persons in Traumatic Brain Injury Program
-Persons incarcerated
-Persons on Refugee Assistance
-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:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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

None

Agencies with which Medicaid Coordinates the Operation of the Program:

None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross Complete of Michigan
CoventryCares of Michigan, Inc.
McLaren Health Plan
Midwest Health Plan
Physicians Health Plan - FamilyCare
ProCare Health Plan
UnitedHealthcare Community Plan
CareSource of Michigan
HealthPlus Partners, Inc.
Meridian Health Plan of Michigan
Molina Healthcare of Michigan
Priority Health Government Programs, Inc.
Total Health Care
Upper Peninsula Health Plan

ADDITIONAL INFORMATION

Outpatient Mental Health services are limited to twenty (20) visits per contract year.
As of October 1, 2011 Physicians Health Plan of Mid Michigan - FamilyCare changed its name to Physicians Health Plan - FamilyCare
As of January 1, 2012 Great Lakes Health Plan changed its name to UnitedHealthcare Community Plan.
As of January 1, 2012 Health Plan of Michigan changed its name to Meridian Health Plan.
As of April 4, 2012 BlueCaid of Michigan changed its name to Blue Cross Complete of Michigan
As of June 1, 2012 Omnicare Health Plan changed its name to CoventryCares of Michigan, Inc.

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 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 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. NCPDP, ASC X12 837)
-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

State conducts general data completeness assessments:

Yes

-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

Performance Measures

Process Quality:

-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
-Childhood immunization rates
-Chlamdyia screening in women
-Comprehensive Diabetic Care
-Controlling high blood pressure
-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:

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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 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
Covers all MCO members

Rewards Model:
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs

Clinical Conditions:
Asthma
Blood Lead
BMI - Adult and Child
Cancer
Child Immunizations
Diabetes
High Blood Pressure
Prenatal/Post Partum 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.)

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:

Mary Kay Valenzio
Michigan Department of Community Health
(517) 335-5285

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), Selective Contracting

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:
December 31, 2013

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Kids Dental

ADDITIONAL INFORMATION

MDCH contracts for the administration of the Medicaid dental benefit called Healthy Kids Dental in 65 counties and 10 expansion counties. The contractor administers the Medicaid dental benefit to all Medicaid beneficiaries under age 21 in the participating counties. The dental services provided through the contractor mimic the dental services provided through the FFS Medicaid program. Medicaid beneficiaries have access to dentists through the contractors participating dental networks. Beneficiaries must see a dentist who participates with the Healthy Kids Dental contract.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-This Program does collect some quality data

Use of Collected Data:
-None

Consumer Self-Report Data:
None

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

MINNESOTA
Consolidated Chemical Dependency Treatment Fund

CONTACT INFORMATION

State Medicaid Contact:

Carol Backstrom
Minnesota Department of Human Services
(651) 431-2319

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), Selective Contracting

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:
June 30, 2013

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

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

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

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:

Carol Backstrom
Minnesota Department of Human Services
(651) 431-2319

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), Selective Contracting

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
December 28, 2006

Implementation Date:
January 01, 2007

Waiver Expiration Date:
March 31, 2013

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:

Susan Eagen
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

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Enrollment Broker:
Policy Studies

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 01, 1995

Implementation Date:
September 01, 1995

Waiver Expiration Date:
June 30, 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

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

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

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

HealthCare USA CENTRAL
HealthCare USA EASTERN
HealthCare USA WESTERN
Home State Health Plan Central
Home State Health Plan Eastern
Home State Health Plan Western
Missouri Care CENTRAL
Missouri Care EASTERN
Missouri Care WESTERN

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 Home State Health Plan participate in the Eastern, Central, and Western Regions. 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
-Focused Studies
-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
-Data Mining
-Enhanced/revised 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
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
-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

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Ambulatory Care
-Antidepressant medication management
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Avoidance of antibiotic treatment in adults with acute bronchitis
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-Chlamdyia screening in women
-Cholesterol screening and management
-Comprehensive diabetes care HBA1C poor control (>9.0%)
-Comprehensive diabetes care(eye exam, LDL-C screening, HBA1C testing, medical attention for nephropathy)
-Controlling high blood pressure
-Dental services
-Depression management/care
-Diabetes medication management
-Follow up for children prescribed ADHD medication
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care

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

-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Medical assistance with smoking and tobacco use cessation
-Mental Health Utilization
-Postpartum Care
-Use of imaging studies for low back pain
-Use of 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

Access/Availability of Care:

-Appointment availability for psychiatrists for children =<6 years old, children 7 to 12 years old, adolescents 13 to 17 years old and adults => 18 years old(non HEDIS)
-Average distance to PCP
-Average wait time for an appointment with PCP
-Open-closed panels for psychiatrists for children =<6 years old, children 7 to 12 years old, adolescents 13 to 17 years old and adults => 18 years old (Non HEDIS)
-Open-closed panels for psychiatrists treating children, adolescents and adults (Non HEDIS)
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:

-Alternative services/1000 for behavioral health
-Emergency room visits/1,000 beneficiaries under the age of 19
-For mental health > outpatient visits/1000 and > emergency room visits/1000
-Identification of alcohol and other drug services(HEDIS)
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Mental health utilization(HEDIS)
-Number of PCP visits per beneficiary
-Re-admission rates of MH/SUD
-Residential days/1000 for behavioral health

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
-Childhood Immunization
-Chlamydia
-Dental Utilization
-Depression management
-Diabetes management
-Emergency Room service utilization
-Follow-up with primary care providers
-Hospital Readmission
-Lead toxicity
-Obesity
-Perinatal Care
-Seven and thirty day follow-up after behavioral health admission
-Women, Infant, and Children Collaboration

Non-Clinical Topics:

-ADHD coordinated care
-Encounter acceptance rates
-Grievance/Appeals
-Improved Medical Record Documentation
-Member Satisfaction
-Physical/Behavioral care coordination
-Primary care provider assignment

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:

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

EQR Data included in State's annual EQR technical report:

-None

EQRO Optional Activities:

-Assessment of MCO information systems
-Calculation of performance measures
-Case management record review
-Evaluate 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:

Mary Noel Noel
Department of Health and Human Services
(406) 444-4146

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), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Enrollment Broker:
Xerox State Healthcare, LLC

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, 2014

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

Traditional PCCM Provider - Primary Care Case Management Payments

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)

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
-Special Needs Children (BBA defined)
-Team Care

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
-Special Needs Children (State defined)
-Subsidized Adoption

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

Enhanced PCCM Provider - Primary Care Case Management Payments

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/Alaskan 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)
-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
-No populations are excluded
-Participate in HCBS Waiver
-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

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 Improvement Program

Passport to Health

ADDITIONAL INFORMATION

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:
-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)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Colorectal Cancer Screening
-Depression medication management
-Immunizations for two year olds
-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 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), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

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, 2014

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

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, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

None

-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

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

Service Delivery

Included Services:

Case Management, Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, Outpatient Substance Use Disorders

Allowable PCPs:

-Psychiatrists
-Psychologists

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
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)
-Title XXI CHIP

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 receiving Medicaid Hospice Services
-Clients with Excess Income
-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:

Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:

None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

United Healthcare of the Midlands/UnitedHealthcare Community Plan (formerly Share Advantage)

ADDITIONAL INFORMATION

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.

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:
-Accreditation for Participation
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Network Data
-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:
-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
-Pediatric Obesity
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

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

Accreditation Required for Participation:
-Department of Insurance Certification

Standards

-NCQA (National Committee for Quality Assurance)
-URAC

Non-Duplication Based on Accreditation:
-NCQA (National Committee for Quality Assurance)
-URAC

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans
-Specific Health Plan Data only

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.h

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker

Enrollment Broker:
Xerox (formerly Affiliated Computer Services, Inc. - 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:
June 30, 2017

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, Chiropractic, 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 Day Care, Medical Supplies, Optical Appliances, Optometry, Organ Transplants, Outpatient Hospitals, Outpatient Mental Health, Outpatient Rehabilitation Therapies, Outpatient Substance Use Disorders, Personal Care, 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

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicaid Eligible Blind/Disabled Children Recieiving Services Through Title V

Subpopulations Excluded from Otherwise Included Populations:
-DYFS Children in Institutional Settings
-Full Time Students Attending School and Residing Out of the Country
-Individuals Enrolled in Medicaid Demonstration Program
-Individuals Enrolled in PACE
-Individuals in Out Of State Placements
-Individuals who are Institutionalized in an Inpatient Psychiatric Facility
-Medicare Dual Eligibles
-Retroactive Eligibility

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMERIGROUP New Jersey, Inc.
Amerivantage Specialty + RX
Healthfirst Health Plan of New Jersey, Inc.
Healthfirst NJ Maximum Plan
Horizon Medicare Blue Totalcare
Horizon NJ Health
United HealthCare Dual Complete
UnitedHealthCare Community Plan

ADDITIONAL INFORMATION

A number of changes were made in the 1915(b) and were effective with our amendment effective 7/1/11:

Personal care, medical day care, home health, and outpatient rehabilitation therapies were added as covered services 7/1/11.

Dual eligibles were removed from eligible group.

Special needs children (BBA defined) redefined as Medicaid eligible blind/disabled children receiving services through Title V.

Non dual DDD individuals and DDD children under 19 served by Community Care Waiver no longer eligible.

Lock-in period is 12 months.

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

State conducts general data completeness assessments:

Yes

-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

Performance Measures

Process Quality:

-Adolescent immunization rate
-Adolescent well-care visit rates
-Annual monitoring for patients on persisten medications
-Appropriate Testing for Children with Pharyngitis
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical Cancer Screening
-Check-ups after delivery
-Childhood Immunizations
-Comprehensive Diabetes Care
-Diabetes medication management
-Follow up care for children prescribed ADHD medication
-Frequency of on-going prenatal 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:

-BMI Assessment for Children/Adolescents
-Children with Special Needs Focused Study including DYFS Children
-Chlamydia Screening
-EPSDT Quality Study/Dental and Lead
-Follow-up after Hospitalization for Mental Illness (Clients of DDD only)
-Prenatal and Postpartum Care

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…)
-Medical Home Demonstration

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 Certificate of Authority

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

EQR Data included in State's annual EQR technical report:

-Aggregate Data for all MCO Health Plans

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

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:

Julie Weinberg
NM HSD/Medical Assistance Division
(505) 827-6253

State Website Address:

http://www.state.nm.us/hsd/mad/CSalud.html

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

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, 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:
Ambulatory Surgical, Anesthesia, Case Management, Dental, Diagnostic Imaging and Therapeutic Radiology Services, 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 Services Providers, Midwife, Nutritional, Occupational Therapy, Outpatient Hospital, Personal Care - EPSDT, Pharmacy, Physical Therapy, Physician, Podiatry, Pregnancy Termination (State Funded), Prosthetics and Orthotics, Rehabilitation, Reproductive Health, Rural Health Clinic, School Based, Speech Therapy, Telehealth, Transplant, Transportation, Vision, X-Ray

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)

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 Insurance.
-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 (CoLTS)
-Medicare Dual Eligibles
-Participating in D&E Waiver or MiVia Waiver due to Brain Injury

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

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
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Reporting to CMS on Medicaid/CHIP quality of care measures
-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 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 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 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 rate
-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
-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 PCPs to beneficiaries

Use of Services/Utilization:

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit
-Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Health Plan Stability/ Financial/Cost of Care:

None

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:

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

Clinical Topics:

-Adolescent Immunization
-Asthma management
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization

Non-Clinical Topics:

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

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:
-HealthInsight New Mexico dba 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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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
Withholds as an incentive

Clinical Conditions:
Asthma
Childhood immunizations
Diabetes
Perinatal Care
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:

Julie Weinberg
NM HSD/Medical Assistance Division
(505) 827-6253

State Website Address:

http://www.state.nm.us/mad

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

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:
December 31, 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 Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Opioid Treatment Programs, Outpatient Substance Use Disorders, Peer Support for Substance Use Disorders, Peer Support Services for Mental Health, 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
-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)
-CMHC 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
-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 program.
-Clients eligible for family planning services only.
-Clients participating in Health Insurance Premium program.
-Medicare Dual Eligibles
-Retroactive Eligibility
-State Coverage Initiative (SCI) ages 19-64

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

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

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). It operates as a Medicaid Managed Care program with mandatory enrollment with the exception of Native Americans.

Reinsurance: asymmetrical (gains and losses are not equally shared between the State and managed care entity).

QUALITY ACTIVITIES FOR PIHP

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

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

-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
-Consumer/Beneficiary Focus Groups

-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:

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

-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 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:

-Antidepressant medication management

Health Status/Outcomes Quality:

-Mortality rates

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

-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 addictions professionals to number of 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
-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
-Administrative Costs
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Fidelity Bond Coverage
-Medical loss ratio
-Net income
-Net worth
-Profit (Loss)
-Risk Based Capital
-State minimum reserve requirements
-Total revenue
-Value Added Services

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:
-Depression management
-ETOH and other substance abuse screening and treatment

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:
-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
None

EQRO Name:
-HealthInsight New Mexico dba 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

EQR Data included in State's annual EQR technical report:
None

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 Patient Safety and Quality
(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), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

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

SERVICE DELIVERY

Selective Contracting - Other

Service Delivery

Included Services:
Bariatric Surgery

Allowable PCPs:
-Selective contracting with eligible providers.

Enrollment

Populations Voluntarily Enrolled:
-Selective Contracting

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Selective contracting

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

None

ADDITIONAL INFORMATION

Negotiated rate with eligible providers. Program Service Area is New York City only.

Negotiated Rate with eligible providers. Program service area is New York City only.

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), Freedom of Choice
1915(b)(4), Selective Contracting

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, 2016

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
-QMB Plus, SLMB Plus, and Medicaid only
-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

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

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:

Sarah Witmer
Pennsylvania Department of Welfare
(717) 257-7778

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), Freedom of Choice
1915(b)(4), Selective Contracting

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
-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)

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
-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
-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)

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

PENNSYLVANIA
ACCESS Plus Program

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Plus Program

ADDITIONAL INFORMATION

Special Needs Children is broadly defined as non-categorical to include all children

The providers in the network are reimbursed on a Fee for Service basis. The Access Plus contractor receives a capitation for EPCCM Services and capitation for Disease Management Services

Under PCCM, the reason for multiple enrollment basis for the included populations: Access Plus is the default, with exceptions. If a voluntary managed care entity 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 in Access Plus.

Special Needs Children is broadly defined as non-categorical to include all children

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

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

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

Non-Clinical Topics:
-Availability of language interpretation services

-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
-Children's access to primary care practitioners
-ER initiative to reduce ER visit rate

PENNSYLVANIA
HealthChoices

CONTACT INFORMATION

State Medicaid Contact:

Darlene Demore
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), Freedom of Choice
1915(b)(4), Selective Contracting

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)

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)

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

Aetna Better Health

AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan

Community Care Behavioral Health - North Central

Community Care Behavioral Health - Northeast

Counties of Armstrong/Indiana - Value Behavioral Health of PA

Counties of Bedford/Somerset - Community Behavioral Healthcare Network of PA

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 PA

Counties of Lycoming/Clinton - Community Behavioral Healthcare Network of PA

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
Coventry Care
Gateway Health Plan, Inc.
Health Partners of Philadelphia
Keystone Mercy Health Plan
United Healthcare of PA
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.

Special Needs Children is broadly defined as non-categorical to include all children. All consumers receiving behavioral 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
-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)
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Immunization for 2 yr. olds
-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 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)
-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:
-Ace Inhibitor/ARB Therapy
-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
-Diabetes management/care
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care - 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:
-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
-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 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:
-Coordination of Primary and Behavioral Health Care
-Diabetes management
-Emergency Room service utilization
-Obesity Screening/Management
-Reducing Potentially Preventable Readmissions

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

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

EQR Data included in State's annual EQR technical report:
-None

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
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Dimitria Pope
Texas Health and Human Services Commission
(512) 706-4901

State Website Address:

http://www.hhsc.state.tx.us/QuickAnswers/index.sht

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4), Selective Contracting

Enrollment Broker:
Logisticare
Medical Transportation Management

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 25, 2011

Implementation Date:
April 01, 2011

Waiver Expiration Date:
June 30, 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

Transportation PAHP - Risk-based Capitation

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
-Foster Care Children
-Special Needs Children (BBA defined)

Populations Mandatorily Enrolled:
-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
-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 except Medicaid QMB

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

Logisticare

Medical Transportation Management

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.
A portion of the funding appropriated to the Medical Transportation Program (MTP) was utilized to implement a regionalized full-risk transportation brokerage model in areas of the state that can sustain such model. The brokerage model utilizes a pre-payment methodology (capitation) to reimburse the broker. The broker is a single point of contact for beneficiaries to request transportation assistance. The broker then directly arranges the least costly and most appropriate type of transportation for each beneficiary. Broker services are authorized under SEC. 1902 [42 U.S.C. 1396a] (a) (70).

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
-Does not collect quality data at this time.

Use of Collected Data:
-NA

Consumer Self-Report Data:
None

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

TEXAS
NorthSTAR

CONTACT INFORMATION

State Medicaid Contact:

Betsy Johnson
Texas Health and Human Services Commission
(512) 462-6286

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), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

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, 2015

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) Single PIHP
-1932(a)(3) More than one PIHP

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, Day Treatment Services, Detoxification, Dual Diagnosis, Emergency Behavioral Health Services, Inpatient Mental Health, Inpatient Substance Use Disorders, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Use Disorders, Psych Practitioner, Psychiatric or Behavioral Health Physician, Psychologist, Residential Substance Use Disorders Treatment Programs, Targeted Case Management

Contractor Types:
-Behavioral Healthcare Organization (BHO)

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

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

ValueOptions

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
-Geographic Mapping
-Monitoring of PIHP Standards
-Ombudsman
-On-Site Reviews

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

-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Provider Data

Consumer Self-Report Data:
-Modified MHSIP survey

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

Encounter Data

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

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-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
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Depression management/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)

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

EQR Data included in State's annual EQR technical report:
None

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
Texas Medicaid Wellness Program

CONTACT INFORMATION

State Medicaid Contact:

Betsy Johnson
Texas Health and Human Services Commission
(512) 462-6286

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)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
March 01, 2011

Implementation Date:
March 01, 2011

Waiver Expiration Date:
February 28, 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

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:
-Fee-for-Service Blind/Disabled Adults and Related Populations
-Fee-for-Service Blind/Disabled Children and Related Populations
-Fee-for-Service Section 1931 Adults and Related Populations
-Fee-for-Service Section 1931 Children and Related

Populations Mandatorily Enrolled:
None

Populations

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Enrollees in hospice, STAR, STAR+PLUS, or STARHealth programs, as wellas undocumented aliens
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-SCHIP Title XXI Children

Lock-In Provision:

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

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

QMB Plus, SLMB Plus, and Medicaid only
QMB
SLMB, QI, and QDWI
Exclude all categories of Medicare Dual Eligibles

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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

None

Agencies with which Medicaid Coordinates the Operation of the Program:

None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

McKesson Health Solutions

ADDITIONAL INFORMATION

Only clients enrolled in Traditional Medicaid (FFS) are included in this program. Technology, such as use of predictive modeling software, uses claims data to help identify potential program eligibles who are high-cost or high-risk and impactable.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Data Analysis
-Enrollee Hotlines
-Independent Assessment
-Measure Disparities
-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
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data:
-SF-12 and SF-10 Health Survey

Use of HEDIS:
-The State uses SOME 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:
-Influenza Vaccination

Access/Availability of Care:
None

Use of Services/Utilization:
-Admission Rate (Pediatric): Asthma, Diabetes (short-term complications)

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
-Provider Satisfaction Survey

Beneficiary Characteristics:
None

Performance Measures - Others:
-HEDIS

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
-Diabetes management
-Emergency Room service utilization
-Hospital discharge planning

Non-Clinical Topics:

-Enrollment and engagement initiative
-Health and wellness initiative
-Tobacco Cessation
-Weight Watchers

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:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

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, 2016

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

Enhanced PCCM Provider - Primary Care Case Management Payments

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

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

-Non-Traditional

-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
-Poverty-Level Pregnant Women
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-1931 non-pregnant adults
-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:

12 month lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

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

Enrollment

Populations Voluntarily Enrolled:

-Non-Traditional

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
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/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

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
-Federally Qualified Health Centers (FQHCs)
-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

Enrollment

Populations Voluntarily Enrolled:

-Non-Traditional

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
-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

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 Choice Utah
Molina Healthcare of Utah (Molina)
Healthy U
Select Access

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.

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.

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

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
-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
-Children's access to primary care practitioners

Use of Services/Utilization:
None

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

EQR Data included in State's annual EQR technical report:
-Specific Health Plan Data only

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
-On-Site Reviews
-PAHP Standards (see below for details)

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Enhanced/Revise State managed care Medicaid Quality Strategy
-Fraud and Abuse
-Program Evaluation

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

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
-Use of imaging studies for low back pain

Health Status/Outcomes Quality:

-Patient satisfaction with 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

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

Clinical Topics:
-Diabetes management

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

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
None

Use of Collected Data:
None

Consumer Self-Report Data:
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), Freedom of Choice
1915(b)(4), Selective Contracting

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:

-1115 non-traditional Medicaid
-Medicare Dual Eligibles
-Mental Health Services
-Reside in Nursing Facility or ICF/MR
-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

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

Pick Me Up
Transportation

ADDITIONAL INFORMATION

This program is used for the non-emergency transportation for tradional Medicaid clients who are not in a nursing home are at the state hospital.

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.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:

-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

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), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

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, 2016

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B)Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) 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
-Non-Traditional
-Poverty-Level Pregnant Women
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-1925 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

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

Bear River Mental Health Services, Inc

Central Utah Counseling Center

Davis Behavioral Health

Four Corners Community Behavioral Health, Inc.

Northeastern Counseling Center

Salt Lake County Behavioral Health

Southwest Center Behavioral Health Services

Valley Mental Health

Wasatch Mental Health

Weber Human Services

ADDITIONAL INFORMATION

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

Encounter Data

Collection: Requirements:
-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)
-Per member per month analysis and comparisons across PIHPs
-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
-Duplicate encounters

State conducts general data completeness assessments:
Yes

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

Clinical Topics:
-Coordination of primary and behavioral health care

Non-Clinical Topics:
-Increase in detection of co-occurring substance use disorders
-Increase in OQ/YOQ questionaire administrations
-Increase in rate of concurrent documentation of services
-Reduction of no show rates

Standards/Accreditation

PIHP Standards:
-Performance measures or improvement projects aligned with CMS recommended priorities (e.g. Child Core Quality Measures)

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-State Office of Health Care Statistics

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

EQR Data included in State's annual EQR technical report:
None

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

VIRGINIA
Medallion II

CONTACT INFORMATION

State Medicaid Contact:

Mary Mitchell
Department of Medical Assistance Services
(804) 786-3594

State Website Address:

http://WWW.dmas.virginia.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Enrollment Broker:
MAXIMUS, Inc

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 2005

Implementation Date:
April 01, 2005

Waiver Expiration Date:
June 30, 2013

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, 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/Alaskan 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 Meical 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

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

Amerigroup
CareNet
MEDALLION II
Virginia Premier Health Plan
Anthem Healthkeepers Plus
MajestaCare
Optima Family Care

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)
-Focused Studies
-MCO Standards (see below for details)
-Monitoring of MCO Standards

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

-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Performance Measures Validation
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
Adult Medicaid Questionaire
Child Medicaid Questionaire

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-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 well-care visit rate
-Antidepressant medication management
-Asthma care - medication use
-Breast Cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Controlling high blood pressure
-Diabetes medication management
-Enrolee 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
-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
-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:
-Adolescent Well Child Visits
-Follow-up to MH Stay

Non-Clinical Topics:
None

Standards/Accreditation

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

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

Standards

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Delmarva Foundation for Medical Care

EQRO Organization:
-QIO-like entity

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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

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

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

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Enrollment Broker:
MAXIMUS, Inc.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 2005

Implementation Date:
April 01, 2005

Waiver Expiration Date:
June 30, 2013

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 - Fee-for-Service

Service Delivery

Included Services:
Dental, 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:

None

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
-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

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

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

Amerigroup Community Care

Anthem Healthkeepers Plus

MEDALLION
Southern Health CareNet
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)
-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 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 Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure

State conducts general data completeness assessments:

Yes

-Gender-appropriate diagnosis/procedure
-Amount of Payment

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:
-Delmarva Foundation for Medical Care

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

EQR Data included in State's annual EQR technical report:
None

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

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:
None

WASHINGTON
Washington State Integrated Community Mental Health Program

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), Freedom of Choice
1915(b)(4), Selective Contracting

Waiver Expiration Date:
September 30, 2014

Enrollment Broker:
No

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) Permit the State to mandate beneficiaries into a single PIHP or PAHP

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:
Brief Intervention Treatment, Day Support, Evaluation and Treatment/Community Hospitalization, Family Treatment, Group Treatment Services, High Intensity Treatment, Individual Treatment Services, Inpatient Mental Health Services, Intake Evaluation, Medication Management, Mental Health Services Provided in Residential Settings, Peer Support Services for Mental Health, Psychological Assessment, Rehabilitation Case Management, Special Population Evaluation, Stabilization Services, Therapeutic Psychoeducation

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

Contractor Types:
-Regional Authority Operated Entity (Public)
-11 Regional Support Networks

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
-Individuals with Serious and Persistent Mental Health and/or Substance Abuse
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICR/MR
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Homeless People not Enrolled in Medicaid
-Medicare Dual Eligibles
-PACE
-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

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

OptumHealth

Regional Support Network

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-Ombudsman
-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
-Regulatory Compliance/Federal Reporting

-Performance Measures (see below for details)
-PIHP Standards (see below for details)
-Quality Review Team

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

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:

-Consumer Voice in Treatment Planning
-Decrease in the Days to Medication Evaluation Appointment After Request for Service
-Employment Outcomes for Adult Consumers
-Healthy Living Program
-High-Fidelity Wraparound
-Impact of Care Management on Child Readmissions to Inpatient Care
-Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder
-Increased Continuity of Care as a Result of Rehabilitation Case Management
-Metabolic Syndrome Screening and Intervention
-Permanent Supported Housing
-Provision of Outpatient Mental Health Services via TeleHealth System
-Reducing Self-Reported Symptoms of Depression through Participation in Group Psychotherapy
-Treatment Plan Review Following Extraordinary Events

Non-Clinical Topics:

-Consumer Residential Satisfaction
-Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
-Improvement in Inpatient Capacity and Placement Using Evaluation and Treatment
-Improving Coordination of Care and Outcomes
-Improving Early Engagement in Outpatient Services
-Improving Enrollee Engagement
-Improving Percentage of Medicaid Clients Who Receive an Intake Service within 14 Days of Service Request
-Improving the Submission of Correct and Timely Reauthorization Requests
-Increased Penetration Rate for Older Adults Enrolled in the Medicaid Program
-Reporting Mental Health Specialist Consultations
-Weight Monitoring

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:
-Acumentra Health

EQRO Organization:
-External qualtiy review organization (Acumentra)

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

EQR Data included in State's annual EQR technical report:
None

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), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

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, 2014

Sections of Title XIX Waived:
-1902(a)(17) Comparability of Eligibility Standards
-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

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-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

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
-Foster Care Children
-Section 1931 Children and Related Populations

Populations Mandatorily Enrolled:

-Section 1931 Adults 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

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

Carelink Health Plan
Physician Assured Access System
Health Plan of the Upper Ohio Valley
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 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
-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:

-Not Applicable

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, 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

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
-Emergency Room service utilization

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 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

EQR Data included in State's annual EQR technical report:

-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans

EQRO Optional Activities:

-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs to assist them in conducting quality activities
-Validation of 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:

Covers all MCO members

Rewards Model:

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

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) 417-4711

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 for deemed newborns, 6 months guaranteed eligibility for first-time AHCCCS enrollees

Initial Waiver Approval Date:
July 13, 1982

Implementation Date:
October 01, 1982

Waiver Expiration Date:
September 30, 2016

Sections of Title XIX Waived:
-1902(a)(10)((A)(ii)(V) Eligibility based on Institutionalized Status
-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)(A) Freedom of Choice
-1902(a)(34) Retroactive Coverage
-1902(a)(4) Proper & Efficient Administration
-1902(a)(54) Drug Utilization Review

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,

Allowable PCPs:
-Family Practitioners

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 Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Skilled Nursing Facility, Speech Therapy, Transplantation of Organs and Tissue and Related Immunosuppresant Drugs, Transportation, Vision, X-Ray

-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-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

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

Contractor Types:
-Regional Authority Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Adoption Subsidy Children
-Adults Without Minor Children Title XIX Waiver, Frozen as of 7/8/2011
-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, Terminated 9/30/11

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

Lock-In Provision:
No lock-in

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

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AZ Physicians IPA (Family Planning Extension)

AZ Physicians IPA (HP)

Bridgeway (Family Planning Extension)
Bridgeway Health Solution (HP)
Bridgeway Health Solution (PC)
Care 1st Health Plan
Care 1st Health Plan (Family Planning Extension)
Department of Economic Security/Childrens Medical and Dental Program (HP)
Department of Economic Security/Division of Developmental Disabilities (PC)
Department of Health Services (Behavioral Health)
Evercare Select (PC)
Health Choice Arizona (Family Planning Extension)
Health Choice Arizona (HP)
Maricopa County Health Plan (Family Planning Extension)
Maricopa County Health Plan (HP)
Mercy Care Plan (Family Planning Extension)
Mercy Care Plan (HP)
Mercy Care Plan (PC)
Phoenix Health Plan (Family Planning Extension)
Phoenix Health Plan (HP)
University Family Care (Family Planning Extension)
University Family Care (HP)

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:

-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)
-Performance Measures (see below for details)
-Provider Data
-Quality Management/Quality Improvement Annual Plans and Annual Evaluations

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Quality Improvement
-Regulatory Compliance/Federal Reporting
-Reporting to CMS on Medicaid/CHIP quality of care measures
-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

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

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

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

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 Population
-Dental services
-Diabetes 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

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:
-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 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
-Financial Viability Ratios (i.e., Current Ratio, Medical Expense, Adminstrative, Equity/Member)
-Net income
-Total revenue

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

Beneficiary Characteristics:
-Age
-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:
-Health Plan Stability/Financial

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:
-Childhood Immunization
-Diabetes management
-Pharmacy management & coordination of care
-Prevention of Influenza

Non-Clinical Topics:
-Advance Directives
-Availability of language interpretation services
-Provider education regarding cultural health care needs of members

Standards/Accreditation

MCO Standards:
-CMS Core Performance Measures
-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
-URAC Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Services Advisory Group
-Healthcare Excel

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

EQR Data included in State's annual EQR technical report:
-Specific Health Plan Data only

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 MENTAL HEALTH 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)
-Physician Survey
-PIHP Standards (see below for details)
-Provider Data
-Quality Management/Quality Improvement Annual Plans and Annual Evaluations

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

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-Member Survey
-State-developed Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State 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

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)

data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Encounters to be submitted based upon national standardized forms (e.g. UB-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

Performance Measures

Process Quality:
-Appropriateness of services
-Coordination of care with acute contractors/pcp's
-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

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
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
-Agency performance bond requirements
-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

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
-URAC Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Care Excel

EQRO Organization:
-Quality Improvement Organization (QIO)

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

EQR Data included in State's annual EQR technical report:
-Specific Health Plan Data only

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
Safety Net

CONTACT INFORMATION

State Medicaid Contact:

ANDREW ALLISON
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, 2013

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Cost Containment Strategy

SERVICE DELIVERY

Traditional PCCM Provider - Primary Care Case Management Fee

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
-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:

-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

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

Connect
Care

ADDITIONAL INFORMATION

None

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

CALIFORNIA
Bridge to Reform Demonstration: COHS Model

CONTACT INFORMATION

State Medicaid Contact:

Margaret Tatar
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhcs.ca.gov

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:
November 01, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
October 31, 2015

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13) Payment to Providers
-1902(a)(23) Freedom of Choice
-1902(a)(30) Payment to Providers
-1902(a)(5) Single State Agency

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

SERVICE DELIVERY

HIO - Risk-based Capitation

Service Delivery

Included Services:
Acute ICF Visits, Comprehensive Case Management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, FQHC, Health Education and Counseling, Health Risk Assessment (HRA), Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Long Term Care, Medically Necessary, Nurse Practitioner, Optometry, Outpatient Hemodialysis, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Rural Health Clinic (RHC), Skilled Nursing Facility, Subacute Care, Swing Bed, Transitional Inpatient Care, Transportation, Urgent Care, 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
-Specialty Providers (MD)

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 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

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

Caloptima-Orange
CenCal Health Plan
Central California Alliance For Health
Gold Coast Health Plan
Health Plan of San Mateo
Partnership Health Plan

ADDITIONAL INFORMATION

Operating authority under 1115 Demonstration Waiver. Authorizes a county operated managed health care program in 14 counties. Enrollment is mandatory for all covered aid codes. Health Plan of San Mateo is the only MCO that is under contract with the COHS model while the rest of the plans are HIOs.

QUALITY ACTIVITIES FOR MCO/HIO

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

Use of Collected Data:
-Contract Standard Compliance
-Data Mining

-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)
-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 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

Health Status/Outcomes Quality:

-Patient satisfaction with care

-Ambulatory Care
-Avoidance of antibiotic treatment in adults with acute Bronchitis
-Cervical cancer screening rate
-Child and Adolescent Immunizations
-Children and Adolscents' Access to Primary Care Providers
-Diabetes management/care
-Initiation of prenatal care - timeliness of
-Monitoring for Patients on Persistent Medications
-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

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

Access/Availability of Care:

-Average distance to PCP

Use of Services/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:

-All-Cause Readmissions
-Improving Asthma Health Outcomes
-Improving Care and Reducing Acute Readmissions for People with COPD
-Improving the Rates of Cervical Cancer Screening Among Wormen 21-64
-Increasing Timeliness of Prenatal Care
-Weight assessment and counseling for nutrition and physical activity for children and adolescents

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

EQR Data included in State's annual EQR technical report:
-Aggregate Data for all MCO Health Plans

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
Bridge to Reform Demonstration: Geographic Managed Care Model

CONTACT INFORMATION

State Medicaid Contact:

Margaret Tatar
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115(a) - Demonstration Waiver Program

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:
November 01, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
October 31, 2015

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13) Payment to Providers
-1902(a)(23) Freedom of Choice
-1902(a)(30) Payment to Providers
-1902(a)(5)Single State Agency

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

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Acute ICF, Case Management, Cultural/Linguistic, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, FQHCs, Health Education, Health Risk Assessment (HRA), Hospice, Immunization, Inpatient Hospital, Laboratory, Long Term Care Services for Month of Admission Plus one Additional Month, Nurse Practitioner, Occupational Therapy, Optometry, Outpatient Hemodialysis, Outpatient Hospital, Outpatient Rehab, Pharmacy, Physical Therapy, Physician, Preventive Health Screening, Specialist, Subacute Care, Swing Bed, Transitional Outpatient, 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)
-Specialty Providers (MDs)

Enrollment

Populations Voluntarily Enrolled:
-Adoption Assist/Medically Indigent-Child
-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Pregnant/Medically Indigent-Adult

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

Subpopulations Excluded from Otherwise Included Populations:
-CHIP Title XXI Children(Healthy Families)
-Eligibility 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

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

Anthem Blue Cross Partnership Plan - Sacramento
Community Health Group Partnership Plan-San Diego
Health Net Community Solutions, Inc.-San Diego
KP Cal, LLC-San Diego
Molina Healthcare of California Partner Plan, Inc. - San Diego
Care 1st Health Plan/San Diego
Health Net Community Solutions, Inc. - Sacramento
KP Cal, LLC - Sacramento
Molina Healthcare of California Partner Plan, Inc. - Sacramento

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

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining

-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)
-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 submission

Collection: Standardized Forms:

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

Health Status/Outcomes Quality:

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

-Avoidance of antibiotic treatment in adults with acute Bronchitis
-Cervical cancer screening rate
-Child and Adolescent Immunizations
-Children and Adolescents' Access to Primary Care Practitioners
-Diabetes Management/Care
-Initiation of prenatal care - timeliness of
-Monitoring for Patients on Persistent Medications
-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

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:

-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)
-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

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:

-All-Cause Readmissions
-Cervical cancer screening among seniors and persons with disabilities
-Childhood obesity
-Children and Adolescents' Access to Primary Care Practitioners
-Comprehensive Diabetes Care
-Hypertension management
-Improving Treatment of Chronic Obstuctive Pulmonary Disease (COPD)
-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

EQR Data included in State's annual EQR technical report:
-Aggregate Data for all MCO Health Plans

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
Bridge to Reform Demonstration: LIHP Model

CONTACT INFORMATION

State Medicaid Contact:

Jalynne Callori
Low Income Health Program Division
(916) 324-0725

State Website Address:

http://www.dhcs.ca.gov

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:
None

Initial Waiver Approval Date:
November 01, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
October 31, 2015

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:
-1902(a)(14) Cost Sharing Requirements
-1902(a)(17) Comparability Eligibility Expansion
-1902(a)(34) Retroactive Eligibility
-1902(a)(43) Early Periodic Screening Diagnosis & Treatment
-1902(a)(8) Reasonable Promptness
-1903(m)(2)(A)(vi) Disenrollment Rights
-1903(m)(2)(A)(xii) Compliance with Section 1932(b)(2) Out-of-network emergency services
-1903(m)(2)(A)(xii) External Quality Review
-1903(m)(2)(A)(xii) Marketing Restrictions
-1903(m)(2)(A)(xii) Network Adequacy
-1903(m)(2)(A)(xii) Provider Choice
-1903(m)(2)(A)(xii) State Quality Strategy

SERVICE DELIVERY

Medical-only PIHP (risk or non-risk, non-comprehensive with inpatient hospital) - Other

Service Delivery

Included Services:
Durable Medical Equipment, Emergency Care, Inpatient Hospital, Laboratory, Mental Health, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Prescription Drugs, Prosthetic and Orthotic Devices, Radiology, Transportation

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)
-Specialized Providers (MDs)

Enrollment

Populations Voluntarily Enrolled:
-HCCI: Individuals - 19-64 (not enrolled in Medicaid with incomes above 133% to 200%, non-pregnant, n
-MCE: Individuals - 19-64 (not enrolled in Medicaid with incomes at or below 133% FPL), non-pregnant

Populations Mandatorily Enrolled:
None

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access, Coverage, Enrollment Program (ACE Program for Adults)
ArrowCare
Contra Costa Health Plan - LIHP
Healthy Way LA
HealthyPAC
Kern Medical Center Health Plan
Medical Services Initiative
MediCruz Advantage Program
Path2Health
Riverside County Healthcare
San Diego LIHP
San Joaquin LIHP
San Mateo Access and Care for Everyone (ACE)
SF Path
Valley Care

ADDITIONAL INFORMATION

Low Income Health Programs (LIHPs) are county-based elective programs that consist of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The services listed are the minimum benefits that must be provided to the MCE population. HCCI minimum benefits exclude mental health and transportation. While LIHPs must provide the minimum benefit packages many also offer additional services, which vary by program.

The Low Income Health Program began with all local programs reimbursed as fee-for-service. The California Department of Health Care Services is waiting for final approval for eight local programs to be reimbursed as risk-based capitation retroactive to the July 1, 2011, beginning of the program. These eight local programs are paid on a cost-basis using certified public expenditures on an interim basis until the capitation rates are approved by CMS.

QUALITY ACTIVITIES FOR MENTAL HEALTH PIHP

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

Use of Collected Data:
-Plan Reimbursement

-Performance Measures (see below for details)

Consumer Self-Report Data:
None

-Program Evaluation

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

Collections: Submission Specifications:
-Plans submit encounter data quarterly

Collection: Standardized Forms:
None

Validation - Methods:
-Basic logic test
-Rates of utilization are validated between counties and against previous data

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

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Timely access

Use of Services/Utilization:
-Rate of service utlization for required services

Health Plan Stability/ Financial/Cost of Care:
None

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:
-NA (Exempt)

EQRO Organization:
-NA (Exempt)

EQRO Mandatory Activities:
-NA (Exempt)

EQR Data included in State's annual EQR technical report:
None

EQRO Optional Activities
-NA (Exempt)

CALIFORNIA
Bridge to Reform Demonstration: Sacramento Dental PAHP

CONTACT INFORMATION

State Medicaid Contact:

Jon Chin
Medi-Cal Dental Services Division
(916) 464-3888

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Health Care Options/Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
November 01, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
October 31, 2015

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13) Payment to Providers
-1902(a)(23) Freedom of Choice
-1902(a)(30) Payment to Providers
-1902(a)(5) Single State Agency

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

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

-Pregnant/Medically Indigent-Adult

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Less Than 3 Months
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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

ADDITIONAL INFORMATION

This waiver allows mandatory enrollment into dental managed care under Sacramento GMC. This program also includes EPSDT, screening, preventive, and health education services relating to dental services.

QUALITY ACTIVITIES FOR PAHP

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
Bridge to Reform Demonstration: Two-Plan Model

CONTACT INFORMATION

State Medicaid Contact:

Margaret Tatar
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115(a) - Demonstration Waiver Program

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:
November 01, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
October 31, 2015

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13)Payment to Providers
-1902(a)(23) Freedom of Choice
-1902(a)(30)Payment to Providers
-1902(a)(5) Single State Agency

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

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Acute ICF, Case Management, Cultural/Linguistic, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, FQHC, Health Education, Health Risk Assessment (HRA), Hospice, Immunization, Inpatient Hospital, Laboratory, Long Term Care for Month of Admission Plus 1 Additional Month, Nurse Practitioner, Occupational Therapy, Optometry, Outpatient Hemodialysis, Outpatient Hospital, Outpatient Rehab, Pharmacy, Physical Therapy, Physician, Preventive Health Screening, Specialist, Subacute Care, Swing Bed, Transitional Outpatient, 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
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)
-Specialty Care Providers (MDs)

Enrollment

Populations Voluntarily Enrolled:
-Adoption Assistance/Medically Indigent Children
-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Pregnant/Medically Indigent Adults

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Public Assistance - Family
-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
-Other Insurance
-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

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

Alameda Alliance for Health
CalViva Health
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 1115 Demonstration Waiver.

QUALITY ACTIVITIES FOR MCO/HIO

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
-MCO Standards (see below for details)
-Ombudsman
-On-site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-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 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

Health Status/Outcomes Quality:

-Patient satisfaction with care

-Ambulatory Care
-Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
-Cervical cancer screening rate
-Child and Adolescent Immunizations
-Children and Adolescents' Access to Primary Care Practitioners
-Diabetes Management/Care
-Initiation of prenatal care - timeliness of
-Monitoring for Patients on Persistent Medications
-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
-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:

-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)
-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

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
-All-Cause Readmissions
-Asthma management
-Attention deficit hyperactivity disorder management
-Cervical cancer screening among seniors and persons with disabilities
-Childhood obesity
-Comprehensive diabetic quality improvement
-Diabetic testing & retinal exam screening
-Hypertension management
-Improving Diabetes Management
-Improving HbA1c testing rates (Diabetes)
-Improving postpartum care rates

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

EQR Data included in State's annual EQR technical report:
-Aggregate Data for all MCO Health Plans

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

DELAWARE
DIAMOND STATE HEALTH PLAN

CONTACT INFORMATION

State Medicaid Contact:

Glyne Williams
Division of Medicaid and Medical Services
(302) 255-9628

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:
HP Enterprise Services, LLC

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:
Adult Day Services, Case Management, Day Habilitation, Durable Medical Equipment, Emergency Response Systems, EPSDT, Family Planning, Hearing, Home Delivered Meals, Home Health, Immunization, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Integrated Services, Laboratory, Minor Home Modifications, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Attendant Services, Physical Therapy, Physician, Podiatry, Private Duty Nursing, Respite Care, 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)

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:

QMB, SLMB

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, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Private Duty Nursing, 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
-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

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

Delaware Physicians Care, Inc
UnitedHealthcare Community Plan
Diamond State Partners

DELAWARE
DIAMOND STATE HEALTH PLAN

ADDITIONAL INFORMATION

The Diamond State Health Plan (DSHP) is a state-wide mandatory managed care program. Approximately 82% 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.

Unison Health Plan of Delaware, Inc. is now rebranded UnitedHealthcare Community Plan

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)
-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 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:

-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

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

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

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
-Adults' Access to Preventive/Ambulatory Health Services
-Ambulatory Care
-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
-Comprehensive Diabetes Care
-Controlling high blood pressure
-Immunizations for two year olds
-Inpatient Utilization
-Lead screening 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:
-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 panels
-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

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:

Clinical Topics:

-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

-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 Government Human Services

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

EQR Data included in State's annual EQR technical report:
-Specific Health Plan Data only

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

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 has collaborated with a private sector entity to support the P4P program

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

Rewards Model:
To be determined

Clinical Conditions:
Possible clinical conditions not yet identified

Measurement of Improved Performance:
To be determined

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR OTHER

Quality Oversight Activities:
None

Use of Collected Data:
None

Consumer Self-Report Data:
None

DISTRICT OF COLUMBIA
Childless Adults 1115 Demonstration

CONTACT INFORMATION

State Medicaid Contact:

Lisa Truitt
Department of Health Care Finance
(202) 422-9109

State Website Address:

http://www.dchealth.dc.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Policy Studies, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 28, 2010

Implementation Date:
November 01, 2010

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(3)
-1902(a)(34) Retroactive Eligibility
-1902(a)(8)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Expenditures not otherwise specified under 1903
-Uncompensated Care Expenditures

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, 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:
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Addiction Professionals (i.e. Substance Use Disorder counselors, alcohol and drug counselors,
-Pediatricians
-Physician Assistants
-Psychiatrists
-Psychologists

DISTRICT OF COLUMBIA
Childless Adults 1115 Demonstration

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Childless adults (21-64) between 133 and 200 FPL

Subpopulations Excluded from Otherwise Included Populations:
-Eligible only for TB-related Services
-Enrolled in CDC BCCT Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman (SOBRA)
-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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

DC Chartered Health Plan, Incorporated

United Healthcare Community Plan

ADDITIONAL INFORMATION

The Childless Adult 1115 Demonstration provides eligibility to childless adults (age 21-64) between 133-200 FPL. Enrollees select one of two managed care organizations, and are enrolled via enrollment broker. They receive the same comprehensive Medicaid benefits package that all Medicaid managed care enrollees receive, and there are no exceptions or limits in place for this population. It was implemented in concert with a state plan amendment (under ACA authority) providing coverage to childless adults up to 133% FPL.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO Standards (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Plan Reimbursement

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

Collections: Submission Specifications:
-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

data submission

Collection: Standardized Forms:
-Not Applicable

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:
-Mortality rates
-Patient satisfaction with care

Access/Availability of Care:
None

Use of Services/Utilization:
None

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
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:
-Delmarva Foundation for Medical Care

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
-Validation of performance measures

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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, but plans to implement one in the future

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.)
Assessing the timely submission of complete and accurate electronic encounter/claims data
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

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, 2014

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) Automatic Re-Enrollment 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
-Physician Assistants
-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

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

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

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

AHF MCO of Florida, Inc.(Reform) d/b/a Positive Healthcare Florida (Reform)
Better Health, LLC (Reform)
Children's Medical Services (Reform)
First Coast Advantage (Reform)
Freedom Health Plan, Inc. (Reform)
Humana Medical Plan, Inc. (Reform)
Medica Health Plans of Florida, Inc. (Reform)
Molina Healthcare of Florida, Inc. (Reform)

Preferred Care Partners, Inc. d/b/a Care Florida (Reform)
Sunshine State Health Plan, Inc. (Reform)
Universal Health Care, Inc. (Reform)
South Florida Community Care Network (Reform)
United Healthcare of Florida, 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), d/b/a Positive Health Care, is 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.

FFS/Administrative Fee

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
-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
-Program Modification, Expansion, or Renewal
-Track Health Service Provision

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)
-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

Collections: Submission Specifications:

-Data submission requirements for file submissions and transactions including documentation describing set of encounter data elements, definitions, required values, standards for transactions, referencing national implementation and standard transaction gu
-Guidelines for testing initial encounter data submission
-Requirement for attestation certifying data is correct for each file

Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Timeframes specified for encounter data submission(s) and corrections.
-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 edits to trending and comparing utilization measures.
-Comparison to benchmarks and to statewide MCO utilization measures (to State FFS utilization rates , and comparisons to submitted reports 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
-Procedure Codes
-Revenue Codes

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
-Appropriate Testing for Pharyngitis
-BMI Assessment
-Breast Cancer screening rate
-Call Abandonment
-Call Answer Timliness
-Cervical cancer screening rate
-Childhood Immunization Status-Combo 2 and 3
-Children and Adolescents Access to Primary Care Practitioners
-Chlamydia Screening for Women
-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
-Prenatal and postpartum care
-Prenatal Care Frequency
-Transportation Availability
-Transportation Timeliness
-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

Health Status/Outcomes Quality:

-Comprehensive Diabetes Care
-Controlling high blood pressure

-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Annual dental visit
-Call Answer Timeliness
-Children's access to primary care practitioners
-Prenatal and postpartum care

Use of Services/Utilization:
-Adolecent wellcare visits
-Ambulatory care
-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:
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 Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Follow up withinseven days after acute discharge for a mental health diagnosis
-HIV/AIDS Prevention and/or Management
-Well Child Care/EPSDT

Non-Clinical Topics:
-Adolescent Child Health Check-up Paticipation Rates Within and Across Racial 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 Services Advisory Group (HSAG)

EQRO Organization:
-Health Services Advisory Group
-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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans

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
-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, but plans to implement one in the future

Program Payers:
Unknown at this time

Population Categories Included:
Unknown at this time

Rewards Model:
Unknown at this time

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Unknown at this time

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR MENTAL HEALTH PIHP

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-Call Abandonment
-Call Answer Timliness
-Children and adolescents access to primary care practitioners
-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
-Adult Access to preventative/ambulatory health services
-Ambulatory Care
-Annual Dental Visit
-Anti-Depressant medication management
-Appropriate testing for Pharyngitis
-BMI Assessment
-Breast Cancer screening rate
-Call Abandonment
-Call Answer Timeliness
-Cervical cancer screening rate
-Children and Adolescents Accesss to Primary Care Practitioners
-Children immunization status combo 2 and 3
-Chlamydia screening for women
-Controlling high blood pressure
-Diabetes medication management
-Follow up care for children prescribed ADHD Medication
-Follow-up After Hospitalization for Mental Illness
-Frequency of HIV disease monitoring lab tests
-Highly active anti-retroviral treatment
-HIV related medical visits
-immunzations for adolescents
-Lead screening in children (LSC)
-Lipid profile annually
-Mental Health Readmission Rate
-Prenatal and Postpartum Care
-Prenatal care frequency
-Transportation availability
-Transportation timliness
-use of angiotensin-converting enzyme inhibitors/angiotensin receptors blockers therapy
-Use of appropriate medications for perople 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

Health Status/Outcomes Quality:
-Comprehensive Diabetes Care
-Controlling high blood pressure

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Annual Dental Visit
-Call Answer Timeliness
-Children's access to primary care practitioners
-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

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:

-Adults access to preventive/ambulatory health services
-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

EQR Data included in State's annual EQR technical report:

-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans

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:

Kenneth Fink
Hawaii Department of Human Services, Med-QUEST Division
(808) 692-8134

State Website Address:

http://www.med-quest.us/

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)(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, Subacute Care (when cost appropriate), Transportation, X-

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

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:
-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

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

Aloha Care
HMSA-Medical
Kaiser Permanente
Ohana QExA
Ohana QUEST
United QExA
United QUEST

ADDITIONAL INFORMATION

Evercare QUEST and Ohana QUEST started from 7/1/2012

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

State conducts general data completeness assessments:

Yes

-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-State contracted with HSAG on encounter validation project

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
-Initiation and engagement of alcohol and other drug dependence treatment
-Prenatal and postpartum care
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:

-Ambulatory care
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 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
-Rate of preventable hospital admissions
-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

Health Plan/ Provider Characteristics:

-Board Certification

-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
-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
-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
-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:
-AAAHC (Accreditation Association for Ambulatory 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:
-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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans
-Specific Health Plan Data only

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:
Quest MCOs (Non-ABD) have imnplemented P4P. QExA Plans (ABD) have not implemented P4P, but plan to in the future.

Program Payers:
Medicaid is the only payer

HAWAII
Hawaii QUEST Expanded (QEx)

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

Clinical Conditions:
5 conditions are measued each year, they change annually
Asthma
Childhood immunizations
Chlamydia Screening
Controlling high blood pressure
Diabetes
Prenatal Care
Well-child visits

Initial Year of Reward:
2010

Member Incentives:
Not Applicable

Rewards Model:
Payment incentives/differentials to reward MCOs

Measurement of Improved Performance:
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

INDIANA
Healthy Indiana Plan

CONTACT INFORMATION

State Medicaid Contact:

Natalie Angel
Office of Medicaid Policy & Planning
(317) 234-5547

State Website Address:

http://www.in.gov/fssa/hip/

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, 2013

Sections of Title XIX Waived:
-1902(a)(1) Statewideness/Uniformity
-1902(a)(10)(6)(i) Income and Resource Test
-1902(a)(10)(A) Eligibility Section
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility
-1902(a)(37)(B) Prepayment Review
-1902(a)(4) Methods of Adminstration: Transportation
-1902(a)(43) Dental and Vision Coverage for Certain HIP Caretakers and HIP Adults

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, FQHC, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, 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
-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

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

Anthem-Healthy Indiana Plan
Enhanced Services Plan (ESP)-Healthy Indiana Plan
Managed Health Services-Healthy Indiana Plan
MDwise-Healthy Indiana Plan

ADDITIONAL INFORMATION

The HIP Enhanced Services Plan (ESP) is designated for certain individuals with health care conditions that require additional support. These conditions include internal cancers, HIV/AIDS, hemophilia, aplastic anemia and organ transplants. ESP is delivered fee for service and it offers the same benefit package as the MCO under this program except for the disease and case management services particular to their health condition. ESP is administered by contract with vendors that administer the Indiana Comprehensive Health Insurance Association (ICHIA). The ESP plan includes a wide selection of providers throughout the State, as every Medicaid or Indiana Health Coverage Program provider is included in the network. Additionally, all ESP members will receive disease and case management services particular to their health condition. The ESP plan has experience with providing health care to persons with significant and serious health conditions. The State reimburses the ESP plan update to the Medicaid allowable. In addition ESP is paid a per member per month fee for administering the health plan.

QUALITY ACTIVITIES FOR MCO/HIO

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

Use of Collected Data:
-Contract Standard Compliance
-Data Mining

-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)
-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
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

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, Inc.

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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:

Natalie Angel
Office of Medicaid Policy & Planning
(317) 234-5547

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, 2014

Sections of Title XIX Waived:
-1902(a)(1) Statewideness/Uniformity
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13)(A) DSH Payments
-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

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

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

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.

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
-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

-Provider Data

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

-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:
-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

Performance Measures

Process Quality:
-Adolescent well-care visit rate
-Annual Monitoring for Persistent Medications
-Antidepressant medication management
-Appropriate Testing and Treatment for COPD
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory

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

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
-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

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

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, Inc.

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

EQR Data included in State's annual EQR technical report:

-Aggregate and Specific Health Plan Data

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

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
Passport Health Plan

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:
December 31, 2012

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

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

Passport Health Plan

Passport Health Plan

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Accreditation for Participation

Use of Collected Data:

-Contract Standard Compliance

-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
-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

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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

LOUISIANA
Greater New Orleans Community Health Connection (GNOCHC)

CONTACT INFORMATION

State Medicaid Contact:

Marisa Naquin
LA Dept of Health & Hospitals
(504) 568-8280

State Website Address:

www.dhh.louisiana.gov

PROGRAM DATA

Program Service Area:
Parish

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

Initial Waiver Approval Date:
September 22, 2010

Implementation Date:
October 01, 2010

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)(B) and 1902(a)(17) Comparability
-1902(a)(17) Eligibility Standards
-1902(a)(2)State Financial Share
-1902(a)(23) Freedom of Choice
-1902(a)(3) and 1902(a)(8) Reasonable Promptness
-1902(a)(34) Retroactive Eligibility
-1902(a)(4),insofar as it incorporates 42CFR 431.53
-1902(a)(43)Early and Periodic Screening, Diagnostic, and Treatment Services

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Department of Health & Hospitals

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

All-Inclusive Encounter-Based Rates - Other

Service Delivery

Included Services:
Basic behavioral care services include mental hearlth and or substance abuse screening, assessment,, Care Coordination, Immunization, Laboratory, Physician, Preventive, Primary Care, Specialty Care- with referral from and by discretion of Primary Care, X-Ray

Allowable PCPs:
-Behavioral health care licensed practitioners
-Clinical Nurse Specialist
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Pediatricians

-Physician Assistants
-Practitioners authorized to provide services directly or under supervision according to Medicaid Men
-Psychiatrists
-Psychologists

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native
-Are between 19 and 64 years old
-Are non-pregnant
-Have a family income up to 200 of the federal poverty level
-Resident of Greater New Orleans Region
-Uninsured for at least 6 months

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Less Than 3 Months
-Enrolled in Another Managed Care Program
-Enrolled in CDC BCCT Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman (SOBRA)
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Greater New Orleans Community Health Connection
(GNOCHC)

ADDITIONAL INFORMATION

The array of services described below is provided under the Greater New Orleans Community Health Connection (GNOCHC) Waiver and must be delivered on an outpatient basis. Requests for pre-admission certification for inpatient hospitalization and inpatient hospital services are not covered.

GNOCHC services fall into two broad categories: core services and specialty services. Core services are medically necessary services coverable under section 1905(a) of the Social Security Act which each GNOCHC provider is expected to provide or purchase on behalf of recipients. Core services include both primary care and behavioral health care services. Specialty services are medically necessary services which each GNOCHC primary care provider is expected to provide to recipients directly or by referral from the primary care provider.

There is no annual visit limit; however, only one primary care visit and/or one behavior health care visit is allowed for the same date of service.

MARYLAND
HealthChoice

CONTACT INFORMATION

State Medicaid Contact:

Pam Williams
Department of Health and Mental Hygiene
(410) 767-3532

State Website Address:

http://www.dhmh.maryland.gov/

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)(15)
-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

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:

Populations Mandatorily Enrolled:

None

-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

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
-Pediatricians
-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

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

AMERIGROUP - PAC

AMERIGROUP Maryland Inc.

JAI Medical System

JAI Medical Systems - PAC

Maryland Physicians Care

Maryland Physicians Care - PAC

Medstar Family Choice
Priority Partners MCO
United Health Care

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 4.0
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
-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 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
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:
None

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:
-Adolescent Well Care/EPSDT
-Cervical cancer screening (Pap Test)
-Initation and Engagement of Alcohol and Other Drug Services
-Substance Use Disorders treatment after detoxification service

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 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

EQR Data included in State's annual EQR technical report:
-Not Applicable

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
Lead Screening
Postpartum Care
Well-child visits

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

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

State conducts general data completeness assessments:
Yes

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, 2014

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(A) Eligibility Procedures and Standards
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(C)(i-iii)
-1902(a)(13) insofar as 1923 DSH Requirements
-1902(a)(17) Eligibility Procedures and Standards
-1902(a)(23) Freedom of Choice
-1902(a)(32) Direct Provider Reimbursements
-1902(a)(34) Retroactive Eligibility
-1902(a)(52) Extended Eligibility

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-BCCTP
-Diversionary Behavioral Health
-Early Intervention for Autism
-ELE
-Peds Asthma Project
-Population Expansion
-Premium Assistance
-SNCPs

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Abortion, Adult Day Health Services, Adult Foster Care Services, Ambulance Services, Ambulatory Surgery,

Allowable PCPs:
-Board Certified Outpatient Hospital Providers
-Family Practitioners

Audiology Services, Chapter 766: home assessments and participation in team meetings, Chiropractic, Chronic Disease and Rehab Inpatient Services, Community Health Center, Day Habitation Services, Dental, Diabetes Self-Management Training, Durable Medical Equipment, Early Intervention, EPSDT, Family Planning, Hearing, Hearing Aid, Home Health, Immunization Administration, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Medical Nutrition Therapy, Medical/Surgical Supplies, Nurse Midwife, Nurse Practitioner, Nursing Facility Services, OB/GYN and Prenatal, Occupational Therapy, Orthotic, Outpatient Hospital, Outpatient Mental Health and Substance Use Disorder services, Oxygen and Respiratory Therapy services and equipment, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Primary Care and Specialty Care Visits, Private Duty Nursing Services, Prosthetics, Radiology and diagnostic services, Rehabilitation services, Renal Dialysis Services, Speech Therapy, Tobacco Cessation, Transportation, Vision, X-Ray

-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Board Certified Specialists Approved on a Case-by-Case Basis
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-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

MH/SUD PIHP - Risk-based Capitation with Incentive Arrangement

Service Delivery

Included Services:

Crisis, Detoxification, Inpatient Mental Health, Inpatient Substance Use Disorders, Mental Health Outpatient, Mental Health Residential, Opioid Treatment Programs, Outpatient Substance Use Disorders, Residential Substance Use Disorders Treatment Programs

Allowable PCPs:

-Not applicable, contractors not required to identify PCPs

Contractor Types:

-Managed Behavioral Health Organization (Private)

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
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-Section 1931 Children and Related Populations
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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:

None

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)

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Abortion, Audiologist, Case Management, Chiropractic, Crisis, Dental - Emergency Related Dental in and Ambulatory Surgery/Outpatient Hospital Care, Detoxification, 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, Mental Health Residential, Opioid Treatment Programs, 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, Residential Substance Use Disorders Treatment Programs, 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 Massach, Vision Care (Medical Component), Wigs, X-Ray

Allowable PCPs:

-Board Certified or Eligible Practitioners in Other Relevant Specialties for Persons with Disabilitie
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Board Certified 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
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-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
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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:

None

Medicare Dual Eligibles Excluded:

All categories of Medicare Dual Eligilbes other that "grandfathered HIV/AIDS Dual Eligibles and Severely Physically Disabled dual Eligibles"

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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

None

Agencies with which Medicaid Coordinates the Operation of the Program:

None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Boston Medical Center HealthNet Plan
Fallon Community Health Plan
Health New England
MA Behavioral Health Partnership
Neighborhood Health Plan
Network Health
Primary Care Clinician Plan

ADDITIONAL INFORMATION

PCCM:

Overview of the PCC Plan
The PCC Plan is a statewide Primary Care case management program administered by MassHealth. MassHealth Members who are eligible for managed care- may choose to enroll in one of the MCOs or the PCC Plan. If a Member chooses to enroll in the PCC Plan, the Member reports to MassHealth's Enrollment Broker which PCC the Member has selected as his or her Primary Care Practitioner. MassHealth may assign the Member to the PCC Plan and to a specific PCC if, after a certain time frame, the Member has not selected an MCO or PCC.
The PCC Plan contracts with approximately 1,040 Primary Care Clinicians (PCCs) that practice at 1,540 PCC service locations. PCCs are individual physicians or nurse practitioners, group practices, community health centers, hospital-licensed health centers, or hospital outpatient departments. PCCs must sign a PCC Provider Contract in addition to a MassHealth Provider Agreement.
The PCC Plan currently pays MassHealth providers on a Fee-for-Service (FFS) basis. In addition, MassHealth pays PCCs an enhanced fee whenever a PCC delivers primary or preventive health care services to one of the Enrollees in their panel.

Enrollees are eligible to receive all Medically Necessary covered services available under their MassHealth Coverage Type. PCCs deliver or refer for most health care services for their Enrollees. Enrollees can obtain non-behavioral health medical services from any willing MassHealth provider, subject to any PCC referral requirements, and other MassHealth prior authorization (PA) requirements that exist.
The vendor administering the behavioral health benefit also assists in the administration of the PCC Plan, including providing management support to the PCCs, including quality improvement focused site visits, and a PCC hotline.

PIHP:

The MassHealth PCCM ensures that enrollees receive all needed behavioral health covered services by contracting with a MH/SUD PIHP. The PIHP provides a network of behavioral health service providers of acute, emergency, diversionary and ambulatory care. There are programmatic standards to ensure access to, and availability of, behavioral health services. The MH/SUD PIHP is responsible for quality management, and network management of the providers in their network, and is responsible to conduct utilization management of the behavioral health covered services. The MH/SUD PIHP also delivers intensive care coordination for enrollees having complex and co-morbid conditions.

The MH/SUD PIHP is responsible to provide the same array of services and supports to certain youth who are in the care and or custody of certain State agencies: the department of Youth Services and the Department of Children and Families.

The MH/SUD PIHP is also responsible to provide certain services specific to the Children Behavioral Health Initiative to youth with third party liability and to MassHealth Fee For Service youth.

Through an interagency service agreement between the Department of Mental Health and MassHealth, The same MH/SUD PIHP also administers 3 special programs for the Commonwealth: The Emergency Service Program of mobile behavioral health crisis evaluation and stabilization teams; The Forensic Evaluation 18a Program of psychological evaluation of the safety of jailed detainees prior to their arraignment; and The Massachusetts Children's Psychiatric Access Program of urgent psychiatric and psychopharmacologic consultation to all Massachusetts pediatricians.

The MH/SUD PIHP also provides Management Support Services to the Primary Care Clinicians in the PCCM.

MCO Program:

The MassHealth Managed Care Organizations (MCO) Program provides medical, pharmacy and behavioral health services through capitated arrangements with five MCOs. Enrollees are eligible to receive all Medically Necessary covered services available under their MassHealth Coverage Type. MCOs are responsible for providing all capitated covered services and arranging for or coordinating non-capitated/non-covered services (or wrap services such as non-emergent transportation, non-medical vision care, and most community Long Term Services and Supports. The MCOs are required to provide varying levels of care management including complex and intensive care management depending on members' care needs.

Excluded from managed care are:
"Members < 65
"*Dual eligibles (Medicare and Medicaid)
"Third Party Liability (TPL) or other health insurance
"Children in the care and custody of the Department of Chidren and Families (DCF) are required to enroll in managed BH/SUD PIHP unless they choose to enroll in the PCC Plan or an MCO

Managed care eligible members may choose to enroll in any MassHealth managed care option plan operating in their respective service areas. Members may switch managed care plans at any time.

*Dual Eligibles - Normally dual eligibles are excluded from participation in the MassHealth managed care plans, however, 141 (as of 7/01/2012) Enrolles are enrolled in one of the MassHealth MCOs (Neighborhood Health Plan/NHP). These dual eligibles Enrollees were grandfathered in managed care as they were enrolled in either the HIV/AIDs or severely disabled pilot programs with NHP (prior to 7/01/2010, the start of the MCO reprocurement). These dual members receive their pharmacy benefit from Medicare Part D Drug Plan which includes OTCs, Barbituates and Benzodiazepines and legislatively mandated drugs.

Effective 1/01/2011, Neighborhood Health Plan (NHP) was awarded the MassHealth state-wide contract for the Special Kids/Special Care (SK/SC) Program, formerly a pilot program. This Program serves children with special health care needs that are in the custody of the Department of Children and Families (DCF) and living in a foster home at the time of enrollment. NHP provides and arranges for the full range of medical and behavioral health services. The clinical criteria consists of: complex medical management and direct administration of skilled nursing care requiring complex nursing procedures; or skilled assessment and/or monitoring related to an unstable medical condition on a regular basis over a prolonged period of time. As of 07/01/2012, NHP served approximately 142 children in the SK/SC program.

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.

Abortion services are provided under a separate contract with the MCOs.

Quality improvement and quality improvement projects with required deliverables and goals to receive incentive payments.

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)

Use of Collected Data:

-ANOVA (Analysis of Variance)
-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
-State Medicaid Managed Care Quality Strategy
-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 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
-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 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 rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women

Health Status/Outcomes Quality:

-Mortality rates
-Patient satisfaction with care
-Percentage of beneficiaries satisfied with their ability to access care

-Controlling high blood pressure
-Dental services
-Depression management/care
-Diabetes management/care
-Follow up care for children prescribed ADHD medication
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Identification of Substance Use Disorders
-Immunizations for two year olds
-Initiation and engagement of SUD treatment
-Initiation of prenatal care - timeliness of
-Pediatric behavioral health screening
-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:

-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
-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
-Days in unpaid claims/claims outstanding
-Debt ratio
-Division of Insurance (DOI) statutory financial reports
-Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, vision, etc.)
-Liquidity ratios (current ratio and acid test ratio)
-Medical loss ratio
-Net income
-Net worth
-Rate of return on assets
-Statutory 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 auto-assigned to a PCP
-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
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services

-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Coordination of Primary and Behavioral Health care
-Depression management
-Diabetes management
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment
-Hospital Discharge Planning
-Inpatient maternity care and discharge planning
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Prescription drug abuse
-Primary Care Medical Home Initiative; Motivational Interviewing
-Smoking prevention and cessation
-Substance Use Disorders treatment after detoxification service
-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:

-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:

-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
-Validation of performance measures

EQR Data included in State's annual EQR technical report:

-Aggregate and Specific Health Plan Data

EQRO Optional Activities:

-Assessment of MCO information systems
-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 MENTAL HEALTH 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 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

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-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

State conducts general data completeness assessments:
Yes

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

Performance Measures

Process Quality:
-Antidepressant medication management
-Follow-up after hospitalization for mental illness

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

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:
-State Developed/Specified Standard of access and availability of behavioral health covered services
-Timeliness Standards of Urgent, Emergent and Routine Care

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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)
-Enrollee Hotlines
-Focused Studies
-Network Data
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-State Medicaid Managed Care Quality Strategy

Consumer Self-Report Data:
-Member Satisfaction collected biennial by PCC Plan

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

Use of Services/Utilization:
-Drug Utilization

-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels
-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
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Prescription drug abuse
-Well Child Care/EPSDT

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

MINNESOTA
Minnesota Prepaid Medical Assistance Project Plus-1115(a)

CONTACT INFORMATION

State Medicaid Contact:

Carol Backstrom
Minnesota Department of Human Services
(651) 431-2319

State Website Address:

http://www.dhs.state.mn.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:
July 27, 1995

Implementation Date:
July 01, 1995

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-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

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
-Disabled children under age 19 who are eligible for SSI under Title XVI who are not using a disabled
-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

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

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 improvement projects
-Validation of performance measures

EQR Data included in State's annual EQR technical report:
-Aggregate Data for all MCO Health Plans

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:

Ellen Costilla
NM HSD/Medical Assistance Division
(505) 827-3180

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)(34) Retroactive Eligibility
-1902(a)(4) Proper and Efficient Administration of the State Plan

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
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other providers who meet the MCO credentialling requirements for PCP.
-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants
-Primary care teams at teaching facilties.
-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 be eligible for regular Medicaid.
-May not have voluntarily dropped private health insurance within the last six months.
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-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

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. When Medicare eligibility is verfiied, SCI members are disenrolled from the SCI program prospectively and provided with adverse action. SCI enrollment may coexist when only Medicare Part A coverage is issued retroactively to SCI members in order to maintain coverage for services other than hospitalization that were provided through the SCI program. An adjusted capitation payment is provided to the managed care organization in such instances.

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
-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 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:
-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 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:
-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
-Administrative Costs
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Fidelity Bond Coverage
-Medical loss ratio
-Net income
-Net worth
-Profit (Loss)
-Risk Based Capital
-State minimum reserve requirements
-Total revenue
-Value Added Services

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

Clinical Topics:
-Asthma management
-Diabetes management
-Emergency Room service utilization

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:
-HealthInsight New Mexico dba 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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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

NEW YORK
F-SHRP - Medicaid Advantage

CONTACT INFORMATION

State Medicaid Contact:

Margaret Willard
Division of Long Term Carae
(518) 474-6965

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

Initial Waiver Approval Date:
September 30, 2006

Implementation Date:
October 01, 2006

Waiver Expiration Date:
March 31, 2014

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
-Twelve Month Continuous Eligibility

Guaranteed Eligibility:
6 months guaranteed eligibility

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, Pharmacy, Physical Therapy, Podiatry, Private Duty Nursing, Prostate Cancer Screening, Prosthetics, Radiation therapy, Routine Physical Exam - 1

Allowable PCPs:
-Not Applicable

year, Skilled Nursing Facility, Specialty Office Visits, Speech Therapy, 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
QMB

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

Affinity/Medicaid Advantage
ElderPlan/Medicaid Advantage
GHI/Medicaid Advantage
HIP Health Plan/Medicaid Advantage
Liberty Health Advantage/Medicaid Advantage
Managed Health Inc/Medicaid Advantage
MetroPlus/Medicaid Advantage
NYS Catholic Health Plan/Fidelis/Medicaid Advantage
Senior Whole Health/ Medicaid Advantage
Touchstone/Prestige/Medicaid Advantage
United HealthCare/Medicaid Advantage
WellCare/Medicaid Advantage

ADDITIONAL INFORMATION

The Medicaid Advantage program serves only dual eligibles on a voluntary enrollment basis. 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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans

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 Health Plan Contracting & Oversight
(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:
March 31, 2014

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, Personal Care, Personal Emergency Response System, Pharmacy, 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

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
-Foster children in direct care
-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

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

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

Affinity Health Plan
AmidaCare Special Needs
Excellus
Health Now
Amerigroup
Capital District Physicians Health Plan
Health First
HIP Combined

Hudson Health Plan
MetroPlus Health Plan
MVP Health Plan
NYS Catholic Health Plan/Fidelis
Southern Tier Pediatrics
United Healthcare
VNS Choice Special Needs
Independent Health/Hudson Valley&WNY
MetroPlus Health Plan Special Needs
Neighborhood Health Providers
SCHC TotalCare
Southern Tier Priority
Univera Community Health
Wellcare

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.

PCCMs are capitated for primary care services, only.

Enrollment in a PCCM is voluntary. There is no auto-assignment to PCCMs in mandatory 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)
-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 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 well-care visit rate
-Adult BMI Assessment
-Annual monitoring of patients on persistent medications
-Antidepressant medication management
-Appropriate testing for pharyngitis
-Appropriate use of antibiotics for URI
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia testing
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Drug therapy for rheumatoid arthritis
-Follow up ADHD medication - new prescription
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Imaging studies for low back pain
-Immunizations for two year olds
-Influenza immunization for adults (50 - 64 years)
-Initiation of prenatal care - timeliness of
-Lead Screening rate
-Medical assistance with tobacco use cessation
-Pharmacotherapy for COPD exacerbation
-Spirometry in COPD assessment
-Weight, nutrition, 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

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
-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
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Frequency of selected procedures/1,000 beneficiaries
-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)

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:
-Eliminating disparities in asthma care
-Reducing potentially preventable readmissions

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

EQR Data included in State's annual EQR technical report:
-Specific Health Plan Data only

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)

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

Clinical Conditions:
Not Applicable

Initial Year of Reward:
2000

Member Incentives:
Not Applicable

Rewards Model:
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs
Public reporting to reward MCOs

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

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

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-On-Site Reviews
-Performance Measures (see below for details)

Consumer Self-Report Data:
None

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

Performance Measures

Process Quality:
None

Access/Availability of Care:
None

Provider Characteristics:
None

Performance Measures - Others:
None

Health Status/Outcomes Quality:
None

Use of Services/Utilization:
-Number of primary care case manager visits per beneficiary

Beneficiary Characteristics:
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:
December 31, 2013

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:
-Adults 19-64 no children up to 100% FPL
-Adults 19-64 with children up to 150% FPL

Populations Mandatorily Enrolled:
None

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

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity Health Plan
Capital District Physicians Health Plan
Health First
HIP Combined
Independent Health/Hudson Valley&WNY
MVP Health Plan
NYS Catholic Health Plan/Fidelis
United Healthcare
Wellcare
Amerigroup
Excellus
Health Now
Hudson Health Plan
MetroPlus Health Plan
Neighborhood Health Providers
SCHC TotalCare
Univera Community Health

ADDITIONAL INFORMATION

Benefit Limitations (per calendar year): Home Health is limited to 40 visits; Outpatient Substance Use Disorders and Outpatient Mental Health are limited to 60 visits combined. Inpatient Mental Health and Inpatient Chemical Dependence stays are limited to 30 days per year combined.

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

Use of Collected Data:
-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation

-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
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

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 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:
-Adult BMI assessment
-Asthma care - medication use
-Avoidance of antibiotics for bronchitis

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

-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia screening
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Depression management/care
-Diabetes medication management
-Drug therapy for rheumatoid arthritis
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Imaging studies for low back pain
-Influenza immunization for adults (50-64 years)
-Initiation of prenatal care - timeliness of
-Medical assistance with tobacco use cessation
-Monitoring of patients on persistent medications
-Pharmacotherapy for COPD exacerbation
-Spirometry in COPD assessment

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)

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:

-Eliminating disparities in asthma care
-Reducing potentially preventable readmissions

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Island Peer Review Organization

EQRO Organization:
-Quality Improvement Organization (QIO)

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans

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 Health Plan Contracting & Oversight
(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:
December 31, 2014

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, Personal Care, Personal Emergency Response System, Pharmacy, 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

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
-Foster children in direct care
-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

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

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

Affinity Health Plan
AmidaCare Special Needs
Excellus
Amerigroup
Capital District Physicians Health Plan
Health First

Health Now
Hudson Health Plan
MetroPlus Health Plan
MVP Health Plan
NYS Catholic Health Plan/Fidelis
Southern Tier Pediatrics
United Healthcare
VNS Choice Special Needs
HIP Combined
Independent Health/Hudson Valley&WNY
MetroPlus Health Plan Special Needs
Neighborhood Health Providers
SCHC TotalCare
Southern Tier Priority
Univera Community Health
Wellcare

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

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:
-Adolescent preventive care
-Adult BMI assessment
-Antidepressant medication management
-Appropriate testing for pharyngitis
-Appropriate use of antibiotics for URI
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia testing
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Drug therapy for rheumatoid arthritis
-Follow-up ADHD medication - new prescription
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Imaging studies for low back pain
-Immunizations for two year olds
-Influenza immunization for adults (50-64 years)
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Medical assistance with tobacco use cessation
-Monitoring patients on persistent medications
-Pharmacotherapy for COPD exacerbation
-Spirometry in COPD assessment
-Weight, nutrition, physical activity for children & adolescents
-Well care visits for ages 12-21
-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:
-Adults access to preventive & ambulatory care
-Children's access to primary 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)

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:
-Eliminating disparities in asthma care
-Reducing potentially preventable readmissions

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans

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

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

Initial Waiver Approval Date:
October 12, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2015

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 percent of annual gross income for individuals enrolled in the Insure Oklahoma Program

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

Traditional PCCM Provider - Primary Care Case Management Payments

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
-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 custody (option for voluntary enrollment in managed care)
-Covered by an HMO
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Soon-To-Be-Sooners (STBS)
-Title XXI stand alone Insure Oklahoma dependents

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

American Indian Trational PCCM - Primary Care Case Management Payments

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:
-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 custody (option for volunary enrollment in managed care)
-Covered by an HMO
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility os ICF/MR
-Soon-To-Be-Sooners (STBS)
-Title XXI stand alone Insure Oklahoma dependents

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

SoonerCare American Indian PCCM

SoonerCare PCCM

ADDITIONAL INFORMATION

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.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
None

Use of Collected Data:
None

Consumer Self-Report Data:
None

QUALITY ACTIVITIES FOR OTHER

Quality Oversight Activities:
None

Use of Collected Data:
None

Consumer Self-Report Data:
None

OREGON
Oregon Health Plan Plus

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:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
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

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)

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:

Allowable PCPs:

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

Contractor Types:

-Regional Authority Operated Entity (Public)
-County Operated Entity (Public)
-Behavioral Health MCO (Private)
-CMHC Operated Entity (Public)

-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

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

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

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

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

Access Dental Plan
Accountable Behavioral Health
Advantage Dental Services
Capitol Dental Care, Inc.
CareOregon
Cascade Comprehensive Care
Clackamas County Mental Health
Doctors of the Oregon Coast South
Douglas County IPA
Family Dental Care
FamilyCare (Mental Health)
FamilyCare Health Plans

FamilyCare, Inc. (PCO)
InterCommunity Health Network
Kaiser Permanente Oregon Plus
Lane Individual Practice Association
Marion Polk Community Health Plan
Mid Valley Behavioral Care Network
ODS Community Health (Dental)
Oregon Health Management Services
PacificSource Community Solutions (Mental Health)
Providence Health Assurance
Verity MHO
Willamette Dental
Greater Oregon Behavioral Health, Inc.
Jefferson Behavioral Health
Lane Care MHO
Managed Dental Care of Oregon
Mid Rogue Independent Physician Association
MultiCare Dental
ODS Community Health Inc.
PacificSource Community Solutions
PCCM
Tuality Health Alliance
Washington County Health (Mental Health)

ADDITIONAL INFORMATION

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.

Children 18 years and under are 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 as needed
-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
-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
  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 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

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

data submission

Collection: Standardized Forms:

-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-CMS 1500
-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:

-Adolescent well care visits
-Adult access to preventive/ambulatory care
-Breast Cancer screening rate
-Cervical cancer screening rate
-Children and Adolescents access to primary care practitioners
-Chlamydia screening
-Colon Rectal Cancer Screening Rate
-Dental Preventive Services (all ages)
-Follow-up after hospitalization for mental illness
-Immunizations for two year olds
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of child beneficiaries with at least one dental visit
-Percentage of ED visits with a follow up outpatient visit within 30 days
-Percentage of hospital visits with a follow up outpatient visit with in 30 days
-Percentage of members with persistent asthma
-Percentage of members with persistent asthma who had a hospital visit for asthma
-Percentage of members with persistent asthma who had an ED visit for asthma
-Percentage of members with persistent asthma who had an outpatient visit for asthma
-Percentage of members with persistent asthma who overused rescue medicine
-Percentage of members with persistent asthma who received an influenza immunization
-Percentage of members with persistent asthma who received at least one maintenance medicine dispensing
-Percentage of members with persistent asthma who received at least one rescue medicine dispensing

Health Status/Outcomes Quality:

-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with obtaining care

-Percentage of members with persistent asthma with a satisfactory asthma medicine ratio
-Percentage of members with persistent asthma with good asthma medicine ratio
-Smoking prevention and cessation
-Well child visits in 3rd, 4th, 5th and 6th years of life
-Well child visits in first 15 months of life

Access/Availability of Care:
-Average wait time for an appointment with PCP
-Prevention Quality Indicator - Ambulatory Care Sensitive Conditions Hospitalizations

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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 MENTAL HEALTH 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 as needed
-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 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:
-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

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:
-Ambulatory Care ED and Outpatient
-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

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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:
-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 PAHPs 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 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 that have at least one preventive service
-Percentage of child 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:

Use of Collected Data:

-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-Health Services Research
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:

-CAHPS
- "Cores" Adult/Child Survey with elected Medicaid and Special Needs Questions

RHODE ISLAND
Connect Care Choice

CONTACT INFORMATION

State Medicaid Contact:

Ellen Mauro
RI Medicaid, EOHHS Medical Services, Office of Long Term S
(401) 462-0140

State Website Address:

http://www.ohhs.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:
No

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:
-Other

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 Cessation, Speech Therapy, State Plan Benefits, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists

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:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

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.

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
-Depression management
-Diabetes management
-Hypertension management
-Smoking prevention and cessation

Non-Clinical Topics:
None

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.ohhs.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)(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

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Benefit Expansion
-HCBS

Guaranteed Eligibility:
No guaranteed eligibility

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

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

Neighborhood Health Plan of Rhode Island

United HealthCare of New England

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.

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

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

-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

Consumer Self-Report Data:

-CAHPS
Adult Medicaid AFDC Questionnaire
-Consumer Advisory Committee

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:
-5% reduction in ER use for ambulatory care sensitive conditions
-Adult BMI Assessment
-Annual monitoring for patients on persistent medications
-Antidepressant medication management
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Comprehensive diabetes care
-Controlling high blood pressure
-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
-Pharmacotherapy management of COPD
-Smoking prevention and cessation
-Use of imaging studies for low back pain

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)

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

Performance Improvement Projects

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

Clinical Topics:
-Cervical cancer screening (Pap Test)
-Chlamydia screening
-Completion of initial health screen
-Use of imaging studies for low back pain

Non-Clinical Topics:

-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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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 Care

CONTACT INFORMATION

State Medicaid Contact:

Deborah J. Florio
Center for Child & Family Health
(401) 462-0140

State Website Address:

http://www.ohhs.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:
No

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
-Family Planning Services
-FQHC payments
-HCBS
-Population Expansion
-Premium Assistance
-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

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

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, Rite Care and Rite Smiles.

Under Data Element: Section of Title XIX Waived: 1902(a)(14) Cost Sharing Requirements in so far as it incorporates 1916

Children who have or 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 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

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
-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

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:

-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:
-Cervical cancer screening (Pap Test)
-Chlamydia screening
-Initial health screens for CSHCNs
-Use of imaging studies for lower back pain

Non-Clinical Topics:
-None

Standards/Accreditation

MCO Standards:
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

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

Non-Duplication Based on Accreditation:
-None

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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

RHODE ISLAND
Rite Care

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
Asthma
Cervical Cancer Screening
Childhood immunizations
Chlamydia Screening
COPD
Depression
Diabetes
Lead Screening
Low back pain
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
RIte Smiles

CONTACT INFORMATION

State Medicaid Contact:

Deborah J. Florio
Center for Child and Family Health
(401) 462-0140

State Website Address:

http://www.ohhs.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:
No

Guaranteed Eligibility:
None

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)(34) Retroactive Eligibility
-1902(a)(37)(B) Payment Review

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:
-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

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

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

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

Consumer Self-Report Data:

-State-developed Survey

Use of HEDIS:

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

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:

Gary Smith
TennCare
(615) 507-6493

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

Guaranteed Eligibility:
No guaranteed eligibility

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)
-1902(a)(10)
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(17)
-1902(a)(23)
-1902(a)(34)
-1902(a)(4)(A)
-1902(a)(54)
-1902(a)(8)

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

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Case Management, Chiropractic, 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, Personal Care, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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
-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
-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:

QMB
SLMB, QI, and QDWI

Dental PAHP - Non-Risk Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not Applicable, contractors are 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
-SSI Children

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Medicare dual eligibles (under 21)

Medicare Dual Eligibles Excluded:
Medicare beneficiaries (21 and over)

Pharmacy PAHP - Risk-based Capitation

Service Delivery

Included Services:
Pharmacy

Allowable PCPs:
-Not required

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
-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:
No lock-in

Medicare Dual Eligibles Included:
None

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

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

Service Delivery

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

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
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related 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

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

AmeriGroup Community Care
Catamaran
Delta Dental of Tennessee
United Healthcare - East TN
United Healthcare - Middle TN
United Healthcare - West TN
Volunteer State Health Plan (Bluecare) - East
Volunteer State Health Plan (Bluecare) - West
Volunteer State Health Plan (TennCare Select)

ADDITIONAL INFORMATION

1. Continuous 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.

2. Not all categories included in TennCare are mandatory Medicaid categories.

3. 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.

4. 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.

5. 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.

6. 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.

7. MCO/PIHP: Full Benefit Medicare Dual Eligibles are enrolled in managed care programs. QMB only, SLMB only, QI and QDWI are not full benefit eligible hence they are not enrolled in managed care.

9. 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.

10. 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.

Lock-in: Enrollees have 45 days after initial enrollment to change plans, after which they must stay in their plan until annual redetermination unless there is a good cause reason.

Partial Capitation

The Pharmacy Benefits Manager (PBM) is a PAHPs and paid an Administrative Services Fee. The manager handles claims administration and is reimbursed for the claims amount(s).The PBM is currently non-risk but may be renegotiated as at risk. Provider rates are established inaccordance with the State plan for the PBM.

Partial Risk Contract

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
-Network Data
-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:

-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
-Reporting to CMS on Medicaid/CHIP quality of care measures
-Track Health Service provision

-Provider Data

Consumer Self-Report Data:
-CAHPS
  Health Plan Survey 5.0H Adult
  Health Plan Survey 5.0H Child
-Children with Chronic conditions

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 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:
-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
-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:
-Ace Inhibitor/ARB Therapy
-Adolescent immunization rate

Health Status/Outcomes Quality:
-Mortality rates
-Patient satisfaction with care

-Adolescent well-care visit rate
-Antidepressant medication management
-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
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-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
-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
-Ratio of addictions professionals to number of beneficiaries
-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
-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 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
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics:

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

Beneficiary Characteristics:

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

Clinical Topics:

-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

-Appropriate testing for children with Pharyngitis
-Cholesterol screening and management
-Depression management
-Diabetes management
-Follow-up care for children prescribed ADHD medication
-Improving Compliance with Continuing Treatment for Major Depressive Disorders
-Increasing LDL screens in Cardiovascular conditions
-Obesity Screening/Management
-Pharmacy management (including psychotropic)
-Post-natal Care
-Smoking prevention and cessation

Non-Clinical Topics:

-Cultural Assessment data collection
-Followup 7 and 30 days after BH discharge
-Long Term Care (CHOICES)

Standards/Accreditation

MCO Standards:

-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-Performance measures or improvement projects aligned with CMS recommended priorities (e.g. Child Core Quality Measures)
-State-Developed/Specified Standards

Accreditation Required for Participation:

-NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:

-NCQA (National Committee for Quality Assurance)

EQRO Name:

-Q Source

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

EQR Data included in State's annual EQR technical report:

-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans
-Specific Health Plan Data only

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
-Validation of encounter data
-Validation of Performance Improvment 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:

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.)
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 MENTAL HEALTH 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
-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
-Reporting to CMS on Medicaid/CHIP quality of care measures
-Track health services provision

Consumer Self-Report Data:
-CAHPS
Health Plan Survey 5.0H Adult
Health Plan Survey 5.0H Child
-Children with Chronic Conditions

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 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 Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting 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.

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:
-Ace Inhibitor/ARB Therapy
-Adolescent immunization rate
-Adolescent well-care visit rate
-Antidepressant medication management
-Appropriate Testing for Children with Paryngitis
-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
-Dental services
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-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:
-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
-Ratio of addictions professionals to number of beneficiaries
-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
-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 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
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

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

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Weeks of pregnancy at time of enrollment in PIHP, for women giving birth during the reporting period

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:
-Appropriate testing for children with Pharyngitis
-Cholesterol screening and management
-Depression management
-Diabetes management
-Follow-up Care for Children Prescribed ADHD medication
-Improving compliance with continuing treatment for major depressive disorder
-Increasing LDL screens in cardiovascular conditions
-Obesity screening/management
-Pharmacy management (including psychotropic)
-Post-natal Care
-Smoking prevention and cessation

Non-Clinical Topics:
-Cultural Assessment data collection
-Follow-up 7 and 30 days after BH discharge

Standards/Accreditation

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

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

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Q Source

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans
-Specific Health Plan Data only

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Validation of encounter data
-Validation 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)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PAHP Standards
-Ombudsman
-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
-Health Services Research

Consumer Self-Report Data:
-Customer 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:
-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
-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
-State FFS utilization rates, comparisson to PAHP commercial utilization rates, comparisson to national norms, comparison to submitted bills or cost-ratios)

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

State conducts general data completeness assessments:
Yes

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

Performance Measures

Process Quality:
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Dental services
-Diabetes medication management
-Heart attack care
-Heart failure care
-HIV/AIDS care
-Influenza vaccinationa rate
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation

Health Status/Outcomes Quality:
None

Access/Availability of Care:
-Ratio of dental providers to beneficiaries

Use of Services/Utilization:
-Drug 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.)
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

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

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Percentage of beneficiaries who are auto-assigned to PAHPs

Performance Measures - Others:
None

Performance Improvement Projects

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

Clinical Topics:
-Quality of endodontic treatment

Non-Clinical Topics:
-Provider prior authorization requests within 14 days
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

Standards/Accreditation

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

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

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CONTACT INFORMATION

State Medicaid Contact:

Gary Jessee
Texas Health and Human Services Commission
(512) 491-1379

State Website Address:

http://www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area:
Region

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 12, 2011

Implementation Date:
December 12, 2011

Waiver Expiration Date:
September 30, 2016

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)(32) Self Direction of Care for HCBS Members
-1903(m)(2)(H) Enrollment after loss of Medicaid eligibility for 2 months or less
-1932(a)(4) Enrollment and Disenrollment

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Chemical Dependency Treatment 1905(a)(13)
-Drug Expenditures {1903(i)(10)}
-Family Planning Expenditures
-Guaranteed Eligibility Expenditures
-Institute For Mental Disease Expenditures
-MCO Choice {1932(a)(3)}
-MCO Definition {1903(m)(1)(A)}
-MCO Limits Disenrollment Rights {1903(m)(2)(A)(vi)}
-MCO Payments to FQHC/RHC {1903(m)(A)(ix)}
-Other MCO Requirement
-Secretary Definition {1903(m)(2)(A)(i)}

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Ambulance, Audiology, Cancer screening,diagnosis,treatment, Chiropractic, Dialysis, Durable

Allowable PCPs:
-Advanced Practice Registered Nurses(APRNs) under supervision of a physician specializing in family p

Medical Equipment, Early Childhood Intervention, Emergency Services, EPSDT, Family Planning, Home Health, Imaging, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Medical checkups and comprehensive care program(CCP), Oral evaluation and fluoride varnish in medical home, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorder treatments, Pharmacy (outpatient drugs and biological and drugs and biological provided in an inpatient setting), Physician, Podiatry, Prenatal, Preventive services, Primary care services, Radiology, Residential substance use disorder treatment, Therapies, Transplant of organs or tissues, Vision, X-Ray

-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants (under supervision of a physician specializing in family practice, internal med
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Aged/Blind/Disabled Adults and Related Populations(Medical Rural Service Area Only)
-Blind/Disabled Children and Related Populations(Medical Rural Service Area Only)
-Childen Under 1 (Proverty Level Infants)
-Children Age 1-5
-Children Age 6-18
-Newborn Children
-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
-Medicaid Beneficiaries who live outside the Medicaid Rural Service Area and participate in one of the followingthe STAR+PLUS DADS 1915(c) Waiver Programs: Community Based Alternatives(CBA), Community
-Medicare Dual Eligibles
-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

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

Aetna

Amerigroup (STAR)

Blue Cross Blue Shield

Christus

Community First
Cook Children's
El Paso First Premier
Molina (STAR)
Scott and White
Seton
Texas Children Health Plan
Community Health Choice
Driscoll
First Care
Parkland Community Health Plan
Sendero
Superior HealthPlan (STAR)
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. 837I, 837P, 837D, NCPDPD.0)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:

-NCPDP D.0 - National Council for Prescription Drug Programs Post–Adjudication Pharmacy Claim Transaction
-X12 5010 837 Professional, Institutional and Dental - transactions

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
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Preparing HEDIS and risk adjustment software

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rates
-Annual pediatric hemoglobin (HbA1C) testing
-Annual Percentage of Asthma patients with one or more Asthma
-Asthma care - medication use
-Cervical cancer screening rate
-Childhood Immunization Status
-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 treatment or counseling
-Good access to routine care
-Good access to special therapies
-Good access to specialist referral
-Good access to urgent care
-High blood pressure control
-Human papillomavirus (HPV) vaccine for female Adolescents
-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
-Prenatal/postnatal care
-Readmission w/in 30 days after an inpatient stay for mental health
-Related Emergency Room Visit(s)
-Smoking prevention
-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:
-AHRQ Pediatric Quality Indicators
-AHRQ Prevention Quality Indicators
-Patient satisfaction with care
-Percentage of low birth weight infants

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

Use of Services/Utilization:
-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

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

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:

-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 improvement projects
-Validation of performance measures

EQR Data included in State's annual EQR technical report:

-Aggregate and Specific Health Plan Data

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

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:
5% At-risk Premium. HMO at risk for 5% 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:
5% At-risk Premium. Standards are established for the calendar year time period that must be met in order to retain the point value and
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., NCQA,HEDIS,AHRQ,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

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CONTACT INFORMATION

State Medicaid Contact:

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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:
Region

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 12, 2011

Implementation Date:
December 12, 2011

Waiver Expiration Date:
September 30, 2016

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)(32) Self-Direction of Care for HCBS Members
-1903(m)(2)(H) Enrollment after loss of Medicaid eligibility for 2 months or less
-1932(a)(4) Enrollment and Disenrollment

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Chemical Dependency Treatment 1905(a)(13)
-Drug Expenditures {1903(i)(10)}
-Family Planning Expenditures
-Guaranteed Eligibility Expenditures
-Institute For Mental Disease Expenditures
-MCO Choice {1932(a)(3)}
-MCO Definition {1903(m)(1)(A)}
-MCO Limits Disenrollment Rights {1903(m)(2)(A)(vi)}
-MCO Payments to FQHC/RHC {1903(m)(A)(ix)}
-Other MCO Requirement
-Secretary Definition {1903(m)(2)(A)(i)}

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

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

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)

Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Vision, X-Ray

-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)

Enrollment

Populations Voluntarily Enrolled:

-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles under 21

Populations Mandatorily Enrolled:

-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles
-Medicare Dual Eligibles 21 and older

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

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

Amerigroup (STAR+PLUS)
Molina (STAR+Plus)
United Health Care
Health Spring
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.

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:

-NCPDP D.0 - National Council for Prescription Drug Programs Post–Adjudication Pharmacy Claim Transaction
-X12 5010 837 Professional, Institutional and Dental - transactions

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 Well care Visits
-Adults Access to Preventive/Ambulatory Health Services
-Ambulatory Care
-Annual Monitoring for Patients on Persistent Medication
-Antidepressant Medications Management (Acute & Continuation)
-Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
-Breast Cancer Screening
-Cervical Cancer Screening
-Comprehensive Diabetes Care- Diabetic nephropathy
-Comprehensive Diabetes Care- LDL_C screening
-Comprehensive Diabetes Care—Diabetic Eye Exam
-Follow Up after Hospitalizations for Mental Illness (7&30day)
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation and engagement of Alcohol and Other Drug Services
-Inpatient Utilization
-Medication Management for people with Asthma
-Mental Health Utilization
-Pediatric Quality Indicators
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Prenatal and Postpartum Care
-Prevention Quality Indicators
-Readmission w/in 30days after an inpatient stays for Mental Health
-Use of Appropriate Medications for People with Asthma (all)
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3,4,5, and 6 years of life
-Well-child care visit rates in first 15 months of life

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

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
-Validation of performance measures

EQR Data included in State's annual EQR technical report:

-Aggregate and Specific Health Plan Data

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

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
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

Enhanced PCCM Provider - Primary Care Case Management Payments

Service Delivery

Included Services:
Crisis, Dental, Laboratory, Pharmacy, Physician, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-American Indian/Alaska Native
-Section 1931 Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Eligible only for TB-related Services

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

-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles
-Other Insurance
-Poverty Level Pregnant Woman (SOBRA)

managed care entity

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Select Access

ADDITIONAL INFORMATION

This program covers adults that dont have any other medical coverage who dont otherwise qualify for Medicaid assistance.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Consumer Satisfaction Survey
-Performance Improvement Projects (see below for details)

Use of Collected Data:
-Contract Standard Compliance

Consumer Self-Report Data:
None

Performance Improvement Projects

Clinical Topics:
None

Non-Clinical Topics:
None

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

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)(13)
-1902(a)(14)
-1902(a)(17)
-1902(a)(17)(D)
-1902(a)(19)
-1902(a)(23) Freedom of Choice
-1902(a)(3)
-1902(a)(30)
-1902(a)(32)
-1902(a)(34)
-1902(a)(4)
-1902(a)(8)

For All Areas Phased-In:
No

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)
-Populations 3-10

Guaranteed Eligibility:
No guaranteed eligibility

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, Nursing Home Health, Occupational Therapy, Outpatient Addiction, Outpatient Hospital, Outpatient Mental Health, Personal Care, 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
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-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
-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

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

Global Commitment to Health

PACE

ADDITIONAL INFORMATION

The Vermont Agency of Human Services was granted permission through a 1115 waiver (our Global Commitment to health waiver) to make improvements to the way we deliver certain Medicaid services. According to our Global Commitment's Special Terms and

Conditions (STCs), Vermont operates its managed care model in accordance with federal managed care regulations found at 42 CFR 438. The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care model. DVHA operates the Medicaid program as if it were a Managed Care Organization in accordance with federal managed care regulations. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. CMS reviews and approves the IGA annually to ensure compliance with Medicaid Managed Care contract requirements.

DVHA also has sub-agreements with the other State entities that provide specialty care for Global Commitment enrollees (e.g., mental health services, developmental disability services and specialized child and family services). As such, since the inception of the Global Commitment Demonstration, DVHA has modified operations to meet managed care program requirements including requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance, and quality improvement. Additionally, in its role as the designated unit responsible for operation of the traditional Medicaid program (including long term care, CHIP and DSH), DVHA is responsible for meeting requirements defined in federal regulations at 42 CFR 455 for those services excluded from the Global Commitment waiver.

For the purposes of mental health: Children with severe emotional distrubance having a DSM diagnosis, a GAF score less than or equal to 60 and are ages 6-17.

Globally the state provides financial assistance and cost sharing in support of CSHN, but there is no set administratively defined roll.

The federal definition defines the scope of a subpopulation for the purposes of public health.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-Grievances and Appeals
-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)
-Comprehensive Diabetes Care, Antidepressant Medicaition Management, Use of Appropriate Medications with Asthma
-Effectiveness of care, Access/Availability of Care Process
-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
-Use of Services/Utilization

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
-Adult Access to Preventative /Ambulatory Health Services
-Asthma care - medication use
-Children and Adolescent access to Primary Care Practicioners
-Dental services
-Increasing adherence to evidence-based pharmacy guidelines for members diagnosed with CHF
-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:
-Anti-depressant medication management

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

Use of Services/Utilization:
-Adolescent well-care visits 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:

Clinical Topics:

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

-Increasing adherence to Evidence Based Guidelines in Members with Congestive Heart failure

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:
-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

EQR Data included in State's annual EQR technical report:
-Specific Health Plan Data only

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

WASHINGTON
Bridge to Reform: Medical Care Services

CONTACT INFORMATION

State Medicaid Contact:

Mary Anne Lindeblad
Washington Health Care Authority
(360) 725-1040

State Website Address:

http://hrsa.dshs.wa.gov/programsandservices.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:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 2011

Implementation Date:
January 01, 2011

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)(43); 1902(a)(13)(A); 1902(a)(3) from date of approval until 07/01/2011
-1902(a)(8)
-1902(a)18 and 1902(a)(25)(i) as well as 1902(a(45) and (60) insofar as they incorporate Section 1917

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(xii) but only insofar as it requires compliance with section 1932(a)(4)
-MCO Limits Disenrollment Rights {1903(m)(2)(A)(vi)}

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Disease Management, Family Planning, Hearing, Home Health, Immunization, Laboratory, Occupational Therapy, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Speech Therapy, Transportation, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-American Indian/Alaskan Native
-Non-pregnant individuals ages 19 to 64 with incomes up to and including 133% of FPL who have not bee

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Poverty Level Pregnant Woman (SOBRA)
-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

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

Community Health Plan

ADDITIONAL INFORMATION

Population consists of adults ages 19 through 64 and who are not otherwise eligible for Medicaid; are physically or mental incapacitated and expected to be unable to work for at least 90 days. Eligible enrollees are automatically enrolled in managed care organization through state enrollment and payment system at the first of every month and then remained enrolled while eligibility lasts.

Medical Care Services used to be known as Disability Lifeline.

WASHINGTON
Bridge to Reform: The Basic Health Plan

CONTACT INFORMATION

State Medicaid Contact:

Mary Anne Lindeblad
Washington Health Care Authority
(360) 725-1040

State Website Address:

http://www.hca.wa.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 01, 2011

Implementation Date:
January 01, 2011

Waiver Expiration Date:
December 31, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(b)(i) Waiting Period for Pre-existing Conditions
-1902(a)(13)(A) Public Process for Hospital Payments
-1902(a)(14) Cost-Sharing Requirements
-1902(a)(17)(D) Comparability for Eligibility Standards
-1902(a)(18) and 1902(a)(25)(i) as well as 1902(a)(45) and (60) insofar as they incorporate section 1917 Liens, Adjustments and recoveries collection o
-1902(a)(23) Freedom of Choice
-1902(a)(3) Fair Hearings (Restricted Period)
-1902(a)(34) Retroactive Eligibility
-1902(a)(43) EPSDT
-1902(a)(8) Reasonable Promptness

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(xii), but only insofar as it requires compliance with section 1932(a)(3)(A)
-MCO Limits Disenrollment Rights {1903(m)(2)(A)(vi)}

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Disease Management, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental

Allowable PCPs:
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers

Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Skilled Nursing Facility, X-Ray

-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Psychiatrists
-Psychologists
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Must be age 19 to 64, U.S. citizen or qualified non U.S. citizen, not eligible or enrolled in free o

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-Eligibility Less Than 3 Months
-Eligible only for TB-related Services
-Enrolled in Another Managed Care Program
-Enrolled in CDC BCCT Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Other Insurance
-Participate in HCBS Waiver
-Poverty Level Pregnant Woman (SOBRA)
-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

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

Amerigroup
Coordinated Care
United Health Care
Community Health Plan
Molina Healthcare

ADDITIONAL INFORMATION

Enrollees may terminate their enrollment at any time, however, depending on the reason for the termination, an enrollee may not be allowed to reenroll for a period of at least 12 months and may first have to have their name added to the established wait list before they may reapply.

Basic Health is intended for low-income Washington residents who are not eligible for other state-purchased health programs. It has historically been fully state funded, but is now partially funded through federal funds under the Transitional Bridge waiver. Federal approval of the waiver required some eligibility changes, which led to changes in state law regarding program eligibility. For example, today an enrollee must be a U.S. citizen or qualified noncitizen and the program no longer covers children, who are by definition eligible for other state programs. The program also includes enrollee cost sharing in the form of premiums based on the family's gross income in addition to point of service co-pays, deductibles, and coinsurance. Enrollee cost sharing is limited to a yearly per-person maximum based on the deductible and coinsurance

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

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

Use of Collected Data:

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

Consumer Self-Report Data:

-Use the most recent HEIDIS version of the commercial adult questionnaire or as instructed by NCQA for 2012 CAHPS surveys

Use of HEDIS:

-The State uses 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

Performance Measures

Process Quality:

-Antidepressant medication management

Health Status/Outcomes Quality:

-Ambulatory Care - Out Patient and Emergency Department Visits
-Inpatient Utilization General Acute Care
-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 mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization:

-Drug Utilization

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.)
-Net income
-Reinsurance Premium Paid
-Reinsurance Recoveries
-State minimum reserve requirements
-Third-Party Liability (TPL) Recoveries

Health Plan/ Provider Characteristics:

-Board Certification
-Languages Spoken (other than English)
-Whether the provider is accepting new BH enrollees as patients

-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
-Percentage of beneficiaries who are auto-assigned to PCP

Performance Measures - Others:
None

Performance Improvement Projects

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

Clinical Topics:
-One clinical PIP of contractors choosing a second clinical PIP if HEIDIS EPSDT rates below defined threshold.

Non-Clinical Topics:
-A non-clinical PIP on Transitional Healthcare Services

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:
-Accumentra

EQRO Organization:
-EQRO

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

EQR Data included in State's annual EQR technical report:
-None

EQRO Optional Activities:
-HCA reserves the right to include additional optional activities described in 42 CFR 438.358 if additional funding becomes available and as mutually negotiated between HCA and the

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:
Based on RFD Performance

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
None

Initial Year of Reward:
2013

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

COLORADO
Accountable Care Collaborative (ACC) Program

CONTACT INFORMATION

State Medicaid Contact:

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

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:
March 01, 2011

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

Enhanced PCCM Provider - Primary Care Case Management Payments

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Speech Therapy, Telemedicine, 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:
-Aged and Related Populations
-American Indian/Alaskan Native
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

-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:
-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

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

Accountable Care Collaborative Program

ADDITIONAL INFORMATION

Program is a PCCM that closely resembles an ACO organization and pays benefits on a FFS basis and also pays a pmpm for medical home, case management, care coordination.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-CAHPS Survey
-Consumer Self-Report Data (see below for details)
-On-Site Reviews
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Program Evaluation
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data:
-State-developed Survey

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:
None

Use of Services/Utilization:
-30-day all cause hospital readmissions
-Emergency room visits/1,000 beneficiaries
-Use of high cost imaging

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

COLORADO
Primary Care Physician Program

CONTACT INFORMATION

State Medicaid Contact:

Greg Trollan
Department of Health Care Policy and Financing
303-866-3674

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

Enhanced PCCM Provider - Primary Care Case Management Payments

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Pharmacy, Physician, Speech Therapy, Vision, 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

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

Primary Care Physician Program

ADDITIONAL INFORMATION

None

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
-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:
-None

Health Status/Outcomes Quality:
-CAHPS Health Plan
-Survey 4.0 Child
-Survey 4.0 H Adult

Access/Availability of Care:
-None

Use of Services/Utilization:
-None

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:
Policy Studies, Inc.

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

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

DC Chartered Health Plan, Incorporated

United Healthcare Community Plan

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

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

-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
-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

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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:
2006

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

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

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Low-income Medicaid
-Poverty-Level Pregnant Women
-Refugees
-Right from Start 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

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

Amerigroup Community Care
Peach State Health Plan
WellCare

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)
-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
-Date of Birth
-Diagnosis Primary and Secondary
-Facility Code
-NPI Number
-Patient Name
-Place of Service
-Tax Identification Number
-Treating Provider
-Units of Service

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)

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

-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
-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

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

EQR Data included in State's annual EQR technical report:
-Aggregate Data for all MCO Health Plans

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

Traditional PCCM Provider - Primary Care Case Management Payments

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

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
-Enrolled in Another Managed Care Program
-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

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

Illinois Health Connect

ADDITIONAL INFORMATION

Enrollment in Illinois Health Connect is mandatory for all included populations except; American Indian/Alaskan Native may choose to enroll in the Illinois Health Connect health plan and in areas with voluntary managed care plans available most clients have the option to choose a primary care provider in Illinois Health Connect or a managed care organization.

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
-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

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

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

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

-Specialties

Performance Measures - Others:
None

ILLINOIS
Integrated Care Program

CONTACT INFORMATION

State Medicaid Contact:

Michelle Maher
Healthcare and Family Services
(217) 524-7478

State Website Address:

http://www.hfs.illinois.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:
May 01, 2011

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:
Advanced Practice Nurse, Ambulatory Surgical Treatment Center, Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Federally Qualified Health Centers, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Nursing Care for Medically Fragile Technology Dependant children not in the Home and Community Based, Nursing Services for the purpose of transitioning children (under age 21) from a hospital to home pl, Occupational Therapy, Other Encounter Rate Clinics, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Post-Stabilization Services, Practice Visits for Enrollees with special needs, Renal Dialysis services, Rural Health Centers, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Certified Local Health Departments
-Community Mental Health Centers
-Cook County Bureau of Health Clinics
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricans/Gynecologists or Gynecologists
-Other Clinics including Specified Hospitals
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)
-School Based/Linked Clinics

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations (Age 19 and older)

Subpopulations Excluded from Otherwise Included Populations:
-Children under 19 years of age
-Enrolled in CDC BCCT Program
-Medicaid beneficiaries in programs with presumptive eligibility
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Other Insurance
-Poverty Level Pregnant Woman (SOBRA)

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna Better Health

IlliniCare Health Plan, Inc.

ADDITIONAL INFORMATION

Serves Aged, Blind and Disabled Medicaid clients age 19 and older, including those enrolled in Home and Community Based Waivers.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Access to Care Standards monitoring
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Enrollee Satisfaction Survey
-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
-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

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:
-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)
-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
-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:
-Ace Inhibitor/ARB Therapy
-Adult BMI assessment
-Ambualtory Care Follow-up after inpatient discharge
-Antidepressant medication management
-Appropriate Follow-up with any provider following first behavioral health diagnosis
-Behavioral Health risk assessment and follow-up
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate

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

-Cervical cancer screening rate
-Cholesterol screening and management
-Chronic Objective Pulmonary Disease
-Colorectal Cancer Screening
-Coronary Artery Disease
-Dental services
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Follow-up visit within 14 days of every inpatient discharge
-Heart Failure care
-Influenza vaccination rate
-Medication reviews
-Percentage of beneficiaries with at least one dental visit

Access/Availability of Care:

-Access to Substance Abuse Treatment
-Adult's access to preventive/ambulatory health services
-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:

-Average number of visits to MH/SUD providers per beneficiary
-ED reduction with primary diagnosis dental
-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
-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:

-Languages Spoken (other than English)
-Provider NPI number
-Provider Specialty

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

Clinical Topics:

-Ambulatory Care Follow-up
-Care Coordination
-Inpatient Hospital Readmissions

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
-State-Developed/Specified Standards

Accreditation Required for Participation:

None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Health Service Advisory Group

EQRO Organization:
-External Quality Review Orgnization

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-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
-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:
Bonus
Withholds as an incentive

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:
2012

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

INDIANA
Care Select

CONTACT INFORMATION

State Medicaid Contact:

Natalie Angel
Office of Medicaid Policy & Planning
(317) 234-5547

State Website Address:

http://www.in.gov/fssa/ompp/2546.htm

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:
March 25, 2011

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, 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, Long-Term Care Acute Hospitalization, 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
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

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

None

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Enrolled with Spend Down
-HCBS Waiver Participants
-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

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

Advantage Health Solutions-Care Select

MDwise-Care Select

ADDITIONAL INFORMATION

None

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

Health Status/Outcomes Quality:

-Patient satisfaction with care

-Annual dental visit for ages 21-64
-Annual dental visits for ages 3-20
-Annual medical attention for Nephropathy for those with diabetes
-Annual monitoring for members on ACE inhibitors or ARB
-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
-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 in the 3rd through 6th years of life, one or more visits
-Well child visits, ages 7 through 11, one or more visits

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

INDIANA
Hoosier Healthwise (1932)

CONTACT INFORMATION

State Medicaid Contact:

Natalie Angel
Office of Medicaid Policy & Planning
(317) 234-5547

State Website Address:

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

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:
March 25, 2011

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, 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

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
-Members receiving services in a HCBS waiver
-Reside in Nursing Facility or ICF/MR/SOF/PRTF

Lock-In Provision:

12 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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

None

Agencies with which Medicaid Coordinates the Operation of the Program:

None

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 1932(a) SPA effective March 25, 2011. 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

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

Performance Measures

Process Quality:

-Adolescent well-care visit rate
-Annual Monitoring for Persistent 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
-Chlamydia screening in women
-Cholesterol screening and management

Health Status/Outcomes Quality:

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

-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

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

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, Inc.

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

EQR Data included in State's annual EQR technical report:

-Aggregate and Specific Health Plan Data

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

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

Measurement of Improved Performance:

Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

INDIANA
Hoosier Healthwise (1932)

Well-Child Visits for children 7-11 years old (state)

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 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

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:

Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Personal Care, 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
-Physician Assistants
-Rural Health Clinics (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:

-American Indian/Alaskan Native
-Eligible only for TB-related Services
-Enrolled in CDC BCCT Program
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR
-Retroactive Eligibility
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)

Lock-In Provision:

6 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medipass

Meridian Health Plan of Iowa

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 MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Encounter Data (see below for details)
-MCO Standards (see below for details)
-Network Data
-On-Site Reviews

Use of Collected Data:
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research
-Program Evaluation

Consumer Self-Report Data:
None

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

Encounter Data

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

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

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Provider ID
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Random medical record validation

State conducts general data completeness assessments:
Yes

Standards/Accreditation

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

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

Standards

Non-Duplication Based on Accreditation:
None

EQRO Name:
-Iowa Foundation for Medical Care

EQRO Organization:
-Quality Improvement Organization (QIO)

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

EQR Data included in State's annual EQR technical report:
-Specific Health Plan Data only

EQRO Optional Activities:
-Assessment of MCO information systems

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
-Performance Measures (see below for details)

Use of Collected Data:
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling

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

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
-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:

Sharon Johnson
Division of Health Care Finance
(785) 291-3792

State Website Address:

http://www.kdheks.gov/hcf/

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

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

HealthConnect Kansas

ADDITIONAL INFORMATION

None

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)

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Data Mining
-Fraud and Abuse
-Health Services Research

-Provider Data

-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:

Sharon Johnson
Division of Health Care Finance
(785) 291-3792

State Website Address:

http://www.kdheks.gov/hcf/

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:
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

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:

Populations Mandatorily Enrolled:

-American Indian/Alaska Native
-Special Needs Children (BBA-defined)
-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

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

Coventry Health Care of Kansas

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)

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

-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

-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs 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 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

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

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

-Children's access to primary care practitioners
-Panel size
-Percent of PCPs with open or closed patient assignment panels
-Ratio of PCPs to beneficiaries

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:
-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

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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

Clinical Conditions:
Not Applicable

Initial Year of Reward:
Not Applicable

Member Incentives:
Not Applicable

Rewards Model:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

LOUISIANA
Bayou Health

CONTACT INFORMATION

State Medicaid Contact:

Jodie Herbert
Department of Health and Hospitals
(225) 342-4294

State Website Address:

http://new.dhh.louisiana.gov/index.cfm/page/32/n/7

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:
Continuous eligibility for children under age 19

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
February 01, 2012

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, Disease Management, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Substance Use Disorders, Personal Care, 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
-Indian Health Service (IHS) Providers
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Psychiatrists
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Poverty-Level Pregnant Women
-Special Needs Children (State defined)

-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 Less Than 3 Months
-Medicare Dual Eligibles

Lock-In Provision:

10 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

QMB
QMB Plus, SLMB Plus, and Medicaid only
SLMB, QI, and QDWI

Enhanced PCCM Provider - Primary Care Case Management Payments

Service Delivery

Included Services:

Case Management, Chiropractic, Dental, Disease Management, EPSDT, Family Planning, 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
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Psychiatrists
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:

-Aged and Related Populations
-American Indian/Alaskan 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

Populations Mandatorily Enrolled:

-Poverty-Level Pregnant Women
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Less Than 3 Months
-Medicare Dual Eligibles

Lock-In Provision:

10 month lock-in

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

QMB
QMB Plus, SLMB Plus, and Medicaid only
SLMB, QI, and QDWI

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Americagroup
LaCare/AmeriHealth Caritas Health Plan
United Healthcare Community Plan of Louisiana
Community Health Solutions of Louisiana
Louisiana Healthcare Connection

ADDITIONAL INFORMATION

The Risk-Sharing arrangement is symmetrical (gains and losses are equally shared between the State and managed care entities)

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Encounter Data (see below for details)
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-ANOVA (Analysis of Variance)
-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining

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 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)

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 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 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 rate
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Immunizations for two year olds
-Influenza vaccination rate
-Lead screening rate
-Pneumonia vaccination
-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:
None

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

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

Health Plan Stability/ Financial/Cost of 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
-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
-Emergency Room service utilization
-Low birth-weight baby

-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
None

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

Non-Duplication Based on Accreditation:
None

EQRO Name:
-IPRO
-ULM

EQRO Organization:
-Private accreditation organization
-QIO-like entity
-Quality Improvement Organization (QIO)
-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

EQR Data included in State's annual EQR technical report:
-Aggregate Data for all MCO Health Plans

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 has collaborated with a private sector entity to support the P4P program

Population Categories Included:
Covers all MCO members

Rewards Model:
Member incentives in the MCO P4P program
Payment incentives/differentials to reward MCOs
Preferential auto-enrollment to reward MCOs
Public reporting to reward MCOs
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:
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:
Withhold incentive

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-ANOVA (Analysis of Variance)
-Beneficiary Provider Selection
-Contract Standard Compliance

-Data Mining

Consumer Self-Report Data:
None

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visits rates
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia screening in women
-Cholesterol screening and management
-Immunizations for two year olds
-Lead screening rate
-Pneumonia vaccination
-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:
-Number of children with diagnosis of rubella(measles)/1,000 children
-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 access to preventive/ambulatory health services

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of home health visits per benificiary
-Number of OB/GYN visits per adult female beneficiary
-Number of 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
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

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

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Clinical Topics:
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Emergency Room service utilization
-Low birth-weight baby
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics:
None

MAINE
MaineCare Primary Care Case Management

CONTACT INFORMATION

State Medicaid Contact:

Loretta Dutill
MaineCare Services
(207) 624-6954

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 - Primary Care Case Management Payments

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

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

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)

Use of Collected Data:

-Beneficiary Provider Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement

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

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of OB/GYN visits per adult female beneficiary
-Number of primary care case manager visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Provider Characteristics:
-Board Certification
-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:

Carol Backstrom
Minnesota Department of Human Services
(651) 431-2319

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
-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

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

Blue Plus
Itasca Medical Care
Metropolitan Health Plan
South Country Health Alliance
Health Partners
Medica
PrimeWest Health System
UCARE

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
-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:
-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

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
-Validation of performance measures

EQR Data included in State's annual EQR technical report:
-Aggregate Data for all MCO Health Plans

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys

Pay for Performance (P4P)

MINNESOTA
Minnesota Prepaid Medical Assistance Program-1932(a)

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:
Cardiac Care
Diabetes

Initial Year of Reward:
1999

Member Incentives:
Not Applicable

Program Payers:
MCOs
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.)
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

MISSISSIPPI
MississippiCAN

CONTACT INFORMATION

State Medicaid Contact:

Will Crump
Division of Medicaid
(601) 359-9276

State Website Address:

www.medicaid.ms.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:
January 01, 2011

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, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Laboratory, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, 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
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

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

Populations Mandatorily Enrolled:
None

-Breast and Cervical Cancer Group
-Foster Care Children

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

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

Magnolia Health Plan

United HealthCare

ADDITIONAL INFORMATION

MississippiCAN is a statewide Medicaid coordinated care program. The program It is limited to no more than 15% of the entire Medicaid population. Currently, beneficiaries in the following categories of eligibility are eligible to participate: SSI, Disabled Child Living at Home, Working Disabled, Department of Human Services Foster Care, and Breast/Cervical Cancer Group. There are exclusions to this program. Beneficiaries in these categories of eligibility cannot participate if they are locked-in to any waiver program, dual eligible (Medicare/Medicaid), and those who at the time of application are institutionalized (i.e., Nursing Facility, ICF-MR, Correctional Facility, etc.). The program is voluntary and there is an annual open enrollment period.

The Mississippi Division of Medicaid has contracted with Magnolia Health Plan and United HealthCare to provide services to Medicaid beneficiaries enrolled in MississippiCAN. These health plans must provide, at a minimum, the same comprehensive services as Medicaid, with the exception of inpatient hospital services, mental health services and non-emergency transportation which are carved out of the program and covered by Medicaid. Both Magnolia and United offer additional benefits, i.e., additional office visits, additional prescriptions, etc. Both are required to have disease management programs which include, but are not limited to, diabetes, asthma, hypertension, organ transplants, obesity, hemophilia and congestive heart disease.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Focused Studies
-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
-Enhanced/Revise State managed care Medicaid Quality Strategy

Consumer Self-Report Data:

None

Use of HEDIS:

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

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

Encounter Data

Collection: Requirements:
-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

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.)

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
-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
-Children's access to primary care practitioners

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

Health Plan Stability/ Financial/Cost of 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:

-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization

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:

-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:

-The Carolinas Center for Medical Excellence CCME

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

EQR Data included in State's annual EQR technical report:

-Specific Health Plan Data only

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

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:
Statewide

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:
No

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

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, 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

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

Arbor Health Plan
Magellan Behavioral Health
Coventry Cares of Nebraska
United Healthcare of the Midlands/UnitedHealthcare Community Plan (formerly Share Advantage)

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
-Network Data
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-State Qualities Assessment and Improvement

State Quality Assessment and Improvement

Use of Collected Data:

None

Consumer Self-Report Data:
None

Use of HEDIS:
-Not Applicable

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

Collection: Standardized Forms:
None

Validation - Methods:
None

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

State conducts general data completeness assessments:
N/A

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:
None

Performance Improvement Projects

Project Requirements:
None

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

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
None

EQRO Organization:
None

EQRO Mandatory Activities:
None

EQR Data included in State's annual EQR technical report:
None

EQRO Optional Activities:
None

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:
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

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, Personal Care Aide, Pharmacy, Physical Therapy, Physician, Physician Assistants, Podiatry, Prosthetics, Pyschologist, Radiology, Residential Treatment Center, Respiratory Therapy, Rural Health Clinics, Skilled Nursing Facility, Special Clinics, Speech Therapy, Swing Beds, 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

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

Amerigroup Community Care
Health Plan of Nevada

ADDITIONAL INFORMATION

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

Health Status/Outcomes Quality:
-Blood Lead Screening
-Diabetes
-Improving Immunization Rates

-Check-ups after delivery
-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
-Mental Health Utilization
-Percentage of beneficiaries receiving inpatient, day/night care and ambulatory service
-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

Access/Availability of Care:

-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:

-Avoilable emergency room visits
-Emergency room visits/1,000 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)
-Provider turnover

Beneficiary Characteristics:

-Information of beneficiary ethnicity/race
-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
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:

-Childhood Immunization
-Decreasing avoidable emergency ER visits
-Diabetes management
-Lead toxicity

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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 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 - 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.h

PROGRAM DATA

Program Service Area:
Statewide

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

Statutes Utilized:
Not Applicable

Enrollment Broker:
Xerox (formerly 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, Chiropractic, 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 Day Care, Medical Supplies, Optical Appliances, Optometrist, Organ Transplants, Outpatient Hospital, Outpatient Mental Health, Outpatient Rehabilitation Therapies, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physician, Podiatrist, Post-acute care, Preventive Health Care and Counseling and Health Promotion, Prosthetics, Orthotics, Rehabilitation and Specialty 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

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-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
-Full Time Students Attending School and Residing Out of the Country
-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/ID

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

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

AMERIGROUP New Jersey, Inc.
Amerivantage Specialty + RX
Healthfirst Health Plan of New Jersey, Inc.
Healthfirst NJ Maximum Plan
Horizon Medicare Blue Totalcare
Horizon NJ Health
United HealthCare Dual Complete
UnitedHealthCare Community Plan

ADDITIONAL INFORMATION

Individuals eligible for enrollment choose one of the four MCOs or are auto-assigned by our enrollment broker. All individuals are locked-in to enrollment for a twelve month period, with allowances for change for good cause. Individuals who are auto-assigned are also given an opportunity to change to another MCO within 90 days of enrollment.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Accreditation for Participation
-Appointment Availability Studies

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

-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
-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

State conducts general data completeness assessments:

Yes

-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Reported Changes of Reasonable and Custormary Fees

Performance Measures

Process Quality:
-Adolescent immunization rate
-Adolescent well-care visit rate
-Annual monitoring for patients on persistent medications
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-BMI Assessment for Children/Adolescents
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Childhood Immunizations
-Chlamdyia screening in women
-Comprehensive Diabetes Care
-Follow up care for children prescribed ADHD medication
-Follow-up after hospitalization for mental illness
-Follow-up Care for Children Prescribed ADHD Medicaition (Initial Phase Only)
-Frequency of Ongoing Prenatal Care
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Prenatal and Postpartum Care
-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
-Total revenue

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
-Information of beneficiary ethnicity/race

Performance Measures - Others:
-EPSDT Performance

-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs
-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:

-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

EQR Data included in State's annual EQR technical report:

-Aggregate and Specific Health Plan Data

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

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:

Michael Watson
Division of Medical Assistance
(919) 855-4100

State Website Address:

http://www.ncdhhs.gov/dma/

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

Traditional PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Dialysis, 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
-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

Populations Voluntarily Enrolled:
-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Special Assistance to the Aged (SAA)
-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
-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

Lock-In Provision:
No lock-in

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carolina Access

ADDITIONAL INFORMATION

Carolina ACCESS is fee for service with a per member per month management fee paid to participating primary care providers. It increases access to primary care providers and services. Primary care providers provide direct care and coordinate care by authorizing specialty services not exempt from authorization.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
-Enrollee Hotlines
-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
-Health Services Research
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
None

Performance Measures

Process Quality:
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
None

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

Use of Services/Utilization:
None

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 PCCM

Performance Measures - Others:
-Afterhours
-Enrollment
-Overrides

Performance Improvement Projects

Clinical Topics:
None

Non-Clinical Topics:
None

NORTH CAROLINA
Community Care of North Carolina

CONTACT INFORMATION

State Medicaid Contact:

Sandra Terrell
Division of Medical Assistance
(919) 855-4335

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

Enhanced PCCM Provider - Primary Care Case Management Payments

Service Delivery

Included Services:
Chiropractic, Dental, Dialysis, Disease Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Personal Care, Pharmacy, Physical Therapy, Physician, Private Duty Nursing, Speech Therapy, Vision, 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

Populations Voluntarily Enrolled:
-American Indian/Alaska Native
-Foster Care Children
-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-QMB Plus
-SLMB Plus
-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:
QMB Plus, SLMB Plus, and Medicaid only

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care of North Carolina

ADDITIONAL INFORMATION

Community Care of North Carolina (CCNC) is a public-private partnership comprised of 14 individual individual community based networks of physicians, nurses, pharmacists, hospitals, health departments, social service agencies and other community organizations. Participating practices receive support from local Community Care networks to help manage medical care across their patient populations, coordinate care across their patient populations, coordinate care with other health care professionals and integrate behavioral care through the Medical Home model. This approach matches each patient with a primary care physician who leads a health care team that addresses the patients health needs. Community Care of North Carolina emphasizes team-based care and careful management of hand-offs between providers and care settings.

The Community Care Networks and primary care providers receive a PCCM care managemnt fee to coordinate care, implement disease management initiatives, target preventive activities, and manage the enrolled beneficiaries. The medical care provided by primary care providers is reimbursed through a fee for service model.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:

Use of Collected Data:

-Consumer and Provider Complaints
-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
-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
-Reporting to CMS on voluntary Medicaid care measures
-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
-Check-ups after delivery
-Cholesterol screening and management
-Colon Cancer screening rates
-Controlling high blood pressure
-Depression medication management
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-Heart Failure care
-Initiation and engagement of SUD treatment
-LVF Assessment
-Percentage of beneficiaries with at least one dental visit
-Primary cesarean section rates amoung term patients with a singleton,vertex fetus
-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 readmissions rate
-Diabetes eye exams
-ED & Hospitalization Rates
-HbA1C Testing
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of low birth weight infants
-Preventable Hospital Readmissions
-Well visit rates

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:

-Average number of visits to MH/SUD providers per beneficiary only Aged, Blind, Disabled population
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions for MH/SUD conditions/100 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Inpatient Readmission
-Inpatient Stays
-Number of primary care provider visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of well visit exams
-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

Beneficiary Characteristics:

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

-EHR useage
-Languages spoken (other than English)
-PCMH certification
-Percentage of beneficiaries who are auto-assigned to PCCM
-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)
-Cardiovascular Disease Management
-Cervical cancer screening (Pap Test)
-Child developmental screening (behavioral)
-Child developmental screening (physical)
-Child/Adolescent Dental Screening and Services
-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
-ETOH and other substance abuse screening and treatment
-Hospital Discharge Planning
-Hypertension management
-Low birth weight baby
-Obesity screening/management
-Palliative Care
-Pharmacy management
-Post natal care
-Pre-natal care
-Prevention of Influenza
-Service coordination for high-risk children
-Smoking prevention and cessation
-Transition of care
-Well Child Care/EPSDT

Non-Clinical Topics:
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners
-Clinical integrity
-Engagement, education and empowerment of patients
-Health Information Technology
-Practice Readiness for Quality Improvement
-Reducing health care disparities

NORTH DAKOTA
Health Management

CONTACT INFORMATION

State Medicaid Contact:

Annette Fischer
Department of Human Services Medical Services Division
(800) 755-2604

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

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 2011

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
-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

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 Management

ADDITIONAL INFORMATION

This program is to available to individuals with one or more of the following chronic diseases: Asthma, Diabetes, Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). The program offers participants education and coordination of care related to their chronic disease condition(s). In providing this Health Management program, the North Dakota State Department of Human Services proposes to give clients a tool to improve their health and by doing so increase fiscal savings. These serves are provided by a nurse case manager.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Monitoring of PAHP Standards
-On-Site Reviews
-Performance Measures (see below for details)

Use of Collected Data:

-Enhanced/Revise State managed care Medicaid Quality Strategy
-Program Evaluation

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

NORTH DAKOTA
North Dakota Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

Annette Fischer
Department of Human Services Medical Services Division
(800) 755-2604

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

Guaranteed Eligibility:
Continuous eligibility for children under age 19

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

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

SERVICE DELIVERY

Traditional PCCM Provider - Primary Care Case Management Payments

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Primary Care Case Management

ADDITIONAL INFORMATION

The PCCM program requires that eligible recipients choose a Primary Care Provider(PCP) who will provide the majority of their health care and give referrals for the services that are needed when it is a service that the PCP cannot provide. The services are paid for on a fee-for-services basis. There is also a $2.00 PMPM rate paid but, RHC, FQHC and IHS are excluded from this due to the encounter fee paid to these facilities. The objective of this program is to assure Medicaid recipients recieve: Adequate access; Coordination and continuity of Health care services; and Quality Care.

This Managed Care Entity is paid for by Fee For Service

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
The Ohio Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

John McCarthy
Ohio Department of Job and Family Services
(614) 466-4443

State Website Address:

http://Medicaid.ohio.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, Inc.

For All Areas Phased-In:
No

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, Pharmacy, Physical Therapy, Physician, Podiatry, 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
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaska Native

Populations Mandatorily Enrolled:
-Aged and Related Populations

-Foster Care Children

-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

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

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

Amerigroup Ohio
CareSource
Paramount Advantage
WellCare of Ohio
Buckeye Community Health Plan
Molina Healthcare of Ohio
United Healthcare Community Plan of Ohio

ADDITIONAL INFORMATION

MCEC, identifies the health plan to which the beneficiary will be assigned if a health plan is not selected by a date specified in the notice.

The Managed Care Contract Administration Section within the Office of Medical Assistance (OMA) is responsible for developing the MCP procurement and selection process, administering contracts with the MCPs, and serving as the primary contact with the MCPs. In awarding contracts to MCPs, the state places strong emphasis on an applicant's ability to provide care coordination and healthcare services necessary for improving health outcomes. Selected MCPs must successfully complete a readiness review process, demonstrating their ability to meet all program requirements, prior to executing a signed contract. OMA generally executes contracts with MCPs on an annual basis. The programmatic goal is to develop stable and long-term relationships with successful MCPs over many years. Other sections within OMA oversee additional managed care administrative functions such as enrollment and payment activities, rate setting, quality assurance, and performance assessment.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Care management
-Consumer complaints and grievances

Use of Collected Data:

-Contract Standard Compliance
-Data Mining

-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
-On-Site Reviews
-Pay 4 performance (P4P) program
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Provider complaints
-Provider Data
-State hearings
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Pay-for-Performance (P4P) Incentive System Determination
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Reporting to CMS on Medicaid/CHIP quality of care measures
-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 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

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
-Encounter EDI 837 Companion Guides
-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
-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:

-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
-Type of Provider, Specialty Code

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Adolescent well-care visit rates
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Care management of high-risk members
-Check-ups after delivery
-Cholesterol screening and management
-Controlling high blood pressure
-Diabetes management/care
-Emergency Department Utilization Rate of Members In High Risk Care Management
-Follow-up after hospitalization for mental illness
-Follow-Up Care for Children Prescribed ADHD Medication
-Frequency of on-going prenatal care
-Heart Attack care
-Heart Failure care
-Initiation and engagement of SUD treatment
-Initiation of prenatal care - timeliness of
-Inpatient Hospitalization Rate of Members In High Risk Care Management
-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:
-Annual Number of Asthma Patients with One or More Asthma-Related Emergency Department Visits
-Cholesterol Management for Patients with Cardiovascular Conditions - LDL-C Control (<100 mg/dL)
-Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)
-Comprehensive Diabetes Care - HbA1c Control (<8.0%)
-Controlling High Blood Pressure
-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
-Provider Panel Requirements for PCP Capacity and Provider Type, by Region and County

Use of Services/Utilization:
-Ancillary services/1,000 member months
-Behavioral health services/1,000 member months
-Dental visits/1,000 member months
-Durable medical equipment/supply services/1,000 member months
-Emergency Department Utilization Rate of Members in High Risk Care Management
-Emergency room visits/1,000 member months
-Inpatient discharges/1,000 member months
-Inpatient Hospitalization Rate of Members in High Risk Care Management
-Maternity/deliveries/1,000 member months
-Pharmacy prescriptions/1,000 member months
-Primary care visits/1,000 member months
-Vision visits/1,000 member months

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,

Health Plan/ Provider Characteristics:
-Provider Panel by specialty and service area and capacity

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

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
-Diabetes management
-Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-NCQA (National Committee for Quality Assurance) Standards
-Performance measures or improvement projects aligned with CMS recommended priorities (e.g. Child Core Quality Measures)
-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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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)

OHIO
The Ohio Medicaid Managed Care Program

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

Population Categories Included:
Covers all MCO members

Clinical Conditions:
Not Applicable

Initial Year of Reward:
2002

Member Incentives:
Not Applicable

Program Payers:
Medicaid is the only payer

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.

Measurement of Improved Performance:
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

SOUTH CAROLINA
Health Maintenance Organization (HMO)

CONTACT INFORMATION

State Medicaid Contact:

Timothy Harnett
Managed Care
(803) 734-0230

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:
-Medicare Dual Eligibles

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
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR

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

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

Absolute Total Care
First Choice by Select Health of South Carolina, Inc.
BlueChoice Health Plan
United HealthCare 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
-Drug Quantity Units not greater than zero
-Invalid Drug Unit Type
-Prescribing Provider Number Not on File
-Submitting Provider Not on File

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

-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

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

-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

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

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

EQR Data included in State's annual EQR technical report:

-Specific Health Plan Data only

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)

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
Preferential auto-enrollment to reward MCOs

Clinical Conditions:

Asthma
Diabetes
Obesity
Perinatal Care
Well-child visits

Measurement of Improved Performance:

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.)

Initial Year of Reward:

Not Applicable

Evaluation Component:

Not Applicable

Member Incentives:
Not Applicable

SOUTH CAROLINA
Medical Homes Network

CONTACT INFORMATION

State Medicaid Contact:

Jennifer Campbell
Managed Care
(803) 898-2593

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

Traditional PCCM Provider - Primary Care Case Management Payments

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Skilled Nursing Facility, 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:
-Aged and Related Populations
-American Indian/Alaskan 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

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

Carolina Medical Homes
South Carolina Solutions
Palmetto Physician Connections

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.

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
-Colorectal Cancer Screening
-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 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:
-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

Performance Improvement Projects

Clinical Topics:
-Asthma management
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-Low birth-weight baby
-Pharmacy management
-Post-natal Care

Non-Clinical Topics:
None

SOUTH DAKOTA
PRIME

CONTACT INFORMATION

State Medicaid Contact:

Kathi Mueller
Division 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

Traditional PCCM Provider - Primary Care Case Management Payments

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

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

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
-Fraud and Abuse

Consumer Self-Report Data:

-Change Form Reports and Consumer calls

WASHINGTON
Healthy Options

CONTACT INFORMATION

State Medicaid Contact:

Barbara Lantz
Division of Health Care Services/Health Care Authority
(360) 725-1640

State Website Address:

www.hca.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 months guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 2012

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, 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
-Obstetricans/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Optional 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:

-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

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

Community Health Plan

Molina Healthcare

ADDITIONAL INFORMATION

Children with special health care needs are those who have are at increased rish 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 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:

-Conduct Performance Improvements 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 use/requires MCOs to follow NCQA specifications for all of

the HEDIS measures listed for Medicaid that it collects

Encounter Data

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

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-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
-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:
-Ambulatory Care (Out Patient and Emergency Department Visits)
-Inpatient Utilization General Acute Care

Health Status/Outcomes Quality:
-None

Access/Availability of Care:
-None

Use of Services/Utilization:
-Inpatient Acute Care Utilization

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:

-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:

-A second clinical project if EPSDT Services are below a defined Threshold
-One Clinical Project of own choosing

Non-Clinical Topics:

-One non-clinical project on Transitional Health Care Services

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

EQR Data included in State's annual EQR technical report:
-None

EQRO Optional Activities:
-Conduct of 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:
Based on RFD Performance

Rewards Model:
PMPM Adjustment

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
PMPM Adjustment

Initial Year of Reward:
1800

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
Not Applicable

WISCONSIN
BadgerCare Plus

CONTACT INFORMATION

State Medicaid Contact:

Brett Davis
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:
Ambulatory Surgery Centers, Chiropractic Care, Dental, Disease Management, Durable Medical Equipment, Durable Medical Supplies, End Stage Renal Disease Therapy, 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, Podiatry Care, Prenatal Care, 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 Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Physician Assistants
-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

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
QMB Plus, SLMB Plus, and Medicaid only

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

Children's Community Health Plan - Medicaid HMO
Compcare -- Medicaid HMO
Group Health Cooperative Of Eau Claire -- Medicaid HMO
Gundersen Lutheran Health Plan - Medicaid HMO
Independent Care (iCare) - Medicaid HMO
MercyCare Insurance Company -- Medicaid HMO
Network Health Plan -- Medicaid HMO
Security Health Plan -- Medicaid HMO
Unity Health Insurance -- Medicaid HMO
CommunityConnect Health Plan - Medicaid HMO
Dean Health Plan -- Medicaid HMO
Group Health Cooperative Of South Central WI -- Medicaid HMO
Health Tradition Health Plan -- Medicaid HMO
Managed Health Services -- Medicaid HMO
Molina Health Plan -- Medicaid HMO
Physicians Plus Health Plan - Medicaid HMO
UnitedHealthcare Community Plan of WI - Medicaid HMO

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Satisfaction Survey
-External Quality Review
-MCO Standards (see below for details)

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Data Mining
-Enhanced/Revise State managed care Medicaid Quality Strategy

-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Non-Duplication of mandatory EQR Activities Base on Accreditation
-Ombudsman
-On-Site Reviews
-Pay for Performance
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)
-Quality Improvement Goal Setting
-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 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. 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)
-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

State conducts general data completeness assessments:
Yes

-Patient status code
-Place of service codes
-Quantity

Performance Measures

Process Quality:
-Breast 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
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-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:
-Antidepressant medication management

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

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

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)
-Childhood Immunization
-Depression management
-Diabetes management
-Emergency Room service utilization
-Improving Birth Outcome Project
-Increase Utilization of Preventative Dental Care
-Inpatient maternity care and discharge planning
-Lead toxicity
-Low birth-weight baby
-Post-natal Care
-Pre-natal care
-Prescription drug abuse
-Smoking prevention and cessation
-Substance Use Disorders treatment after detoxification service

-Well Child Care/EPSDT

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:

-State-Developed/Specified Standards

Accreditation Required for Participation:

None

Non-Duplication Based on Accreditation:

-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 performance measures

EQR Data included in State's annual EQR technical report:

-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans

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
Public reporting to reward MCOs
Withholds as an incentive

Clinical Conditions:

AMM- Depression
Asthma
Blood Lead Testing
Breast Cancer Screening
Childhood immunizations
Dental
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 the timely submission of complete and accurate electronic encounter/claims data
Delivery of EPSDT Services
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

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:

Brett Davis
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
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

-American Indians
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

None

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

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

Compcare - SSI
Group Health Cooperative of Eau Claire County SSI
Independent Care Health Plan -- SSI
Managed Health Services -- SSI
Molina Health Plan -- SSI
Network Health Plan - SSI
UnitedHealthcare Community Plan 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
-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
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data:
-CAHPS
Adult Medicaid SSI Questionnaire
Adult with Special Needs Questionnaire

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
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Admission Source
-Admission Type
-Days Supply
-Modifier Codes
-Patient Status Code
-Place of Service Codes
-Quantity

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services

Health Status/Outcomes Quality:
-Patient satisfaction with care

-Diabetes management/care
-Follow-up after hospitalization for mental illness and substance abuse at 7 and 30 days
-Initiation and engagement of SUD treatment

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

Use of Services/Utilization:
-Number of hospital admissions per member per year
-Number of hospital days per member per year

Health Plan Stability/ Financial/Cost of Care:
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-OCI certification
-Review of medical loss ratios

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

Beneficiary Characteristics:
-Beneficiary need for interpreter

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:
-Breast cancer screening (Mammography)
-Diabetes management
-ETOH and other substance abuse screening and treatment
-Follow-up After Mental Health Hospitalization
-Substance Use Disorders treatment after detoxification service

Non-Clinical Topics:
-Access to and availability of services
-Care Management for SSI Members
-Cultural competency of the HMO and its providers
-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
-Validation of performance measures

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans

EQRO Optional Activities:
-Assessment of MCO information systems
-Case Management Review
-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

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

Clinical Conditions:
Breast cancer screening
Diabetes
Follow-up after MH Hospitalization
Substance abuse

Initial Year of Reward:
2005

Member Incentives:
HMOs pay a max of $25 pmpm for disease prev. activities.

Program Payers:
Medicaid is the only payer

Rewards Model:
Member incentives in the MCO P4P program
Payment incentives/differentials to reward MCOs
Public reporting to reward MCOs
Withholds as an incentive

Measurement of Improved Performance:
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, but plans to conduct an evaluation in the future

CALIFORNIA
AIDS Healthcare Foundation

CONTACT INFORMATION

State Medicaid Contact:

Margaret Tatar
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:
Yes

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

-Poverty-Level Pregnant Women
-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

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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

None

Agencies with which Medicaid Coordinates the Operation of the Program:

None

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

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 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 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
-Controlling high blood pressure

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:
-Advance Care Directives
-CD4 and Viral Load Testing

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

EQR Data included in State's annual EQR technical report:
-Specific Health Plan Data only

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

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:

Margaret Tatar
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
City
County

Initial Waiver Approval Date:
Not Applicable

Operating Authority:
1915(a) - Voluntary

Implementation Date:
January 01, 1996

Statutes Utilized:
Not Applicable

Waiver Expiration Date:
Not Applicable

Enrollment Broker:
No

Sections of Title XIX Waived:
None

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

SERVICE DELIVERY

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

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

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.

CALIFORNIA
Prepaid Health Plan Program

CONTACT INFORMATION

State Medicaid Contact:

Jon Chin
Medi-Cal Dental Services Division
(916) 464-3888

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:
Health Care Options/Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

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

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:

Lock-In Provision:

-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Populations residing outside plans service area defined by contract
-Reside in Nursing Facility or ICF/MR (after 30 days)

No lock-in

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan-LA

American Health Guard-Dental Plan-LA

Care 1st Health Plan-Dental-LA

Health Net of CA-Dental-LA

Liberty Dental Plan of CA-LA

Safeguard Dental-LA

Western Dental Services-LA

ADDITIONAL INFORMATION

None

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:

Joseph Billingsley
Long Term Care Division
(916) 440-7538

State Website Address:

http://www.dhcs.ca.gov

PROGRAM DATA

Program Service Area:
Zip Code

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:
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

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

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

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

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

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 Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) 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; including 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
-Medicaid Eligibility
-Procedure Codes

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate

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

Health Plan/ Provider Characteristics:
None

-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

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

Clinical Topics:
-All-Cause Readmissions
-Care for Older Adults

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

EQR Data included in State's annual EQR technical report:
-Specific Health Plan Data only

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

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:

Jeremy Sax
Department. of Health Care Policy and Financing
(303) 866-3227

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:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, 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

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

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

Denver Health and Hospital Authority

Rocky Mountain Health Plan Authority

ADDITIONAL INFORMATION

MCO options and PIHP options are available and vary by county. A monthly payment (capitation payment) is made by the State agency to each contractor on behalf of each recipient enrolled under a contract for the provision of medical services. The State agency makes the payment regardless of whether the particular recipient receives services during the period covered by the payment. Contractors are required to provide the same services as those covered under the State plan.

The State Agency makes a full capitated payment for comprehensive physical health services on behalf of each client enrolled in the MCO. The State Agency makes a partially capitated payment for administrative services on behalf of each client enrolled in the non-risk PIHP.

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
-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:
-Managed Care is performing a focus study

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans
-Specific Health Plan Data only

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

-Provider Data

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 (QISMC) Standards for Medicaid and Medicare
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-QIO-like entity

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans
-Specific Health Plan Data only

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
Children and Adolescent Supplemental Security Income Program

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:
1915(b)(4)

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:
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Special Needs Children (State defined)

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-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:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

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 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
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

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

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

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-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 improvement projects
-Validation of performance measures

EQR Data included in State's annual EQR technical report:
None

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
-Enrolled in CDC BCCT Program
-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

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
-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:
-Contract Standard Compliance
-Data Mining - HEDIS calculations
-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

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:
-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
-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:
No

Performance Measures

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
-Diabetes management/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
-Percentage of very low birth weight infants

-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in 3, 4, 5 and 6 years of life
-Well-child care visit rates in first 15 months of life

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

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:

-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

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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:
Payment for well child visits under age 5
Payment incentives/differentials to reward MCOs
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
Special Needs Basic Care

CONTACT INFORMATION

State Medicaid Contact:

Carol Backstrom
Minnesota Department of Human Services
(651) 431-2319

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

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

Medica

PrimeWest Health System

South Country Health Alliance

UCARE

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)
-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

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS

Adult with Special Needs Questionnaire
-Disenrollment Survey

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
-Diabetes screening
-Mental health discharges
-Osteoporosis care after fracture

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:
-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 improvement projects
-Validation of performance measures

EQR Data included in State's annual EQR technical report:

-Aggregate Data for all MCO Health Plans

EQRO Optional Activities:

-Administration or validation of consumer or provider surveys

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

NEBRASKA
Nebraska Medicaid Medical Home Pilot

CONTACT INFORMATION

State Medicaid Contact:

Margaret Brockman
Medicaid and Long-Term Care
402-471-9368

State Website Address:

http://dhhs.ne.gov/medicaid/Pages/med_pilot_index.

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
February 01, 2011

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 - Primary Care Case Management Fee

Service Delivery

Included Services:
Case Management

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

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaskan 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

Populations Mandatorily Enrolled:
None

-Special Needs Children (State defined)
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
-Retroactive Eligibility

Lock-In Provision:
No lock-in

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

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Nebraska Medicaid Medical Home Pilot

ADDITIONAL INFORMATION

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 PCCM

Quality Oversight Activities:
-Accreditation
-Consumer Self-Report Data (see below for details)
-Encounter Data
-Enrollee Hotlines
-Non-Duplicated Based On Accredidation
-Ombudsman
-Onsite Reviews
-Perfected Important Projects
-Perfected Measures
-Provider Data
-State Quality Assessment and Improvement

Use of Collected Data:
-Program Evaluation

Consumer Self-Report Data:
-State-developed Survey

NEW YORK
Managed Long Term Care Program

CONTACT INFORMATION

State Medicaid Contact:

Margaret Willard
Division of Long Term Care
(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:
New York Medicaid Choice/Maximus

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

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

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

Amerigroup Community Connections
ElderPlan/Managed Long Term Care
Fidelis Care at Home
Health Advantage/Elant Choice
HIP/Managed Long Term Care
Senior Health Partners
Total Aging in Place
VNS Choice
Centerlight Select
Elderserve
Guildnet
HHH Choices
Independent Care Systems
Senior Network Health
Village Care Max
WellCare Advocate

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance 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 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:
-Influenza vaccination rate
-Semi-annual assessment (SAAM index)

Health Status/Outcomes Quality:
-Depression
-Emergent care
-Experience pain daily
-Incontinence
-Independence in medication management
-Living alone
-Mean ADLs score
-One or more falls
-Percentage of members confused
-Percentage of members not alert
-Percentage of members with anxiety

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

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:

-Advanced 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

EQR Data included in State's annual EQR technical report:

None

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:

Margaret Willard
Division of Long Term Care
(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, Pharmacy, 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

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

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

AmeriGroup Advantage Plus/Medicaid Advantage Plus
Elder Plan/Medicaid Advantage Plus
GuildNet/Medicaid Advantage Plus
HealthFirst/Medicaid Advantage Plus
HIP Health Plan/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

None

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Grievance and Appeal Data
-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 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:
-Influenza vaccination rate

Health Status/Outcomes Quality:
-Daily pain
-Depression
-Incontinence
-Independence in medication management
-Living alone
-Mean ADLs score
-One or more falls
-Percentage members not alert
-Percentage members with anxiety
-Percentage members with confusion
-Received emergent care
-Semi-annual assessment (SAAM index)

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

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

Clinical Topics:
-Diabetes 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

EQR Data included in State's annual EQR technical report:
None

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
Adult Community Autism Program (ACAP)/Keystone Autism Services

CONTACT INFORMATION

State Medicaid Contact:

Regina Wall
Bureau of Autism Services/Office of Developmental Programs
(717) 265-8960

State Website Address:

www.dpw.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
Keystone Autism Services

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
August 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

Long Term Care PIHP - Risk-based Capitation

Service Delivery

Included Services:
Assistive Technology, Behavioral Support, Case Management, Chiropractic, Community Transition Services, Dental, Disease Management, Durable Medical Equipment, Environmental Modifications, Family Counseling, Habitation Services, Hearing, Home Health, Hospice, Intermediate Care Facility, Nursing Facility Services, Occupational Therapy, Outpatient Mental Health, Personal Care, Physical Therapy, Physician, Podiatry, Pre-vocational Services, Prosthetic eyes and other eye applicances, Residential Support, Respite Services, Speech Therapy, Supportive Employment, Supports Coordination, Transportation, Vision

Allowable PCPs:
-Addictionologists
-Clinical Social Workers
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-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
-Psychiatrists
-Psychologists
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Adults with Autism Spectrum Disorder
-Medicare Dual Eligibles
-Meets Intermediate Care Facility level of care in PA
-Minimum age 21 years
-Resides in Cumberland, Dauphin, Chester or Lancaster Counties

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Less Than 3 Months
-Eligible only for TB-related Services
-Enrolled in Another Managed Care Program
-Enrolled in CDC BCCT Program
-Enrolled in Health Insurance Premium Payment
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-Requres more than 16 hours of care per day
-Reside in Nursing Facility or ICF/MR
-Under age 21

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

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

Adult Community Autism Program/Keystone Autism Services

ADDITIONAL INFORMATION

ACAP functions as a managed care organization for Adults (age 21+) with Autism Spectrum Disorder who require Intermediate Care Facility level services but can live in a community setting and is responsible for clinical and administrative oversight of all services provided pursuant to an individual care plan. ACAP manages all health services for its clients, including hospital, diagnostic, laboratory and pharmacy services. ACAP contracts with a small provider network of physicians, psychologists and nutritionists. The participant can not require more than 16 hours of care per day. It is a voluntary program. It has a contract with Keystone Autism Services.

QUALITY ACTIVITIES FOR PIHP

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

Use of Collected Data:
-Contract Standard Compliance
-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)

Consumer Self-Report Data:
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey

Use of HEDIS:
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires PIHPs 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
-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

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
-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:
No

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:
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of addictions professionals to number of beneficiaries
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries

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

-Ratio of PCPs to beneficiaries

-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/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:

None

Non-Clinical Topics:

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Reducing health care disparities via health literacy, education campaigns, or other initiatives

Standards/Accreditation

PIHP Standards:

-Performance measures or improvement projects aligned with CMS recommended priorities (e.g. Child Core Quality Measures)
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-The Quality Company

EQRO Organization:
-Quality Improvement Organization (QIO)

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

EQR Data included in State's annual EQR technical report:
None

EQRO Optional Activities
-Conduct of performance improvement projects

PENNSYLVANIA
Living Independence for the Elderly (LIFE) Program (PIHP)

CONTACT INFORMATION

State Medicaid Contact:

Randy Nolen
PA Department of Public Welfare, Office of Long Term Living
(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:
1915(b)(4)

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

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

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

Life Butler

LIFE Northwestern PA

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

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

EQR Data included in State's annual EQR technical report:
None

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

PENNSYLVANIA
Voluntary HMO Contracts

CONTACT INFORMATION

State Medicaid Contact:

Darlene Demore
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)

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

Not Applicable

ADDITIONAL INFORMATION

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:

-ANOVA (Analysis of Variance)
-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

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
-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 Management/Care
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care - 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:
-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
-Children's access to primary care practitioners
-Percent of PCPs with open or closed patient assignment panels

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:

-Coordination of Primary and Behavioral Health Care
-Diabetes management
-Emergency Room service utilization
-Obesity Screening/Management
-Reducing Potentially Preventable Readmissions

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:

-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

EQR Data included in State's annual EQR technical report:

-None

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:

Walter Dobek Bareira
PR Department of Health - Medicaid Office
(787) 250-0453

State Website Address:

http://www.ases.pr.gov

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
1915(b)(4)

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

Subpopulations Excluded from Otherwise Included Populations:

Lock-In Provision:

-All populations who are not dual eligibles

No lock-in

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

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

American Health Medicare
Humana Puerto Rico
MMM Healthcare Inc.
Triple S
First Medical/First Plus
MCS Advantage
PMC Medicare Choice

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

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

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

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

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

Access/Availability of Care:
-Adult's access to preventive/ambulatory health services
-Call abandoment
-Call answer timeliness
-Inititation 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:

-Island Peer 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
-Validation of performance measures

EQR Data included in State's annual EQR technical report:

-Aggregate Data for all MCO Health Plans

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
Mi Salud

CONTACT INFORMATION

State Medicaid Contact:

Walter Dobek Bareira
PR Department of Health - Medicaid Office
(787) 250-0453

State Website Address:

http://www.ases.pr.gov

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
1915(b)(4)

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

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Crisis, Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Prevention Programs (MH), Transportation

Allowable PCPs:
-Psychiatrists
-Psychologists

Contractor Types:
-Behavioral Health MCO (Private)

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

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

APS Healthcare - MBHO

Humana Health Plans of Puerto Rico, Inc.- MCO

Triple-S, Inc.- TPA

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 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

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

Health Status/Outcomes Quality:
-Patient satisfaction with care

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
-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

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
-Hypertension management
-Retinopathy Screening and Long Term Control in Diabetic Population

Non-Clinical Topics:
-Clinical Edits Improvement Project

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

EQR Data included in State's annual EQR technical report:
-Aggregate Data for all MCO Health Plans

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

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
-Patient Safety and Reduction of Medical Errors in Hospitals

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:
-Island Peer Review 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

EQR Data included in State's annual EQR technical report:
-Aggregate Data for all MCO Health Plans

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:

Betsy Johnson
Texas Health and Human Services Commission
(512) 462-6286

State Website Address:

http://www.hhs.state.tx.us/medicaid/StarHealth.sht

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 enrolled in an institute of higher educ
-Young adults who have exited care and are participating in foster care youth transitional program

Subpopulations Excluded from Otherwise Included Populations:

-Determined Manifestly Dangerous and placed in a state hospital
-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

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

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)
-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

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
  Child Medicaid 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
-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:
-NCPDP D.0 - National Council for Prescription Drug Programs Post-Adjudication Pharmacy Claim Transaction
-X12 5010 837 Professional,Dental and Institutional transactions

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

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

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

-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia screening in women
-Colorectal Cancer Screening
-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

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
-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
-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
-Validation of performance measures

EQR Data included in State's annual EQR technical report:
-None

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

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:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

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

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, Inpatient Mental Health, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, 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
-Psychiatrists
-Psychologists

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

-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

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

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 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
-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
-Program Evaluation
-Rate Setting

Consumer Self-Report Data:

-Plan Developed 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)
-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)
-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

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Antidepressant medication management
-Appointment Availability by Provider Type

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

Use of Services/Utilization:
-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

Health Plan/ Provider Characteristics:
-Availability of Providers by Speciality
-Board Certification
-HOME Requires at least dual Board Certification (Medical and Mental Health)

Beneficiary Characteristics:
-Beneficiaries have a dual diagnosis (mental health and developmental disability)

Performance Measures - Others:
-Health Promotion

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:

-Coordination of care for persons with physical disabilities
-Diabetes management
-Impact of care coordinaton on hospital bed days
-Physical Activity Questionaire and Impact on BMI

Non-Clinical Topics:

-Client access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-HCE QualityQuest

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

EQR Data included in State's annual EQR technical report:
-Specific Health Plan Data only

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

WASHINGTON
Washington Medicaid Integration Partnership (WMIP)

CONTACT INFORMATION

State Medicaid Contact:

Barbara Lantz
Health Care Authority
(360) 725-1640

State Website Address:

http://www.dshs.wa.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
1915(b)(4)

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:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

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, 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

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

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

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

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:
-Antidepressant medication management
-Follow-up after hospitalization for mental illness
-Initiation and engagement of SUD treatment
-Use of High-Risk Medications in the Elderly

Health Status/Outcomes Quality:
-Comprenhensive Diabetes Care

Access/Availability of Care:
-Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

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

Performance Improvement Projects

Project Requirements:

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

Clinical Topics:

-Increasing depression assessments
-Increasing Influenza vaccine participation

Non-Clinical Topics:

-Improve the rate of completion of Documented Care Plans.
-Increasing successful initial contacts between WMIP members and Care Coordination Team

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

EQR Data included in State's annual EQR technical report:
-None

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

WISCONSIN
Children Come First (CCF)

CONTACT INFORMATION

State Medicaid Contact:

Brett Davis
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

Contractor Types:
-County Operated Entity (Public)

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

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

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

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

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

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,

-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
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

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
-Validation of performance meassures

EQR Data included in State's annual EQR technical report:
None

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:

Brett Davis
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

Contractor Types:
-County Operated Entity (Public)

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

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaskan Native
-Blind/Disabled Children and Related Populations
-Foster Care Children
-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
-Participate in HCBS Waiver

Lock-In Provision:

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

Medicare Dual Eligibles Included:

None

Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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

None

Agencies with which Medicaid Coordinates the Operation of the Program:

None

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

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

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
-Validation of performance measures

EQR Data included in State's annual EQR technical report:
None

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

KANSAS
Mental Health and Substance Abuse Services

CONTACT INFORMATION

State Medicaid Contact:

Elizabeth Phelps
Kansas Department of Health & Environment, Division of Healt
(785) 296-4552

State Website Address:

http://www.kancare.ks.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

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:
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

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

Mental Health (MH) PAHP - Risk-based 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

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

Kansas Health

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.

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

State conducts general data completeness assessments:

Yes

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

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
-URAC Standards

Accreditation Required for Participation:
None

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

EQR Data included in State's annual EQR technical report:
None

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

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:

Marlana Hutchinson
DHMH Living at Home Waiver Program
(410) 767-7479

State Website Address:

http://www.dhmh.maryland.gov/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(4), Selective Contracting

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, 2013

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

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

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) is based on a rate defined in COMAR. Maryland used a competitive solicitation process to select its case management provider that provides case management as an administrative and waiver service.

MICHIGAN
Specialty Prepaid Inpatient Health Plans

CONTACT INFORMATION

State Medicaid Contact:

Elizabeth Knisely
MDCH, Bureau of Community Mental Health Services
(517) 335-8401

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), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

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:
September 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:
Assertive Community Treatment, Assessments, Assistive Technology *, Behavior Management Review, Child Therapy, Clubhouse, Community Living Supports *, Crisis Interventions, Crisis Residential, Enhanced Pharmacy *, Environmental Modifications *, Family Support and Training *, Fiscal Intermediary Services, 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-

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

around for Children and Adolescents *

Contractor Types:
-County Community Mental Health Services

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

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))
-Residing in ICF/MR
-Waiver for Children with Serious Emotional Distubance (Section 1915 (c) Residing in a Child Psychiatric Hospital

Lock-In Provision:
No lock-in

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

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Alliance of Michigan
CMH Affiliation of Mid-Michigan
CMH for Central Michigan
CMH Partnership of Southeast Michigan
Detroit-Wayne County CMH Agency
Genesee County CMH Services
Lakeshore Behavioral Health Alliance
LifeWays
Macomb County CMH Services
Network 180
North Care
Northern Affiliation
Northwest CMH Affiliation
Oakland County CMH Authority
Saginaw County CMH Authority
Southwest Affiliation
Thumb Alliance PIHP
Venture Behavioral Health

ADDITIONAL INFORMATION

Southwest Michigan Urban & Rural Consortium had a name change since the last submission and is now Southwest Affiliation.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-CMHSP Certification for Participation
-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:
-5010 - transaction set format for transmitting health care claims data
-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

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
-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:
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:
None

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

EQR Data included in State's annual EQR technical report:
None

EQRO Optional Activities
-ER and Hospitalization Use Study

MINNESOTA
Minnesota Senior Care/Minnesota Senior Care Plus

CONTACT INFORMATION

State Medicaid Contact:

Carol Backstrom
Minnesota Department of Human Services
(651) 431-2319

State Website Address:

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1), Freedom of Choice

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, 2016

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, 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

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
-Medically Needy Individuals with Spend-down
-Medicare Dual Eligibles
-Other Insurance
-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

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

Blue Plus

Health Partners

Itasca Medical Care

Medica

Metropolitan Health Plan

PrimeWest Health System

South Country Health Alliance

UCARE

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
-Annual HCBS quality assurance plan

Use of Collected Data:
-Assess program results

-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)
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-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
-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

Health Status/Outcomes Quality:

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

-Dental services
-Diabetes screening
-Number of Mental Health Inpatient 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 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 improvement projects
-Validation of performance measures

EQR Data included in State's annual EQR technical report:
-Aggregate Data for all MCO Health Plans

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:
Dental

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
Coordination of Long-Term Services (CoLTS)

CONTACT INFORMATION

State Medicaid Contact:

Julie Weinberg
NM HSD/Medical Assistance Division
(505) 827-6253

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), Freedom of Choice
1915(b)(4), Selective Contracting

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:
December 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:
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 Certified
-Nurse Practioners Certified
-Obstetricans/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

None

-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
-HIV/AIDS
-Medicare Dual Eligible without full Medicaid Benefits
-Participate in HCBS Waiver for DD and Medically Fragile
-Reside in ICF/MR

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

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

AMERIGROUP Community Care of New Mexico, Inc.
United Healthcare

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.

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

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

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

Consumer Self-Report Data:

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

-Track Health Service provision

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State 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 Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments:

Yes

Performance Measures

Process Quality:

-Asthma care - medication use
-Diabetes medication management
-Influenza vaccination
-Influenza vaccination rate

Health Status/Outcomes Quality:

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

-Pneumonia care
-Pneumonia vaccination

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:
-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:
None

Health Plan/ Provider Characteristics:
None

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:
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Coordination of care for persons with physical disabilities
-Coordination of Primary and Behavioral Health care
-Diabetes management

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:
-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:
-HealthInsight dba New Mexico Medical 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
-Validation of performance measures

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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

NEW MEXICO
Coordination of Long-Term Services (CoLTS)

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

Clinical Conditions:
Asthma
Cardiac Care
Diabetes

Initial Year of Reward:
2012

Member Incentives:
Not Applicable

Rewards Model:
Withholds as an incentive

Measurement of Improved Performance:
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

NORTH CAROLINA
Mental Health Developmental Disabilities & Substance Abuse Services

CONTACT INFORMATION

State Medicaid Contact:

Kathy Nichols
Division of Medical Assistance
(919) 855-4289

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), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Enrollment Broker:
No

For All Areas Phased-In:
Yes

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:
Assistive Technology Equipment and Supplies, Care Giver Training, Community Guide, Community Networking, Community Transitions Support, Crisis, Day Support, Detoxification, Financial Management, Home Modifications, ICF/IID, Individual Directed Goods and, In-Home Intensive Supports, In-Home Skill Building, Inpatient Mental Health, Inpatient Substance Use Disorders, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Natural Supports Education, Opioid Treatment Programs, Outpatient Substance Use Disorders, Personal Care, Residential Substance Use Disorders Treatment Programs, Residential Support, Respite, Specialized Consultation, Supported Employment, Vehicle Modifications

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

Contractor Types:
-Regional Authority Operated Entity (Public)

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
-Special Needs Children

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

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

Cardinal Innovations
Eastern Carolina Behavioral Health
Smokey Mountain Center
Western Highlands Network

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PIHP

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

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

-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Other
-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
-Track Health Service provision

Consumer Self-Report Data:
-State Approved 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

Encounter Data

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

Collections: Submission Specifications:
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)

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:
None

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:
-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

Health Status/Outcomes Quality:
-Number of Consumers moved from institutional care to community care
-Patient satisfaction with care
-Readmission rates for mental health
-Readmission rates for substance abuse

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:
-Capacity
-Diversity of Medicaid Membership

Beneficiary Characteristics:
-none

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:
-Decrease admission rate to PTF and/or Inpatient for Consumers discharged from residential level III placement
-Improve community tenure for enrollees with multi-systemic therapy and intensive in-home services
-Improve metabolic screening for patients on second generation antipsychotics

Non-Clinical Topics:
-Improved provider compliance with coordination of benefits and sliding fee schedules

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:
-Accreditation Agencies Recognized by CMS for Non-Duplication

EQRO Name:
-Carolina Centers for Medical Excellence (CCME)

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

EQR Data included in State's annual EQR technical report:
None

EQRO Optional Activities
None

WISCONSIN
Family Care

CONTACT INFORMATION

State Medicaid Contact:

Monica Deignan
Wisconsin Department of Health Services
(608) 261-7807

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), Locality as Central Broker
1915(b)(4), Selective Contracting

Enrollment Broker:
Aging and Disability Resource Centers

For All Areas Phased-In:
Yes

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, Day Treatment, Disposable Medical Supplies, Durable Medical Equipment, Home Health, ICF-MR, Mental Health Community Support Program, Occupational Therapy, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Physical Therapy, Respiratory Therapy, Skilled Nursing, Skilled Nursing Facility, Speech and Language Therapy, Transportation

Allowable PCPs:
-Not applicable, primary care is carved out

Enrollment

Populations Voluntarily Enrolled:

Populations Mandatorily Enrolled:

-Adults with Developmental Disability or Mental Retardation
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

None

Subpopulations Excluded from Otherwise Included Populations:

-Certain Meidcare Dual Eligibles
-Enrolled in Another Managed Care Program
-Have an Eligibility Period that Is Only Retroactive
-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

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

Care Wisconsin First, Inc. (FC)
Community Care of Central Wisconsin (FC)
Lakeland Care District
Northern Bridges
Western Wisconsin Cares
CHP-LTS, Inc. (FC)
Community Care, Inc. (FC)
Milwaukee County Department of Family Care
Southwest Family Care Alliance

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Individualized Service Plan Reviews
-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
-Structured Member Outcome Interviews

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Monitor member health and safety
-Monitor Quality Improvement and Identify Improvement Opportunities
-Performance Measurement
-Program Evaluation
-Program Modification, Expansion, Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:

-Member satisfaction survey

Use of HEDIS:

-The State uses SOME of the HEDIS measures listed for

-Structured Member Outcome Interviews

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

Encounter Data

Collection: Requirements:
-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:
-Appeals and Grievances
-Member LTC outcomes present
-Outcomes achieved or in process
-Outcomes fully supported
-Quality and functional assessment

Health Status/Outcomes Quality:
-Member health and safety outcomes present
-Members in integrated Employment
-Patient satisfaction with care
-Pressure sores
-Support for member health and safety outcomes provided
-Vaccination rates (Influenza and Pneumococcal

Access/Availability of Care:
-Dental visits
-State assessment of adequate network capacity

Use of Services/Utilization:
-NF and ICF-MR utilization
-Preventable Hospitalizations and ER visits

Health Plan Stability/ Financial/Cost of Care:
-Actual reserves held by plan
-State minimum reserve requirements

Health Plan/ Provider Characteristics:
-Board Certification
-Consumers on governance boards
-State review for cultural competency

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:
-Assessing pain in Family Care Members
-Care Transitions
-Colorectal Cancer Screening
-Diabetes Care Coordination
-Fall Prevention
-Reducing Hospital Re-Admits within 30 days of discharge

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
-Validation of performance improvement projects
-Validation of performance meassures

EQR Data included in State's annual EQR technical report:
None

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:

Phyllis Davis
Florida Agency for Health Care Administration
(850) 412-4207

State Website Address:

http://ahca.myflorida.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(a)/(c)

Statutes Utilized:
1915(b)(4)

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:
None

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

Subpopulations Excluded from Otherwise Included Populations:

Lock-In Provision:

-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

No lock-in

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

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

American Eldercare, Inc.

AMERIGROUP Florida, Inc. (NHD)

Brevard Alzheimer's Foundation, Inc.

Coventry Health Care of Florida, Inc. (NHD)

Florida PACE Centers, Inc. d/b/a Project Independence at Home (NHD)

HOPE Hospice and Community Services, Inc. (NHD)

Humana Medical Plan, Inc. (NHD)

Little Havana Activities and Nutrition Centers of Dade County, Inc. (NHD)

Neighborly Care Network, Inc. (NHD)

Simply Healthcare Plans, Inc. (NHD)

Sunshine State Health Plan, Inc. (NHD)

United Healthcare of Florida, Inc. (NHD)

United Home Care Services, Inc. (NHD)

Universal Health Care, Inc. (NHD)

Urban Jacksonville, Inc. d/b/a Aging True (NHD)

WorldNet Services Corp (NHD)

ADDITIONAL INFORMATION

None

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

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
-Gender-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

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

EQR Data included in State's annual EQR technical report:

None

EQRO Optional Activities

-Assessment of MCO Organizations

MASSACHUSETTS
Senior Care Options (SCO)

CONTACT INFORMATION

State Medicaid Contact:

Ken Smith
Office of Medicaid
(617) 222-7508

State Website Address:

http://www.mass.gov/masshealth

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(a)/(c)

Statutes Utilized:
1915(b)(4)

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:
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, 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
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-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

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

Commonwealth Care Alliance
Senior Whole Health
NaviCare
United Health Care

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. A member must have full MassHealth benefits in order to enroll. All buy in categories are excluded.

Concurrent Operating 1915(a)/1915(c) program refers to the Frail Elder HCBS Waiver and not any of the other HCBS waivers. The target groups for the Frail Elder waiver are 'Aged' and 'Disabled individuals over 65.' The other target groups are not target groups for the Frail Elder Waiver (e.g. intellectually disabled, developmentally disabled).

HCBS Waivers as they pertain to SCO:
MassHealth Members enrolled in SCO may also be concurrently enrolled in the Commonwealth's 1915(c) waiver for Frail Elders (the 'Frail Elder Waiver'). The Frail Elder Waiver offers a variety of HCBS services to enrolled members that enable them to remain in a community setting, and which include non-medical services such as environmental modifications and respite.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:

-Focused Studies
-MCO Standards (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
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

-Provider Data

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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data

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

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

MINNESOTA
Minnesota Senior Health Options

CONTACT INFORMATION

State Medicaid Contact:

Carol Backstrom
Minnesota Department of Human Services
(651) 431-2319

State Website Address:

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(a)/(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:
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:
Case Management, Chiropractic, Community Based Services, 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

-Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:

-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

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

Blue Plus

Health Partners

Itasca Medical Care

Medica

Metropolitan Health Plan

PrimeWest Health System

South Country Health Alliance

UCARE

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)
-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
-Diabetes screening
-Mental health discharges
-Osteoporosis care after fracture

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:
-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 improvement projects
-Validation of performance measures

EQR Data included in State's annual EQR technical report:
-Aggregate Data for all MCO Health Plans

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys

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
Wisconsin Partnership Program

CONTACT INFORMATION

State Medicaid Contact:

Monica Deignan
DHS/DLTC
(608) 261-7807

State Website Address:

http://dhs.wisconsin.gov/wipartnership

PROGRAM DATA

Program Service Area:
County

Operating Authority:

Statutes Utilized:
Not Applicable

Enrollment Broker:
Aging and Disability Resource Centers

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
1915(c) Waiver Services, Case Management, Clinic, Dental, Drugs, 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
-Medicaid Only - Have an eligibility period that is only retroactive
-Medicare Dual Eligibles

Lock-In Provision:

No lock-in

Medicare Dual Eligibles Included:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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

None

Agencies with which Medicaid Coordinates the Operation of the Program:

None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Care Wisconsin Health Plan, Inc. (Partnership)
Community Care Health Plan, Inc. (Partnership)
Independent Care Health Plan (SNP)
Partnership Health Plan, Inc.

ADDITIONAL INFORMATION

The Wisconsin Partnership Program began operating under a 1115 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 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.

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
-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 Imporvement and Identify Improvement Opportunties
-Monitor Quality Improvement
-Performance Measurement
-Program Evaluation
-Program Modification, Expansion, Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:

-Consumer satisfaction survey
-Member satisfaction survey
-Structuredmember interviews

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:
-Member health and safety outcomes present
-Members in Integrated Employment
-Patient satisfaction with care
-Pressure sores
-Support for member health and safety outcomes provided
-Vaccination rates (influzena and pneumococcoal

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 people living at home, CBRF/group home, nursing home
-Preventable hospitalizations and ER visits

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
-Board Certification
-Consumer on governance boards
-State review for cultural competency

Beneficiary Characteristics:
None

Performance Measures - Others:
-Structured member outcome interviews

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:

-Assessing Pain in Family Care Members
-Care Transitions
-Colorectal Cancer Screening
-Diabetes Care Coordination
-Falls Prevention
-Reducing Hospital Re-Admits within 30 days of discharge

Non-Clinical Topics:

-Increasing use of Self-Directed Supports
-Service Authorization
-Service Decision Method

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
-Validation of performance measures

EQR Data included in State's annual EQR technical report:
-Aggregate Data for all MCO Health Plans

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 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

Initial Year of Reward:
Not Applicable

Member Incentives:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Evaluation Component:
Not Applicable

IDAHO
Healthy Connections

CONTACT INFORMATION

State Medicaid Contact:

Meg Hall
Idaho Medicaid
(208) 665-8844

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 - Primary Care Case Management Payments

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

Populations Voluntarily Enrolled:

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

-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
-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

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

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 - Blue Cross

CONTACT INFORMATION

State Medicaid Contact:

Sara Stith
Bureau of Medical Care
(208) 287-1173

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:
September 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

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
-Medicare Dual Eligibles
-Participate in HCBS Waiver
-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
-Medicare-Medicaid Coordinated Plan
-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:

QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:

QMB
SLMB, QI, and QDWI

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

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

None

Agencies with which Medicaid Coordinates the Operation of the Program:

None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Idaho Smiles - Blue Cross

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

Collections - Submission Specifications:

-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-HIPAA 834 transaction
-Use of "home grown" forms

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

Collection: Standardized Forms:
-ADA - American Dental Association dental claim form
-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:
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 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

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

WASHINGTON
Chronic Care Management Program (CCMP)

CONTACT INFORMATION

State Medicaid Contact:

Barbara Lantz
Health Care Authority
(360) 725-1640

State Website Address:

http://www.hca.wa.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1937

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, 2007

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

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
-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

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Cowlitz County Guidance Association

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
-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

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 and self-manage care

Access/Availability of Care:
None

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

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
DSHS Aging and Disability Services Administration

CONTACT INFORMATION

State Medicaid Contact:

Candace Goehring
DSHS Aging and Disability Services Administration
(360) 725-2562

State Website Address:

www.adsa.dshs.wa.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:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 2010

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Chronic Care Management - Risk-based Capitation

Service Delivery

Included Services:
Chronic Care Management, Disease Management

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

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Medically Frail and Individuals with Special Needs

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

Medicare Dual Eligibles Included:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

None

ADDITIONAL INFORMATION

Chronic Care Management program provides Chronic Care management services to clients who are categorically needy, medically frail and with special medical needs, 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.

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

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:

-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:

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

Consumer Self-Report Data:

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

Use of HEDIS:

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

Encounter Data

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

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
-Check-ups after delivery

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:
-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

Clinical Topics:
-Adolescent Immunization
-Asthma management
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization

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 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

EQR Data included in State's annual EQR technical report:
-Aggregate and Specific Health Plan Data
-Aggregate Data for all MCO Health Plans
-Specific Health Plan Data only

EQRO Optional Activities:
None

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

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medical Transportation Management

ADDITIONAL INFORMATION

This program serves the FFS population only.

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 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

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

Subpopulations Excluded from Otherwise Included Populations:

Lock-In Provision:

-Emergency Medical Assistance Members
-Medicare Dual Eligibles
-Title XXI CHIP (PeachCare)

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

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

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

IDAHO
Non-Emergency Medical Transportation - AMR

CONTACT INFORMATION

State Medicaid Contact:

Sara Stith
Bureau of Medical Care
(208) 287-1173

State Website Address:

www.healthandwelfare.idaho.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1902(a)(70)

Statutes Utilized:
Not Applicable

Enrollment Broker:
American Medical Response

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 2010

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/Alaskan Native
-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)
-Special Needs Children (State defined)
-Title XXI CHIP

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-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:
SLMB, QI, and QDWI
QMB

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Medical Transportation - AMR

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:
-Contract Standard Compliance

Consumer Self-Report Data:
-CAHPS
Adult Medicaid SSI Questionnaire

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

IOWA
Non-Emergency Medical Transportation

CONTACT INFORMATION

State Medicaid Contact:

Tim Weltzin
Iowa Medicaid Enterprise
(515) 256-4633

State Website Address:

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

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1902(a)(70)

Statutes Utilized:
Not Applicable

Enrollment Broker:
TMS Management Group, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 2010

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:
-Transportation Broker

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaskan 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:
-Eligible only for TB-related Services

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

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

TMS Management Group,
Inc.

ADDITIONAL INFORMATION

Transportation to medicaid covered services

Those receiving comprehensive community based services from a Title V organization.

QUALITY ACTIVITIES FOR PAHP

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

Use of Collected Data:
-Does Not Use the Data Collected

Consumer Self-Report Data:
None

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.)

PAHP conducts data accuracy check(s) on specified data elements:
None

State conducts general data completeness assessments:
No

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:

Sharon Johnson
Division of Health Care Finance
(785) 296-3981

State Website Address:

http://www.kdheks.gov/hcf/

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

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

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)
-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

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

Consumer Self-Report Data:
-State-developed Survey

Use of HEDIS:
-The State 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:
None

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
-Percentage of beneficiaries who are auto-assigned to PAHPs

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:
-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

MISSISSIPPI
Non-Emergency Transportation Broker Program

CONTACT INFORMATION

State Medicaid Contact:

Dorthy Young
Division of Medicaid
(601) 359-5243

State Website Address:

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:
SLMB, QI, and QDWI
QMB

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

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 the State

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

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:

Kristen Edwards
Department of Social Services, MO HealthNet Division
(573) 751-9290

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

Subpopulations Excluded from Otherwise Included Populations:

Lock-In Provision:

-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

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

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

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

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:

Tom Sargent
Division of Health Care Financing and Policy, Managed Care
(775) 684-3698

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
-Poverty-Level Pregnant Women
-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:
None

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Logisticare

ADDITIONAL INFORMATION

NV's NEMT plan is a brokerage that is operated per the State Plan requirements at 42 CFR 440.170(a)(4).

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:
-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

Collections - Submission Specifications:
-Guidelines for initial encounter data submission

data submission

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
-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

NEW JERSEY
Non-Emergency Transportation Broker Program

CONTACT INFORMATION

State Medicaid Contact:

Richard Hurd
Department of Human Services Division of Medical Assistance
(609) 588-2550

State Website Address:

http://www.state.nj.us/humanservices/dmahs/index.h

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:
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:
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

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

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) 522-7208

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

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

SoonerRide

ADDITIONAL INFORMATION

OHCA contracts with the vendor, LogistiCare, to establish a comprehensive public transit program, known as SoonerRide, for Oklahoma Medicaid members. LogistiCare manages the operations of the SoonerRide program, including creating a network of providers, receiving prior authorizations for transportation, and outreach.

OHCA uses a transportation brokerage system to provide the most cost-effective and appropriate form of transportation to members. The contracted transportation broker is reimbursed on a Capitation rate, per-member-per-month basis (which is broken down by ABD and TANF) members.

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
-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

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:
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)

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
-Per member per month analysis and comparisons across PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

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

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

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

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:

Zenovia Vaughn
Hospitals, Dental, Transportation and DME Services
(803) 898-2682

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:
-No populations are excluded

Lock-In Provision:
Does not apply

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

Medicare Dual Eligibles Excluded:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
None

Agencies with which Medicaid Coordinates the Operation of the Program:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMR

Logisticare

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

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

Collections - Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets

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

Collection: Standardized Forms:
None

of acceptable values, standards for data processing and editing

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

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
-Foster Care Children
-Home and Community Based Waivers
-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:
-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

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

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

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

ALABAMA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

LINDA LACKEY
PROGRAM MANAGER
ALABAMA MEDICAID AGENCY
(334-242-5644

State Website Address:

http://www.medicaid.alabama.gov/

PACE Organization

Approved PACE Organization Name:

Mercy Life of Alabama (MLOA)

Program Agreement Effective Date:

December 01, 2011

PACE Contact:

DIANE LANCASTER
2900 SPRINGHILL AVENUE
MOBILE, AL 36607
(251) 287-8420

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.

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.

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.

CALIFORNIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Joseph Billingsley
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:

AltaMed Health Services Corporation dba Altamed Senior BuenaCare

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Castulo de la Rocha
2040 Camfield Avenue
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:

Jared Nyagol
7000 Franklin Boulevard, Suite 1020
Sacramento, CA 95823
(916) 491-3404

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

CALIFORNIA
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: On Lok Senior Health Services dba On Lok Lifeways

Program Agreement Effective Date: February 01, 2003

PACE Contact:
Robert Edmondson
1333 Bush Street
San Francisco, CA 94109
(415) 292-8888

Approved PACE Organization Name: Coalition Center for 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

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.

COLORADO
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Matthew Ullrich
Contract Manager
Department of Health Care Policy and Financing
(303) 866-6232

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:

Tamrin Apaydin
2335 Robinson Street
Colorado Springs, CO 80904
(719) 314-2327

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.

FLORIDA
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Kym Holcomb
Program Administrator
Bureau of Medicaid Services
(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:

Cliff Bauer
5200 Northeast 2nd Avenue
Miami, FL 33137
(305) 762-1394

Approved PACE Organization Name: Hope PACE

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: Chapters Health Senior Independence PACE

Program Agreement Effective Date: October 14, 2011

PACE Contact:

Kathy Fernandez
Telecom Parkway, Suite 100
Temple Terrace, FL 33637
(813) 870-7090

FLORIDA
Program of All-Inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Suncoast Care

Program Agreement Effective Date: September 01, 2009

PACE Contact: Betty Oldanie
6774 102nd Ave.
Pinellas Prk, FL 33782
(727) 573 -9444

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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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:

Randy Ehlers
4300 Hamilton Blvd
Sioux City, IA 51104
(712) 233-4144

Approved PACE Organization Name: Immanuel Pathways

Program Agreement Effective Date: January 01, 2012

PACE Contact:

Cheri Mundt
1702 North 16th Street
Council Bluffs, IA 51501
(712) 256-7284

ADDITIONAL INFORMATION

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KANSAS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Fran Seymour-Hunter
Manager
Division of Health Care Policy
(785) 296-2212

State Website Address:

http://www.kdheks.gov/hcf/

PACE Organization

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

Approved PACE Organization Name: Via Christi Healthcare Outreach

Program Agreement Effective Date: September 01, 2002

PACE Contact:

Justin Loeven
2622 West Central Avenue, Suite 101
Witchita, KS 67203
(316) 946-5110

ADDITIONAL INFORMATION

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LOUISIANA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Allison Vuljoin
Division Director
Office of Aging and Adult Services
(225) 219-0229

State Website Address:

http://www.dhh.louisiana.gov

PACE Organization

Approved PACE Organization Name: Greater New Orleans

Program Agreement Effective Date: September 07, 2007

PACE Contact:

Stephanie Smith
4201 N. Rampert
New Orlean, LA 70117
(504) 941-6052

Approved PACE Organization Name: Francican PACE Baton Rouge

Program Agreement Effective Date: July 01, 2008

PACE Contact:

Karen Allen
7436 Bishop Ott Dr.
Baton Rouge, MD 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.maryland.gov

PACE Organization

Approved PACE Organization Name:

Hopkins Elder Plus

Program Agreement Effective Date:

November 01, 2002

PACE Contact:

Jonathan Aistrop 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:

Elizabeth Bradley
Commonwealth of Massachusetts
Office of Elder
Affairs
(617) 222-7544

State Website Address:

http://www.mass.gov/masshealth

PACE Organization

Approved PACE Organization Name: Elder Service Plan of Cambridge Health Alliance

Program Agreement Effective Date: November 01, 2003

PACE Contact:

Tom Reiter, Director of Operations
270 Green Street
Cambridge, MA 02139
(617) 575-5850

Approved PACE Organization Name: Elder Service Plan of Harbor Health Services

Program Agreement Effective Date: November 01, 2002

PACE Contact:

Carol Crawford
1135 Morton Street
Mattapan, MA 02126
(617) 533-2400

Approved PACE Organization Name: Elder Services Plan of East Boston Neighborhood Health Center

Program Agreement Effective Date: November 01, 2003

PACE Contact:

Laura Wagner
10 Grove Street
East Boston, MA 02128
(617) 569-5800

MASSACHUSETTS
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Elder Service Plan of the North Shore

Program Agreement Effective Date: November 01, 2003

PACE Contact:
Robert Wakefield Jr.
37 Friend Street
Lynn, MA 01902
(781)715-6608

Approved PACE Organization Name: Summit Elder Care

Program Agreement Effective Date: November 01, 2002

PACE Contact:
Karen Longo
10 Chestnut Street
Worcester, MA 01608
(508) 368-9437

Approved PACE Organization Name: Uphams Elder Service Plan

Program Agreement Effective Date: November 01, 2002

PACE Contact:
Jay Trivedi
1140 Dorcester Avenue
Dorcester, MA 02125
(617) 288-0970

ADDITIONAL INFORMATION

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MICHIGAN
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Peggy Peckman Barrie
Manager
Department of Community Health
(517) 335-5202

State Website Address:

http://www.michigan.gov/mdch

PACE Organization

Approved PACE Organization Name: Center for Senior Independence

Program Agreement Effective Date: November 01, 2003

PACE Contact:

Michael Carson
7800 W. Outer Drive, Suite 240
Detroit, MI 48255
(313) 543-6320

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

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:

Beverly White
3900 South Grand
St. Louis, MO 63118
(314) 771-5800

ADDITIONAL INFORMATION

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NEW JERSEY
Program of All-inclusive Care for the Eldelry (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Paul Sullivan
PACE Team Leader
NJ Department of Human Services, Division of Aging 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: April 09, 2009

PACE Contact:

Sr. 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) 599-5433

Approved PACE Organization Name: Lutheran Senior LIFE at Jersey City

Program Agreement Effective Date: July 01, 2010

PACE Contact:

Mia Phifer
377 Jersey Avenue, 3rd floor
Jersey City, NJ 07302
(201) 706-2091

NEW JERSEY
Program of All-inclusive Care for the Eldelry (PACE)

Approved PACE Organization Name: South Jersey Healthcare LIFE

Program Agreement Effective Date: August 01, 2011

PACE Contact:

Cynthia Lytle
2445 South Delsea Drive
Vineland, NJ 08360
(856) 418-5433

ADDITIONAL INFORMATION

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NEW MEXICO
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Ellen Costilla
Health Care Operations Manager
NM HSD/Medical Assistance Division
(505) 827-3180

State Website Address:

http://www.state.nm.us/hsd/mad/Index.html

PACE Organization

Approved PACE Organization Name:

INNOVAGE GREATER NEW MEXICO PACE DBA TOTAL COMMUNITY CARE, LLC

Program Agreement Effective Date:

July 01, 2004

PACE Contact:

Maria Zemora-Hughes
904 A los Lomas NE
Albuquerque, NM 87102
(505)924-2606

ADDITIONAL INFORMATION

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NEW YORK
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Deb Conley-Flora
Bureau of Managed Long Term Care
Division of Long Term Care
(518) 474-6943

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:

Jill Graziano
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: Total Senior Care

Program Agreement Effective Date: October 01, 2008

PACE Contact:
Carol Mahoney
1225 West State Street
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:
Schifferli Thomas
55 Melroy Avenue
Lackawanna, NY 14281
(716) 819-5102

Approved PACE Organization Name: Complete Senior Care

Program Agreement Effective Date: September 01, 2009

PACE Contact:
Courtney Jacques
1302 Main Street
Niagara Falls, NY 14301
(716) 285-8249

NEW YORK
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Centerlight (CCM)

Program Agreement Effective Date: July 01, 2011

PACE Contact: Joseph Healy Jr.
1250 Waters Place, 6th Floor
Broynx, NY 10467
(347) 640-6020

ADDITIONAL INFORMATION

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NORTH CAROLINA
Program of All-inclusive Care for the Eldelry (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Sabrena Lea
Section Chief, Home and Community Care
Noth Carolina Department of Health and Human Services
(919) 855-4365

State Website Address:

http://www.ncdhhs.gov/dma/

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

Approved PACE Organization Name: PACE of Guilford and Rockingham Counties, Inc. (PACE of the Triad)

Program Agreement Effective Date: May 01, 2011

PACE Contact:

Ursula Robinson
1471 E. Cone Blvd.
Greensboro, NC 27405
(336) 550-4056

NORTH CAROLINA
Program of All-inclusive Care for the Eldelry (PACE)

Approved PACE Organization Name: LIFE at St. Joseph of the Pines

Program Agreement Effective Date: April 01, 2011

PACE Contact: Robert Dickson
4900 Raeford Road
Fayetteville, NC 28304
(910) 483-49111

Approved PACE Organization Name: PACE @Home

Program Agreement Effective Date: December 01, 2011

PACE Contact: Mel Causey
1915 Fairgrove Church Road SE
Newton, NC 28658
(828) 468-3980

ADDITIONAL INFORMATION

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NORTH DAKOTA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Annette Fischer
Administrator, Managed Care
Department of Human Services Medical Services Division
(800) 755-2604

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

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OHIO
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Matthew Hobbs, Aging Policy
Bureau of Long Term Care Services and Supports
Ohio Department of Medicaid
(614) 752-3553

State Website Address:

http://medicaid.ohio.gov

PACE Organization

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

Approved PACE Organization Name: TriHealth Senior Link

Program Agreement Effective Date: November 01, 2002

PACE Contact:

Brett Kirkpatrick
619 Oak Street
Cincinnati, OH 45206
(513) 569-6673

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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OKLAHOMA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Ashley Herron
Pace Program Coordinator
Oklahoma Health Care Authority
(405) 522-7902

State Website Address:

http://www.okhca.org

PACE Organization

Approved PACE Organization Name:

Cherokee Elder Care

Program Agreement Effective Date:

August 01, 2008

PACE Contact:

Sharon Washington-Hilton
1387 W. 4th Street
Tahlequah, OK 74464
(918) 316-0677

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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PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Cheryl Martin
Chief of Staff
PA Department of Public Welfare, Office of Long Term Living
(717) 772-2543

State Website Address:

http://www.state.pa.us

PACE Organization

Approved PACE Organization Name: LIFE Lutheran Services

Program Agreement Effective Date: September 01, 2008

PACE Contact:

Terry Shade
840 5th Avenue
Chambersburg, PA 17201
717) 264-8178

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:

Mary Austin
6970 Germantown Avenue
Philadelphia, PA 19119
215) 951-4405

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: John Paul Marosy
2045 Westgate Drive, Suite 100
Bethlehem, PA 18017
484) 895-4301

Approved PACE Organization Name: LIFE St Mary

Program Agreement Effective Date: April 01, 2008

PACE Contact: Emily Amerman
2500 Interplex Drive
Trevose, PA 19053
267) 991-7620

Approved PACE Organization Name: Senior LIFE Washington

Program Agreement Effective Date: May 01, 2011

PACE Contact: Mark Irwin
401 S. Broad Street
Johnstown, PA 15905
814) 535-6000

Approved PACE Organization Name: Senior LIFE York

Program Agreement Effective Date: February 01, 2009

PACE Contact: Mark Irwin
401 S. Broad Street
Johnstown, PA 15905
814) 535-6000

PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Senior LIFE Altoona

Program Agreement Effective Date: April 01, 2008

PACE Contact: Mark Irwin
401 S. Broad Street
Johnstown, PA 15906
814) 535-6000

Approved PACE Organization Name: Pittsburgh Care Partnership/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 Beaver/Lawrence

Program Agreement Effective Date: November 01, 2008

PACE Contact: Toni Hively
131 Pleasant Drive, Suite 1
Aliquippa, PA 15001
724) 378-5400

Approved PACE Organization Name: LIFE St Agnes Medical Center - Mercy LIFE

Program Agreement Effective Date: October 01, 2005

PACE Contact: Carol Quinn
1001 Baltimore Pike
Springfield, PA 19064
610) 690-2526

PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Albright Care Services

Program Agreement Effective Date: January 01, 2012

PACE Contact: Lou Ann Shively
90 Maplewood Drive
Lewisburg, PA 17837
(570) 522-2853

Approved PACE Organization Name: LIFE - University of Pennsylvania

Program Agreement Effective Date: January 01, 2002

PACE Contact: Daniel Drake
4508 Chestnut Street
Philadelphia, PA 19139
(215) 573-7200

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

Approved PACE Organization Name: LIFE Geisinger

Program Agreement Effective Date: October 01, 2007

PACE Contact: Robert McQuillan
100 North Academy Avenue
Danville, PA 17822
570) 271-5531

ADDITIONAL INFORMATION

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RHODE ISLAND
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Ellen Mauro
Administrator
RI Medicaid, EOHHS Medical Services, Office of Long Term Services and Supports
(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

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SOUTH CAROLINA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Teresa Curtis
Manager
South Carolina Dept of Health and Human Services
(803) 898-0070

State Website Address:

http://www.scdhhs.gov

PACE Organization

Approved PACE Organization Name: Palmetto SeniorCare

Program Agreement Effective Date: November 01, 2003

PACE Contact:

Suzanne Tillman
15 Richland Medical Park Drive, Suite 203
Columbia, SC 29203
(803) 434-4421

Approved PACE Organization Name: The OAKS PACE

Program Agreement Effective Date: March 01, 2008

PACE Contact:

Elaine Till
1000 Methodist Oaks Drive
Orangeburg, SC 29118
(803) 535-1561

ADDITIONAL INFORMATION

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TENNESSEE
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Gary Smith
Director of HealthCare Informatics
TennCare

(615) 507-6394

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

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TEXAS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Lori Roberts
PACE Contact
Department of Aging and Disability Services
(512) 438-5391

State Website Address:

http://www.dads.state.tx.us/provider/PACE/index.cf

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) 562-3444

Approved PACE Organization Name: Silver Star

Program Agreement Effective Date: May 01, 2010

PACE Contact:

Annette Gary
4010 22nd Street
Lubbock, TX 79410
(806) 740-1500

Approved PACE Organization Name: Jan Werner Adult Day Care Center

Program Agreement Effective Date: March 01, 2004

PACE Contact:

Krissy Jones
3108 South Fillmore
Amarillo, TX 79110
(806) 374-5516

ADDITIONAL INFORMATION

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VERMONT
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Megan Tierney-Ward
Aging and Disability Program Supervisor
Department of Disabilities, Aging, and Independent Living
802 871-3047

State Website Address:

http://dail.vermont.gov

PACE Organization

Approved PACE Organization Name:

PACE Vermont

Program Agreement Effective Date:

March 01, 2007

PACE Contact:

Kathy Rainville
Department of Disabilities, Aging, and Independent Living
Williston, VT 05495
802-786-5052

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
Virginia Beach, VA 23462
(757) 502-7800

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

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

VIRGINIA
Program of All-inclusive Care for the Elderly (PACE)

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

Approved PACE Organization Name: Riverside PACE

Program Agreement Effective Date: February 01, 2008

PACE Contact: Erich Wolters
439 C Driana Road
Newport News, VA 23608
(757) 234-8100

Approved PACE Organization Name: InovaCares

Program Agreement Effective Date: April 01, 2012

PACE Contact: Robert Hager
8110 Gatehouse Road
Falls Church, VA 22042
(703) 289-8651

ADDITIONAL INFORMATION

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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.

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WISCONSIN
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Monica Deignan
Deputy Director Office of Family Care Expansion
Wisconsin Department of Health
Service
(608) 261-7807

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:

Alicia Modjeska
1555 South Layton Boulevard
Milwaukee, WI 53215
(414) 385-6600

ADDITIONAL INFORMATION

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National Summary of State Medicaid Managed Care Programs
Glossary as of July 1, 2012

Section: Program Data--Operating Authority Terms

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

Accreditation for Deeming — Some States use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as "deemed compliance" with a standard.

Accreditation for Participation — State requirement that plans must be accredited to participate in the Medicaid managed care program.

Consumer Self-Report Data — Data collected through survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a MCO, PIHP, or PAHP. The survey may be conducted by the State or a contractor to the State.

Encounter Data — Detailed data about individual services provided to individual beneficiaries at the point of the beneficiary's interaction with a MCO, PIHP, PAHP institutional or practitioner provider. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims".

Enrollee Hotlines — Toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their MCO, PIHP, PAHP. The people who staff hotlines are knowledgeable about program policies and may play an "intake and triage" role or may assist in resolving the problem.

Focused Studies — State required studies that examine a specific aspect of health

	care (such as prenatal care) for a defined point in time. These projects are usually based on information extracted from medical records or MCO, PIHP, PAHP administrative data such as enrollment files and encounter /claims data. State staff, EQRO staff, MCO, PIHP, PAHP staff or more than one of these entities may perform such studies at the discretion of the State.
MCO/PIHP/PAHP	These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each MCO/PIHP/PAHP must have in order to participate in the Medicaid program.
Monitoring of Standards	Activities related to the monitoring of standards that have been set for plan structure, operations, and quality improvement/assurance to determine that standards have been established, implemented, adhered to, etc.
Ombudsman	An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PIHP/PAHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PIHP/PAHP, and the provider (as appropriate) to resolve individual enrollee problems.
On-Site Reviews	Reviews performed on-site at the MCO/PIHP/PAHP health care delivery system sites to assess the physical resources and operational practices in place to deliver health care.
Performance Improvement Projects	Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MCO/PIHP/PAHPs choosing or prescribed by the State.
Performance Measures	Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and

	services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PIHP/PAHP.
Provider Data	Data collected through a survey or focus group of providers who participate in the Medicaid program and have provided services to enrolled Medicaid beneficiaries. The State or a contractor of the State may conduct survey.
HEDIS Measures from Encounter Data	*Health Plan Employer Data and Information Set (HEDIS)* measures from encounter data as opposed to having the plans generate HEDIS measures. HEDIS is a collection of performance measures and their definitions produced by the National Committee for Quality Assurance (NCQA).
EQRO	Federal law and regulations require States to use an *External Quality Review Organization (EQRO)* to review the care provided by capitated managed care entities. EQROs may be Peer Review Organizations (PROs), another entity that meets PRO requirements, or a private accreditation body.
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.