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ALABAMA
Maternity Care Program

CONTACT INFORMATION

State Medicaid Contact: Laura Hamilton
Alabama Medicaid Agency
(334) 353-4301

State Website Address: http://www.medicaid.alabama.gov

PROGRAM DATA

Program Service Area: Statewide

Initial Waiver Approval Date: October 01, 2004

Operating Authority:
1915(b) - Waiver Program

Implementation Date: September 23, 2005

Statutes Utilized:
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Waiver Expiration Date: December 31, 2012

Enrollment Broker: No

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

For All Areas Phased-In: No

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility: None

SERVICE DELIVERY

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

Service Delivery

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

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

Enrollment
## ALABAMA
Maternity Care Program

<table>
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<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
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<tr>
<td>None</td>
<td>- American Indian/Alaska Native</td>
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<td>- Poverty-Level Pregnant Women</td>
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<td>- Refugees</td>
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<td>- Section 1931 Adults and Related Populations</td>
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<td>- Section 1931 Children and Related Populations</td>
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<tr>
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<td>- SSI over 19 eligibles</td>
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</table>

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

### Medicare Dual Eligibles Included:
None

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

### Part D Benefit

<table>
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<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
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<th>Part D - Enhanced Alternative Coverage:</th>
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<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
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## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

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

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

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Maternity Care Program

## ADDITIONAL INFORMATION

The reimbursement methodology for the maternity program is capitated "at risk" to a health entity assigned in each district throughout 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 woman's 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

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

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

### Use of Collected Data:
- Contract Standard Compliance
- Monitor Quality Improvement
- Program Evaluation
- Track Health Service provision

### Encounter Data

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

#### Collection: Standardized Forms:
- None

#### 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 ACO/G
ALABAMA
Maternity Care Program

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<th>Health Plan Stability/ Financial/Cost of Care:</th>
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Performance Improvement Projects

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

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

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

Standards/Accreditation

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ALABAMA
Patient 1st

CONTACT INFORMATION

State Medicaid Contact: Chris McInnish
Alabama Medicaid Agency
(334) 353-3512

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

Initial Waiver Approval Date: October 01, 2004

Implementation Date: December 01, 2004

Waiver Expiration Date: May 31, 2013

Enrollment Broker: No

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

Guaranteed Eligibility:
12 months guaranteed eligibility for children

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled: None

Populations Mandatorily Enrolled:
-Aged and Related Populations
### Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in Another Managed Care Program
- Foster Care Children
- Medicare Dual Eligibles
- Other Insurance
- Poverty Level Pregnant Woman
- Recipient is a lock-in
- Recipient is determined to be medically exempt
- Reside in Nursing Facility or ICF/MR

### Lock-In Provision:
1 month lock-in

### Medicare Dual Eligibles Included:
None

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

### Part D Benefit
- **MCE has Medicare Contract:** Not Applicable
- **Provides Part D Benefits:** Not Applicable
- **Scope of Part D Coverage:** Not Applicable
- **Part D - Enhanced Alternative Coverage:** Not Applicable

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

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS
- **Program Includes People with Complex (Special) Needs:** Yes
- **Strategies Used to Identify Persons with Complex (Special) Needs:**
  - Self Referrals
  - Uses provider referrals to identify members of these groups
- **Agencies with which Medicaid Coordinates the Operation of the Program:**
  - Aging Agency
  - Developmental Disabilities Agency
  - Mental Health Agency
  - Public Health Agency

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
- **Patient 1st**

### ADDITIONAL INFORMATION
The 12 months guaranteed eligibility applies to children born to Medicaid eligible mothers and if child remains in mother's home.
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<th>Quality Oversight Activities:</th>
<th>Use of Collected Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Consumer Self-Report Data (see below for details)</td>
<td>- Contract Standard Compliance</td>
</tr>
<tr>
<td>- Independent assessment of program impact, access, quality &amp; cost-effectiveness</td>
<td>- Fraud and Abuse</td>
</tr>
<tr>
<td>- Performance Measures (see below for details)</td>
<td>- Monitor Quality Improvement</td>
</tr>
<tr>
<td>- Provider Data</td>
<td>- Program Evaluation</td>
</tr>
<tr>
<td></td>
<td>- Provider Profiling</td>
</tr>
<tr>
<td></td>
<td>- Regulatory Compliance/Federal Reporting</td>
</tr>
</tbody>
</table>

## 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

<table>
<thead>
<tr>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
</table>
| State Medicaid Contact: | ANDREW ALLISON  
Medicaid Agency  
(501) 682-8292 |
| State Website Address: | http://medicaid.state.ar.us |

<table>
<thead>
<tr>
<th>PROGRAM DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Service Area:</td>
</tr>
<tr>
<td>Operating Authority:</td>
</tr>
</tbody>
</table>
| 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 |

<table>
<thead>
<tr>
<th>SERVICE DELIVERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation PAHP - Risk-based Capitation</td>
</tr>
</tbody>
</table>

Service Delivery

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Non-Emergency Transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowable PCPs:</td>
<td>-Not applicable, contractors not required to identify PCPs</td>
</tr>
</tbody>
</table>

Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>None</th>
</tr>
</thead>
</table>
| 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 |
ARKANSAS

Non-Emergency Transportation

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)

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
Persons with full Medicaid eligibility

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

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR PAHP
### ARKANSAS
Non-Emergency Transportation

<table>
<thead>
<tr>
<th>State Quality Assessment and Improvement Activities:</th>
<th>Use of Collected Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Consumer Self-Report Data  (see below for details)</td>
<td>- Contract Standard Compliance</td>
</tr>
<tr>
<td>- Encounter Data  (see below for details)</td>
<td>- Monitor Quality Improvement</td>
</tr>
<tr>
<td>- Enrollee Hotlines</td>
<td>- Plan Reimbursement</td>
</tr>
<tr>
<td>- Monitoring of PAHP Standards</td>
<td>- Program Evaluation</td>
</tr>
<tr>
<td>- On-Site Reviews</td>
<td>- Program Modification, Expansion, or Renewal</td>
</tr>
<tr>
<td>- PAHP Standards  (see below for details)</td>
<td>Provider Data</td>
</tr>
<tr>
<td>- Provider Data</td>
<td>Use of HEDIS:</td>
</tr>
<tr>
<td></td>
<td>- The State DOES NOT use any of the HEDIS measures</td>
</tr>
<tr>
<td>Consumer Self-Report Data:</td>
<td>- The State DOES NOT generate from encounter data any of the</td>
</tr>
<tr>
<td>- State-developed Survey</td>
<td>HEDIS measure listed for Medicaid</td>
</tr>
</tbody>
</table>

### Encounter Data

<table>
<thead>
<tr>
<th>Collection: Requirements:</th>
<th>Collections - Submission Specifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Requirements for PAHPs to collect and maintain encounter data</td>
<td>None</td>
</tr>
<tr>
<td>- Standards to ensure complete, accurate, timely encounter data submission</td>
<td></td>
</tr>
<tr>
<td>Collection: Standardized Forms:</td>
<td>Validation - Methods:</td>
</tr>
<tr>
<td>None</td>
<td>- 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)</td>
</tr>
<tr>
<td></td>
<td>- Medical record validation</td>
</tr>
<tr>
<td></td>
<td>- Per member per month analysis and comparisons across PAHPs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAHP conducts data accuracy check(s) on specified data elements:</th>
<th>State conducts general data completeness assessments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Date of Service</td>
<td>Yes</td>
</tr>
<tr>
<td>- Provider ID</td>
<td></td>
</tr>
<tr>
<td>- Medicaid Eligibility</td>
<td></td>
</tr>
</tbody>
</table>

### Standards/Accreditation

<table>
<thead>
<tr>
<th>PAHP Standards:</th>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- State-Developed/Specified Standards</td>
<td>None</td>
</tr>
</tbody>
</table>

| 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) 552-9422

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

PROGRAM DATA

Program Service Area: Statewide
Initial Waiver Approval Date: March 17, 1995

Operating Authority: 1915(b) - Waiver Program
Implementation Date: March 17, 1995

Statutes Utilized: 1915(b)(4), Sel
Waiver Expiration Date: June 30, 2013

Enrollment Broker: No
Sections of Title XIX Waived:
-1902(a)(1) Statewidness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable
Granted: None

Guaranteed Eligibility: No guaranteed eligibility

SERVICE DELIVERY

Mental Health Plans - Fee-for-Service

Service Delivery

Included Services: Inpatient Mental Health, Outpatient Mental Health, Targeted Case Management
Allowable PCPs: -Not applicable

Contractor Types: -None

Enrollment

Populations Voluntarily Enrolled: None
Populations Mandatorily Enrolled:
- 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
CALIFORNIA
Medi-Cal Specialty Mental Health Services Consolidation

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

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

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

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

ADDITIONAL INFORMATION

All Medicaid eligibles that meet medical necessity criteria are automatically enrolled. This program covers specialty mental health services. County mental health departments have first right of refusal to serve as the mental health plan.
COLORADO
Colorado Medicaid Community Mental Health Services Program

CONTACT INFORMATION

State Medicaid Contact: Marceil Case
Department of Health Care and Financing
(303) 866-3054

State Website Address: http://www.colorado.gov/hcpf

PROGRAM DATA

Program Service Area: Statewide

Operating Authority: 1915(b) - Waiver Program

Statutes Utilized:
- 1915(b)(1), 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, 2011

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

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

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

Contractor Types:
- Behavioral Health MCO (Private)

Enrollment
COLORADO
Colorado Medicaid Community Mental Health Services Program

Populations Voluntarily Enrolled:
None

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

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

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

Lock-In Provision:
No lock-in

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

Serving People with Complex (Special) Needs

Program Includes People with Complex (Special) Needs:
Yes

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

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

Participating Plans/PCCM and Other Programs

Access Behavioral Care
Colorado Health Partnerships
Northeast Behavioral Health Partnership

Behavioral Healthcare, Inc.
Foothills Behavioral Health Partners

Additional Information

None
## Colorado Medicaid Community Mental Health Services Program

### QUALITY ACTIVITIES FOR PIHP

<table>
<thead>
<tr>
<th>State Quality Assessment and Improvement</th>
<th>Use of Collected Data:</th>
<th>Use of HEDIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities:</strong></td>
<td>- Contract Standard Compliance</td>
<td></td>
</tr>
<tr>
<td>- Consumer Self-Report Data (see below for details)</td>
<td>- Fraud and Abuse</td>
<td></td>
</tr>
<tr>
<td>- Encounter Data (see below for details)</td>
<td>- Health Services Research</td>
<td></td>
</tr>
<tr>
<td>- Focused Studies</td>
<td>- Monitor Quality Improvement</td>
<td></td>
</tr>
<tr>
<td>- Monitoring of PIHP Standards</td>
<td>- Plan Reimbursement</td>
<td></td>
</tr>
<tr>
<td>- Ombudsman</td>
<td>- Program Evaluation</td>
<td></td>
</tr>
<tr>
<td>- On-Site Reviews</td>
<td>- Program Modification, Expansion, or Renewal</td>
<td></td>
</tr>
<tr>
<td>- Performance Improvement Projects (see below for details)</td>
<td>- Regulatory Compliance/Federal Reporting</td>
<td></td>
</tr>
<tr>
<td>- Performance Measures (see below for details)</td>
<td>- Track Health Service provision</td>
<td></td>
</tr>
<tr>
<td>- PIHP Standards (see below for details)</td>
<td>- Provider Data</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

### Encounter Data

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

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

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

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

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

**State conducts general data completeness assessments:**
- Yes
COLORADO
Colorado Medicaid Community Mental Health Services Program

Performance Measures

Process Quality:
None

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

Access/Availability of Care:
-Penetration Rates

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

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

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

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

Non-Clinical Topics:
- Improving Use and Documentation of Clinical Guidelines

Standards/Accreditation

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

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
- Health Services Advisory Group, Inc

EQRO Organization:
- Quality Improvement Organization (QIO)

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

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

CONTACT INFORMATION

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

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

PROGRAM DATA

Program Service Area: Statewide

Operating Authority: 1915(b) - Waiver Program

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

Enrollment Broker: Affiliated Computer Systems

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date: July 20, 1995

Implementation Date: July 01, 2009

Waiver Expiration Date: December 31, 2011

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

Sections of Title XIX Costs Not Otherwise Matchable
Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

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

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

Enrollment
### CONNECTICUT HUSKY

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>None</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Medicare Dual Eligibles</td>
</tr>
<tr>
<td>- Participate in HCBS Waiver</td>
</tr>
<tr>
<td>- Reside in Nursing Facility or ICF/MR</td>
</tr>
<tr>
<td>- Retroactive Eligibility</td>
</tr>
</tbody>
</table>

| Medicare Dual Eligibles Included: | None |

<table>
<thead>
<tr>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- American Indian/Alaska Native</td>
</tr>
<tr>
<td>- Foster Care Children</td>
</tr>
<tr>
<td>- Poverty-Level Pregnant Women</td>
</tr>
<tr>
<td>- Section 1931 Adults and Related Populations</td>
</tr>
<tr>
<td>- Section 1931 Children and Related Populations</td>
</tr>
<tr>
<td>- Special Needs Children (State defined)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lock-In Provision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No lock-in</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Excluded:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclude all categories of Medicare Dual Eligibles</td>
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</table>

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
CONNECTICUT
HUSKY

Dental ASO - Fee-for-Service

Service Delivery

Included Services: Dental

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

Enrollment

Populations Voluntarily Enrolled: None

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

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligibles

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

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

Lock-In Provision:
No lock-in

Part D Benefit

MCE has Medicare Contract: No

Provides Part D Benefits: Not Applicable

Scope of Part D Coverage: Not Applicable

Part D - Enhanced Alternative Coverage: Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
Mental Health ASO - Fee-for-Service

Service Delivery

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

Allowable PCPs:
Not Applicable

Contractor Types:
None

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
American Indian/Alaska Native
Foster Care Children
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:
Medicare Dual Eligibles
Participate in HCBS Waiver
Reside in Nursing Facility or ICF/MR

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

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

Lock-in Provision:
No lock-in

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

PCCM Provider - Fee-for-Service

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
None

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

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

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes
Strategies Used to Identify Persons with Complex (Special) Needs:
- Receive client file indicated Title V from Public Health Department
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Developmental Disabilities Agency
- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna Better Health
Benecare
HUSKY Primary Care

Americhoice by United HealthCare
Community Health Network of Connecticut
Value Options

ADDITIONAL INFORMATION

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

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

QUALITY ACTIVITIES FOR MCO/HIO

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

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

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

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

Encounter Data

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

Collections: Submission Specifications:
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
-None

MCO/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

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

State conducts general data completeness assessments:
-Yes

Performance Measures

Process Quality:
-Ace Inhibitor/ARB Therapy
-Adolescent immunization rate
-Adolescent well-care visit rate
-Appropriate treatment for Children with Upper Respiratory Infection (URI)
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Child Developmental Screening
-Chlamydia screening rate
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-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:
-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's access to preventive/ambulatory health services
-Children's access to primary care practitioners

Use of Services/Utilization:
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
CONNECTICUT HUSKY

- Emergency room visits/1,000 beneficiary
- EPSDT Visit Rates
- Inpatient admissions/1,000 beneficiary
- Percentage of beneficiaries with at least one dental visit

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

Beneficiary Characteristics:
None

Health Plan/ Provider Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

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

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

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
- State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
- Mercer

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

Pay for Performance (P4P)

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

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable
CONNECTICUT
HUSKY

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PCCM

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

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

Consumer Self-Report Data:
- Disenrollment Survey

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

Use of Services/Utilization:
None

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
- Obesity Monitoring
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
Initial Waiver Approval Date: June 07, 2001

Operating Authority: 1915(b) - Waiver Program
Implementation Date: November 01, 2004

Statutes Utilized: 1915(b)(4), Selective Contracting
Waiver Expiration Date: March 31, 2014

Enrollment Broker: No
Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable
Granted: None

Guaranteed Eligibility: None

SERVICE DELIVERY

Transportation PAHP - Flat Rate Per Ride

Service Delivery

Included Services: Non-Emergency Transportation
Allowable PCPs: -Not applicable, contractors not required to identify PCPs

Enrollment

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

Populations Mandatorily Enrolled: None
FLORIDA
Florida Coordinated Non-Emergency Transportation

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

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

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

Agencies with which Medicaid Coordinates the Operation of the Program:
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

The Commission for the Transportation of the Disadvantaged

ADDITIONAL INFORMATION

The 1915(b) authority is used to selectively contract for non-emergency transportation services with the Commission for the Transportation Disadvantaged. The commission subcontracts with a single community transportation coordinator in each county. The reimbursement arrangement is given in a lump sum, twice a month for non-emergency transportation. This program does not meet the
definition of capitation because the fixed rate is not tied to the number of riders, but rather is a fixed rate over a period of time regardless of the number of riders. Foster Care Children receiving medical care are voluntarily enrolled. Special Needs Children (State defined) are children classified as SSI. Under included populations SOBRA Pregnant Women is different than Presumptively Eligible Pregnant Women (PEPW). SOBRA and PEPW are two different programs. SOBRA is a program for women who are not pregnant, 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
FLORIDA
Managed Health Care

CONTACT INFORMATION

State Medicaid Contact: Linda Macdonald
Florida Agency for Health Care Administration
(850) 412-4031

State Website Address: http://ahca.myflorida.com

PROGRAM DATA

Program Service Area: Statewide

Operating Authority: 1915(b) - Waiver Program

Statutes Utilized: 1915(b)(1), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Enrollment Broker: Automated Health Systems, Inc.

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

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

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

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
FLORIDA
Managed Health Care

Populations Voluntarily Enrolled:
None

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
- Medicaid 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

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

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Not Applicable

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

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Provides Part D Benefits:
No

Part D - Enhanced Alternative Coverage:
Not Applicable
FLORIDA
Managed Health Care

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:
-Foster Care Children

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
-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

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

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
## PCCM Provider - Fee-for-Service

### Service Delivery

<table>
<thead>
<tr>
<th>Included Services</th>
<th>Allowable PCPs</th>
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<tbody>
<tr>
<td>Adult Health Screenings, Advanced Registered Nurse</td>
<td>- Family Practitioners</td>
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<tr>
<td>Practioner, Ambulatory Surgical, Birth Center, Child Health</td>
<td>- Federally Qualified Health Centers (FQHCs)</td>
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<td>Check-Up (EPSDT), Chiropractic, County Health Department,</td>
<td>- General Practitioners</td>
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<td>Durable Medical Equipment, Federally Qualified Health Center (FQHC), Home Health, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Midwife, Obstetrical, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Physician assistant, Podiatry, Respiratory Therapy, Speech Therapy, X-Ray</td>
<td>- Internists</td>
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<tr>
<td>- Federally Qualified Health Center - Internists</td>
<td>- Nurse Practitioners</td>
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<td>- Home Health, Immunization</td>
<td>- Obstetricians/Gynecologists or Gynecologists</td>
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<td>- Inpatient Hospital</td>
<td>- Pediatricians</td>
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<td>- Inpatient Substance Use Disorders</td>
<td>- Physician Assistants</td>
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<td>- Laboratory, Midwife</td>
<td>- Rural Health Clinics (RHCs)</td>
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<tr>
<td>- Obstetrical, Occupational Therapy</td>
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<td>- Outpatient Hospital</td>
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<td>- Speech Therapy</td>
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<tr>
<td>- X-Ray</td>
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</tbody>
</table>

### 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

**Medicare Dual Eligibles Included:**
None

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

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

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
No

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

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

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None
MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
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
- Obstetricians/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
- Children's 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

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

Medicare Dual Eligibles Excluded:
None

Lock-In Provision:
12 month lock-in

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Not Applicable

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

Provides Part D Benefits:
No

Part D - Enhanced Alternative Coverage:
Not Applicable
FLORIDA
Managed Health Care

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 and Related Populations (18-20 years old)
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicaid 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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

**Managed Health Care**

**Shared Savings Model - FFS/Some Risk Capitation**

**Service Delivery**

**Included Services:**
- Advanced Registered Nurse Practitioner Service, Ambulatory Services
- Surgical Centers, Birth Centers, Child Health Check-up, Chiropractic, 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 Midwife, 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
- Obstetricians/Gynecologists or Gynecologists
- Other Specialists Approved on a Case-by-Case Basis
- Pediatricians
- Physician Assistants
- Psychiats
- Rural Health Clinics (RHCs)

**Enrollment**

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

**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 eligible in residential commitment facilities
- Medically Complex Children in CMS program
- Medically Needy
- Other Insurance
- Poverty Level Pregnant Woman
- Prescribed Pediatric Extended Care Center Residents
- Reside in Nursing Facility or ICF/MR
- Residents in ADM residential treatment facilities
- Retroactive Eligibility
- Share of Cost (Medically Needy Beneficiaries)
- Special Needs Children (State defined)
- State Hospital Services

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

**Medicare Dual Eligibles Excluded:**
None

**Part D Benefit**

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable
FLORIDA
Managed Health Care

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

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

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
- Foster Care Children

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

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
None

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes
**FLORIDA**  
Managed Health Care

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Community-based care providers
- Department of Juvenile Justice
- Education Agency
- Family Safety Program
- Florida Department of Children and families
- Forensic/Corrections System
- Mental Health Agency

**PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS**

<table>
<thead>
<tr>
<th>Participating Plans/PCCM and Other Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS Healthcare Foundation, Inc.</td>
</tr>
<tr>
<td>Caremark</td>
</tr>
<tr>
<td>Coventry Health Care of Florida, Inc. d/b/a Buena Vista</td>
</tr>
<tr>
<td>DentaQuest of FL, Inc d/b/a Dentaquest</td>
</tr>
<tr>
<td>Freedom Health Plan, Inc.</td>
</tr>
<tr>
<td>Hemophilia of the Sunshine State (Lynnfield Drug, Inc.)</td>
</tr>
<tr>
<td>Integral Health Plan</td>
</tr>
<tr>
<td>Lakeview Center, Inc. d/b/a Access Behavioral Health</td>
</tr>
<tr>
<td>Managed Care of North America d/b/a MCNA Dental Plans</td>
</tr>
<tr>
<td>MediPass</td>
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<tr>
<td>North Florida Behavioral Health Partnership</td>
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<tr>
<td>Preferred Care Partners Inc. d/b/a Care Florida</td>
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<tr>
<td>Prestige Health Choice</td>
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<tr>
<td>Simply Healthcare Plans, Inc.</td>
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<tr>
<td>Sunshine State Health Plan, Inc.</td>
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<tr>
<td>Universal Health Care, Inc.</td>
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<td>Amerigroup of Florida, Inc.</td>
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<tr>
<td>Community Based Care Partnership, Ltd.</td>
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<tr>
<td>Coventry Health Care of Florida, Inc. d/b/a Vista</td>
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<td>Florida Health Partners, Inc.</td>
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<tr>
<td>HealthEase of Florida, Inc.</td>
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<tr>
<td>Humana Medical Plan, Inc.</td>
</tr>
<tr>
<td>JMH Health Plan, Inc. d/b/a Public Health Trust of Miami-Dade County</td>
</tr>
<tr>
<td>Magellan Behavioral Health of Florida</td>
</tr>
<tr>
<td>Medica Health Plans of Florida, Inc.</td>
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<tr>
<td>Molina Healthcare of Florida, Inc.</td>
</tr>
<tr>
<td>Personal Health Plan d/b/a Healthy Palm Beaches, Inc</td>
</tr>
<tr>
<td>Preferred Medical Plan, Inc.</td>
</tr>
<tr>
<td>Public Health Trust of Dade County</td>
</tr>
<tr>
<td>South Florida Community Care Network</td>
</tr>
<tr>
<td>UnitedHealthcare of Florida, Inc.</td>
</tr>
<tr>
<td>WellCare of Florida, Inc. d/b/a Staywell Health Plan of Florida</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**

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

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

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

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

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

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

**QUALITY ACTIVITIES FOR MCO/HIO**
FLORIDA
Managed Health Care

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

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 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

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

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

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

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

State conducts general data completeness assessments:
- Yes

Performance Measures
## FLORIDA Managed Health Care

### Process Quality:
- Adolescent well-care visit rate
- Adults Access to Preventive/Ambulatory Health Services (AAP)
- Ambulatory Care
- Annual Dental Visits
- Antidepressant Medication Management (AMM)
- Appropriate Testing for Pharyngitis
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening Rate
- Childhood Immunization Status (CIS) - Combo 2 and 3
- 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)

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

### Beneficiary Characteristics:
None

### Health Status/Outcomes Quality:
- Controlling High Blood Pressure (CBP)
- Patient satisfaction with 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/ Provider 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 Health 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
FLORIDA
Managed Health 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 Organization:
- Health Services Advisory Group

EQRO Name:
- Health Services Advisory Group

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

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

Pay for Performance (P4P)

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

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable
QUALITY ACTIVITIES FOR PIHP

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

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

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

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

Encounter Data

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

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

Collection: Standardized Forms:
None

Validation - Methods:
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
- Medical record validation

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

State conducts general data completeness assessments:
Yes

Performance Measures
## FLORIDA
### Managed Health Care

<table>
<thead>
<tr>
<th>Process Quality:</th>
<th>Health Status/Outcomes Quality:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Follow-up after hospitalization for mental illness</td>
<td>-Change in level of functioning</td>
</tr>
<tr>
<td>-Mental Health Readmission Rate</td>
<td>-Patient satisfaction with care</td>
</tr>
<tr>
<td>-Mental Health Utilization</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Average distance to PCP</td>
<td>-Drug Utilization</td>
</tr>
<tr>
<td>-Average wait time for an appointment with PCP</td>
<td>-Inpatient admission for MH/SUD conditions/1,000 beneficiaries</td>
</tr>
<tr>
<td>-Ratio of mental health providers to number of beneficiaries</td>
<td>-Inpatient admissions/1,000 beneficiary</td>
</tr>
<tr>
<td>-Ratio of PCPs to beneficiaries</td>
<td>-Re-admission rates of MH/SUD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Plan Stability/ Financial/Cost of Care:</th>
<th>Health Plan/ Provider Characteristics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

### 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

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

### Standards/Accreditation

<table>
<thead>
<tr>
<th>PIHP Standards:</th>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-CMS’s Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare</td>
<td>None</td>
</tr>
<tr>
<td>-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards</td>
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<tr>
<td>-State-Developed/Specified Standards</td>
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</table>

<table>
<thead>
<tr>
<th>Non-Duplication Based on Accreditation:</th>
<th>EQRO Name:</th>
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<tbody>
<tr>
<td>None</td>
<td>-None</td>
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</table>

<table>
<thead>
<tr>
<th>EQRO Organization:</th>
<th>EQRO Mandatory Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Not Applicable</td>
<td>-Review of PIHP compliance with structural and operational standards established by the State</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>EQRO Optional Activities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>-Administration or validation of consumer or provider surveys</td>
<td></td>
</tr>
<tr>
<td>-Calculation of performance measures</td>
<td></td>
</tr>
<tr>
<td>-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services</td>
<td></td>
</tr>
<tr>
<td>-Technical assistance to PIHPS to assist them in conducting</td>
<td></td>
</tr>
</tbody>
</table>
FLORIDA
Managed Health Care

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

QUALITY ACTIVITIES FOR PAHP

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

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

Consumer Self-Report Data:
None

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

Standards/Accreditation

PAHP Standards:
- State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

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 |
<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>State Website Address:</td>
<td><a href="http://ahca.myflorida.com">http://ahca.myflorida.com</a></td>
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### PROGRAM DATA

<table>
<thead>
<tr>
<th>Program Service Area:</th>
<th>Statewide</th>
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<tbody>
<tr>
<td>Operating Authority:</td>
<td>1915(b) - Waiver Program</td>
</tr>
<tr>
<td>Statutes Utilized:</td>
<td>1915(b)(4), Selective Contracting</td>
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<tr>
<td>Solely Reimbursement Arrangement:</td>
<td>Yes</td>
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<td>Initial Waiver Approval Date:</td>
<td>March 23, 1998</td>
</tr>
<tr>
<td>Implementation Date:</td>
<td>April 01, 1999</td>
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<tr>
<td>Waiver Expiration Date:</td>
<td>December 31, 2013</td>
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<tr>
<td>Sections of Title XIX Waived:</td>
<td></td>
</tr>
</tbody>
</table>
-1902(a)(10)(B) Amount, Duration and Scope  
-1902(a)(23) Freedom of Choice |
| Sections of Title XIX Costs Not Otherwise Matchable Granted: | None |
| Guaranteed Eligibility: | 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

Sections of Title XIX Costs Not Otherwise Matchable Granted: None

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

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)

Service Delivery

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
IOWA
Iowa Plan For Behavioral Health

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

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

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

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

Part D Benefit
MCE has Medicare Contract:
No
Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Iowa Plan For Behavioral Health

ADDITIONAL INFORMATION
None

QUALITY ACTIVITIES FOR PIHP
## State Quality Assessment and Improvement

### Activities:
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

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

### Consumer Self-Report Data:
None

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

### Encounter Data

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

#### Collection: Standardized Forms:
None

#### 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

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

#### Collections: Submission Specifications:
- Guidelines for frequency of encounter data submission

#### 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
IOWA
Iowa Plan For Behavioral Health

<table>
<thead>
<tr>
<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
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</table>

### Performance Improvement Projects

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

**Clinical Topics:**
- Co-Occurring Disorders Services
- Intensive Care Management
- Substance Use Disorders treatment after detoxification service

**Non-Clinical Topics:**
- Cultural Differences in Access to Services

### Standards/Accreditation

**PIHP Standards:**
None

**Accreditation Required for Participation:**
None

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

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

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

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

**EQRO Optional Activities:**
- Technical assistance to PIHPs to assist them in conducting quality activities
- Validation of encounter data
KENTUCKY
Human Service Transportation Delivery Program

CONTACT INFORMATION

State Medicaid Contact: Kerry Conlee
Division of Provider Operations
(502) 564-6890

State Website Address: http://www.chfs.ky.gov/dms

PROGRAM DATA

Program Service Area: Statewide

Operating Authority: 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, 2012

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services: Non-Emergency Transportation

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

Population Voluntarily Enrolled: None

Population Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
## KENTUCKY
### Human Service Transportation Delivery Program

**Subpopulations Excluded from Otherwise Included Populations:**
- CHIP Above 150%
- Medicare Dual Eligibles

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

**Medicare Dual Eligibles Excluded:**
- QMB

**MCE has Medicare Contract:**
No

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

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

### Part D Benefit

**Provides Part D Benefits:**
Not Applicable

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

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

**Strategies Used to Identify Persons with Complex (Special) Needs:**
- Asks advocacy groups to identify members of these groups
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses provider referrals to identify members of these groups

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

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Human Service Transportation

### ADDITIONAL INFORMATION

TITLE XXI CHIP is included up to 150% of FPL. 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

**Use of Collected Data:**
- Contract Standard Compliance
- Fraud and Abuse
- Track Health Service provision
KENTUCKY
Human Service Transportation Delivery Program

-Ombudsman

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 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
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)(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

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

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

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- Aged and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Blind/Disabled Adults and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Blind/Disabled Children and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Foster Care Children</td>
</tr>
<tr>
<td></td>
<td>- Section 1931 Adults and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Section 1931 Children and Related Populations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Children in child care institutions</td>
</tr>
<tr>
<td>- Enrolled in Another Managed Care Program</td>
</tr>
<tr>
<td>- Medicare Dual Eligibles</td>
</tr>
<tr>
<td>- Other insurance (HMO or PPO only)</td>
</tr>
<tr>
<td>- Participate in HCBS Waiver</td>
</tr>
<tr>
<td>- Persons disenrolled due to special disenrollment or medical exception</td>
</tr>
<tr>
<td>- Persons enrolled in CSHCS</td>
</tr>
<tr>
<td>- Persons in PACE</td>
</tr>
<tr>
<td>- Persons in Repatriate Assistance Program</td>
</tr>
<tr>
<td>- Persons in Traumatic Brain Injury Program</td>
</tr>
<tr>
<td>- Persons incarcerated</td>
</tr>
<tr>
<td>- Persons on Refugee Assistance</td>
</tr>
<tr>
<td>- Persons without full medicaid coverage, including those in the state medical program or pluscare</td>
</tr>
<tr>
<td>- Reside in Nursing Facility or ICF/MR</td>
</tr>
<tr>
<td>- Spenddown</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Included:</th>
<th>Medicare Dual Eligibles Excluded:</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>Exclude all categories of Medicare Dual Eligibles</td>
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## Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

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

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

<table>
<thead>
<tr>
<th>Program Includes People with Complex (Special) Needs:</th>
<th>Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Strategies Used to Identify Persons with Complex (Special) Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Children who age out of CSHCS are identified to health plans by staff monthly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agencies with which Medicaid Coordinates the Operation of the Program:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Education Agency</td>
</tr>
<tr>
<td>- Maternal and Child Health Agency</td>
</tr>
</tbody>
</table>
MICHIGAN
Comprehensive Health Plan

- Mental Health Agency
- Public Health Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

BlueCaid of Michigan
Great Lakes Health Plan
HealthPlus Partners, Inc.
Midwest Health Plan
Ominicare Health Plan
Priority Health Government Programs, Inc.
Total Health Care
CareSource of Michigan
Health Plan of Michigan
McLaren Health Plan
Molina Healthcare of Michigan
Physicians Health Plan of Mid-Michigan - Family Care
ProCare Health Plan
Upper Peninsula Health Plan

ADDITIONAL INFORMATION

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

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.

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

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

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

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

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

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

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

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

State conducts general data completeness assessments:
Yes

Performance Measures

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

**Standards/Accreditation**

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

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

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

**EQRO Name:**
- Health Services Advisory Group (HSAG)

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

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

**EQRO Optional Activities:**
- CAHPS - Consumer Survey
- Conduct studies on quality and access that focus on a particular aspect of clinical or non-clinical services
- Technical assistance to MCOs to assist them in conducting quality 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
<table>
<thead>
<tr>
<th>Clinical Conditions:</th>
<th>Measurement of Improved Performance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)</td>
</tr>
<tr>
<td>Blood Lead</td>
<td>Assessing levels of technology adoption</td>
</tr>
<tr>
<td>Child Immunizations</td>
<td>Assessing patient satisfaction measures</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Assessing the adoption of systematic quality improvement processes</td>
</tr>
<tr>
<td>Perinatal Care</td>
<td>Assessing the timely submission of complete and accurate electronic encounter/claims data</td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)</td>
</tr>
<tr>
<td>Well-child visits</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial Year of Reward:</th>
<th>Evaluation Component:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>The State has conducted an evaluation of the effectiveness of its P4P program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member Incentives:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td></td>
</tr>
</tbody>
</table>
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
MICHIGAN
Healthy Kids Dental

Medicare Dual Eligibles Included: None
Medicare Dual Eligibles Excluded: Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract: No
Provides Part D Benefits: Not Applicable
Scope of Part D Coverage: Not Applicable
Part D - Enhanced Alternative Coverage: Not Applicable
Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Kids Dental

ADDITIONAL INFORMATION

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities: -This Program does not collect any 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: David Godfrey
Minnesota Department of Human Services
(651) 431-2319

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

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
Statewide January 01, 1998

Operating Authority: Implementation Date:
1915(b) - Waiver Program January 01, 1998

Statutes Utilized: Waiver Expiration Date:
1915(b)(4), Selective Contracting June 30, 2013

Enrollment Broker: Sections of Title XIX Waived:
No -1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable
Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

County Case Manager - Fee-for-Service

Service Delivery

Included Services: Allowable PCPs:
Extended Rehabilitation (Extended Care), Inpatient -Not Applicable
Substance Use Disorders, Outpatient Substance Use Disorders, Transitional Rehabilitation (Halfway House)

Enrollment

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

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Foster Care Children
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP
## MINNESOTA
### Consolidated Chemical Dependency Treatment Fund

<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
<th>Lock-In Provision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Dual Eligibles</td>
<td>No lock-in</td>
</tr>
</tbody>
</table>

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

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

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

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

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

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

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

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

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

none

### ADDITIONAL INFORMATION

All Medicaid recipients are eligible to participate in this program.
MINNESOTA
Minnesota 1915(b)(4) Case Management Waiver

CONTACT INFORMATION

State Medicaid Contact: David Godfrey
Minnesota Department of Human Services
(651) 431-2319

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

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
Statewide December 28, 2006

Operating Authority: Implementation Date:
1915(b) - Waiver Program January 01, 2007

Statutes Utilized: Waiver Expiration Date:
1915(b)(4), Selective Contracting March 31, 2013

Solely Reimbursement Arrangement: Sections of Title XIX Waived:
Yes -1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable
Granted: None

Guaranteed Eligibility: None

ADDITIONAL INFORMATION

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

CONTACT INFORMATION

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

State Website Address: http://www.dss.mo.gov

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
City October 01, 1995
County

Operating Authority: Implementation Date:
1915(b) - Waiver Program September 01, 1995

Statutes Utilized: Waiver Expiration Date:
1915(b)(1), Freedom of Choice June 30, 2012
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

Enrollment Broker: WIPRO INFOCROSSING

For All Areas Phased-In: Guaranteed Eligibility:
Yes No guaranteed eligibility

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

Medicare Dual Eligibles Included:
None

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

Lock-In Provision:
12 month lock-in

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

Agencies with which Medicaid Coordinates the Operation of the Program:
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Other State Agencies as necessary
- Public Health Agency
- Social Security Administration
these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses provider referrals to identify members of these groups

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Plan Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Advantage Plus of Kansas City</td>
<td>Childrens Mercy Family Health Partners</td>
</tr>
<tr>
<td>Harmony Health Plan of Missouri</td>
<td>HealthCare USA Central</td>
</tr>
<tr>
<td>HealthCare USA Eastern</td>
<td>HealthCare USA Western</td>
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<tr>
<td>Missouri Care Central</td>
<td>Missouri Care Eastern</td>
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<tr>
<td>Missouri Care Western</td>
<td>Molina Healthcare of Missouri Eastern</td>
</tr>
<tr>
<td>Molina Healthcare of Missouri Western</td>
<td>Molina Healthcare of Missouri Central</td>
</tr>
</tbody>
</table>

ADDITIONAL INFORMATION

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

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

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement

Activities:
- Accreditation for Participation
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- Network Data
- Ombudsman

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
MISSOURI
MO HealthNet Managed Care/1915b

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

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

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

Collection: Standardized Forms:
- ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Collection: 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

Validation - Methods:
- Automated analysis of encounter data submission to help determine 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

Encounter Data

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
- Chlamydia 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
- 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 visit 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

**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

**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

**Performance Measures - Others:**
- Effectiveness of Care
- 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 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

EQRO Optional Activities:
- Assessment of MCO information systems
- Calculation of performance measures
- Case management record review
- Evaluate performance improvement projects
MISSOURI
MO HealthNet Managed Care/1915b

-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:
Affiliated Computer Services, Inc.

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

PCCM Provider - Fee-for-Service

Service Delivery

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

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

Populations Voluntarily Enrolled:  None

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
- Special Needs Children (State defined)
- Subsidized Adoption

Medicare Dual Eligibles Included:  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

Lock-In Provision:
No lock-in

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

Part D Benefit

MCE has Medicare Contract:  No

Scope of Part D Coverage:
Not Applicable

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

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable
## Nurse First - Selective Contracting - Fee-for-Service

### Service Delivery

<table>
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<th>Included Services:</th>
<th>Allowable PCPs:</th>
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<td>Nurse Advice Line</td>
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### Enrollment

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<th>Populations Mandatorily Enrolled:</th>
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<tbody>
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<td>-Foster Care Children</td>
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<td>-Medicare Dual Eligibles</td>
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<td>-Special Needs Children (BBA defined)</td>
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<th>Lock-in Provision:</th>
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<tbody>
<tr>
<td>-No populations are excluded</td>
<td>Does not apply because State only contracts with one managed care entity</td>
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<thead>
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<th>Medicare Dual Eligibles Included:</th>
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<td>Include all categories of Medicare Dual Eligibles</td>
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### Part D Benefit

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<tr>
<th>MCE has Medicare Contract:</th>
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<tr>
<th>Scope of Part D Coverage:</th>
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<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
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<tbody>
<tr>
<td>None</td>
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</table>
Enhanced PCCM - Primary Care Case Management Fee

Service Delivery

**Included Services:**
- Case Management

**Allowable PCPs:**
- Federally Qualified Health Centers (FQHCs)
- Tribal Health Centers

Enrollment

**Populations Voluntarily Enrolled:**
- Aged and Related Populations
- American Indian/Alaska Native
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Poverty-Level Pregnant Women
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
- 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
- Participate in HCBS Waiver
- Reside in Nursing Facility or ICF/MR
- Retroactive Eligibility

**Medicare Dual Eligibles Included:**
- None

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

Part D Benefit

**MCE has Medicare Contract:**
- No

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

**Provides Part D Benefits:**
- Not Applicable

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Education Agency
PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Improvement Program  Nurse First
Passport to Health

ADDITIONAL INFORMATION

Nurse First - Nurse Advice Line (sub program of Passport) is under waiver for Selective Contracting, is fee for service reimbursement and a voluntary program for recipients.

Health Improvement Program - an enhanced primary care case management program offers clinical case management for high risk, high cost recipients, a per member per month payment and is a voluntary program for recipients.

QUALITY ACTIVITIES FOR PCCM

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

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

Consumer Self-Report Data:
- State-developed Survey

Performance Measures

Process Quality:
- Adolescent immunization rate
- Adolescent well-care visits rates
- Appropriate treatment for children with Upper Respiratory Infection (URI)
- Asthma care - medication use
- Beta-blocker treatment after heart attack
- Breast Cancer screening rate
- Cervical cancer screening rate
- Chlamydia screening in women
- Colorectal Cancer Screening
- Depression medication management
- 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

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

Use of Services/Utilization:
- None
MONTANA
Passport to Health

- 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

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

QUALITY ACTIVITIES FOR OTHER

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

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:
- Client contacts

Health Status/Outcomes Quality: None

Access/Availability of Care:
None

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
NORTH DAKOTA
Experience Health ND

CONTACT INFORMATION

State Medicaid Contact: Tania Hellman
Department of Human Services Medical Services Division
(800) 755-2604

State Website Address: http://www.nd.gov

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: January 01, 2007

Implementation Date:
October 01, 2007

Waiver Expiration Date:
September 30, 2011

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Disease Management PAHP - Risk-based Capitation

Service Delivery

Included Services:
Disease Management

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

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Populations Mandatorily Enrolled:
None
### NORTH DAKOTA
Experience Health ND

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<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
<th>Lock-In Provision:</th>
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<tbody>
<tr>
<td>- Enrolled in Another Managed Care Program</td>
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<td>- Medicare Dual Eligibles</td>
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<tr>
<td>- Other Insurance</td>
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<tr>
<td>- Receiving services related to transplants, HIV/AIDS, cancer, end stage renal disease and hospice</td>
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<tr>
<td>- Recipients with spend-down</td>
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<tr>
<td>- Reside in Nursing Facility or ICF/MR</td>
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<tr>
<td>- Those that are incarcerated</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

#### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

<table>
<thead>
<tr>
<th>Program Includes People with Complex (Special) Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies Used to Identify Persons with Complex (Special) Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- DOES NOT identify members of these groups</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agencies with which Medicaid Coordinates the Operation of the Program:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- DOES NOT coordinate with any other Agency</td>
</tr>
</tbody>
</table>

#### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ExperienceHealth ND

#### ADDITIONAL INFORMATION

None

#### QUALITY ACTIVITIES FOR PAHP

<table>
<thead>
<tr>
<th>State Quality Assessment and Improvement Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Consumer Self-Report Data (see below for details)</td>
</tr>
<tr>
<td>- Enrollee Hotlines</td>
</tr>
<tr>
<td>- Monitoring of PAHP Standards</td>
</tr>
<tr>
<td>- On-Site Reviews</td>
</tr>
<tr>
<td>- Performance Measures (see below for details)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use of Collected Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Enhanced/Revise State managed care Medicaid Quality Strategy</td>
</tr>
<tr>
<td>- Program Evaluation</td>
</tr>
</tbody>
</table>
**NORTH DAKOTA**
Experience Health ND

**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 continuous enrollment requirement for some or all of the measures

**Performance Measures**

**Process Quality:**
None

**Health Status/Outcomes Quality:**
- Results of progress toward defined performance indicators

**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
### CONTACT INFORMATION

**State Medicaid Contact:**
Heather Leschinsky  
Nebraska Medicaid  
(402) 471-9337

**State Website Address:**
http://www.dhhs.ne.gov

### PROGRAM DATA

<table>
<thead>
<tr>
<th>Program Service Area:</th>
<th>Initial Waiver Approval Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide</td>
<td>June 05, 1995</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Operating Authority:</th>
<th>Implementation Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1915(b) - Waiver Program</td>
<td>July 01, 1995</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statutes Utilized:</th>
<th>Waiver Expiration Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1915(b)(1), Freedom of Choice</td>
<td>June 30, 2012</td>
</tr>
<tr>
<td>1915(b)(2), Locality as Central Broker</td>
<td></td>
</tr>
<tr>
<td>1915(b)(3), Sharing of Cost Savings</td>
<td></td>
</tr>
<tr>
<td>1915(b)(4), Selective Contracting</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enrollment Broker:</th>
<th>Sections of Title XIX Waived:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Medicaid Enrollment Center</td>
<td>-1902(a)(1) Statewideness - MCO/PCCM only</td>
</tr>
<tr>
<td></td>
<td>-1902(a)(10)(B) Amount, Duration and Scope</td>
</tr>
<tr>
<td></td>
<td>-1902(a)(23) Freedom of Choice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For All Areas Phased-In:</th>
<th>Sections of Title XIX Costs Not Otherwise Matchable Granted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guaranteed Eligibility:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No guaranteed eligibility</td>
</tr>
</tbody>
</table>

### SERVICE DELIVERY

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

**Service Delivery**

<table>
<thead>
<tr>
<th>Included Services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allowable PCPs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Family Practitioners</td>
</tr>
<tr>
<td>-General Practitioners</td>
</tr>
<tr>
<td>-Internists</td>
</tr>
<tr>
<td>-Obstetricians/Gynecologists</td>
</tr>
<tr>
<td>-Pediatricians</td>
</tr>
</tbody>
</table>

**Enrollment**
### Nebraska Health Connection Combined Waiver Program - 1915(b)

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- American Indian/Alaska Native</td>
</tr>
<tr>
<td></td>
<td>- Special Needs Children (State defined)</td>
</tr>
</tbody>
</table>

#### Subpopulations Excluded from Otherwise Included Populations:
- Children with disabilities receiving in-home services
- Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
- Clients Participating in the State Disability Program
- Clients Participating in the Subsidized Adoption Program
- Clients receiving Medicaid Hospice Services
- Clients with Excess Income
- Medicare Dual Eligibles
- Other Insurance
- Participate in HCBS Waiver
- Presumptive Eligibles
- Reside in Nursing Facility or ICF/MR
- Retroactively Eligible
- Transplant Recipients

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

**Medicare Dual Eligibles Included:**
None

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

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

| Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: | |
|---------------------------------------------------------------|
| None                                                          | 
Specialty Physician Case Management (SPCM) Program - Fee-for-Service

**Service Delivery**

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management, Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, Outpatient Substance Use Disorders</td>
<td>Psychiatrists, Psychologists</td>
</tr>
</tbody>
</table>

**Enrollment**

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td><strong>Populations Voluntarily Enrolled:</strong> None</td>
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<th>Subpopulations Excluded from Otherwise Included Populations:</th>
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<td>-Reside in Nursing Facility or ICF/MR</td>
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<td>-Clients Participating in the State Disability Program</td>
<td>-Retroactively Eligible</td>
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<tr>
<td>-Clients receiving Medicaid Hospice Services</td>
<td>-Transplant Recipients</td>
</tr>
<tr>
<td>-Participate in HCBS Waiver</td>
<td><strong>Lock-In Provision:</strong> Does not apply because State only contracts with one managed care entity</td>
</tr>
<tr>
<td>-Presumptive Eligibility</td>
<td><strong>Medicare Dual Eligibles Included:</strong> Include all categories of Medicare Dual Eligibles</td>
</tr>
<tr>
<td>-Medicare Dual Eligibles Included:</td>
<td><strong>Medicare Dual Eligibles Excluded:</strong> None</td>
</tr>
</tbody>
</table>

**Part D Benefit**

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<tr>
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SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

<table>
<thead>
<tr>
<th>Program Includes People with Complex (Special) Needs:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
**Strategies Used to Identify Persons with Complex (Special) Needs:**
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Title V Agency

---

**PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS**

<table>
<thead>
<tr>
<th>Participating Plans/PCCM</th>
<th>Other Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coventry Nebraska</td>
<td>Magellan Behavioral Health</td>
</tr>
<tr>
<td>Share Advantage</td>
<td></td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**

For MCO, and Specialty Physician Case Management (SPCM), the State defines Special Needs Children as Blind/Disabled Children and Related Populations, Children Receiving Title V Services and State Wards.

MCO operates county wide. SPCM operates statewide. The children with Special Health Care Needs (CSCI) or American Indians/Alaskan Natives (AI/AN) are the only two groups enrolled into the MCO program through 1915(b) authority.

Children under 19 years of age who are-1) Eligible for SSI under title XVI; 2) In foster care or other out-of-state home placement; 3) Receiving foster care or adoption assistance; or 4) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V.

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,
## 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 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

### 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
<table>
<thead>
<tr>
<th><strong>MCO Standards:</strong></th>
<th><strong>Accreditation Required for Participation:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>-NCQA (National Committee for Quality Assurance) Standards</td>
<td>-Department of Insurance Certification</td>
</tr>
<tr>
<td></td>
<td>-NCQA (National Committee for Quality Assurance)</td>
</tr>
<tr>
<td></td>
<td>-URAC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Non-Duplication Based on Accreditation:</strong></th>
<th><strong>EQRO Name:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>-NCQA (National Committee for Quality Assurance)</td>
<td>-Island Peer Review Organization (IPRO)</td>
</tr>
<tr>
<td>-URAC</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>EQRO Organization:</strong></th>
<th><strong>EQRO Mandatory Activities:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>-Quality Improvement Organization (QIO)</td>
<td>-Review of MCO compliance with structural and operational standards established by the State</td>
</tr>
<tr>
<td></td>
<td>-Validation of performance improvement projects</td>
</tr>
<tr>
<td></td>
<td>-Validation of performance measures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>EQRO Optional Activities:</strong></th>
<th><strong>Pay for Performance (P4P)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

### Pay for Performance (P4P)

<table>
<thead>
<tr>
<th><strong>Implementation of P4P:</strong></th>
<th><strong>Program Payers:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The State HAS NOT implemented a Pay-for-Performance program with the MCO</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Population Categories Included:</strong></th>
<th><strong>Rewards Model:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Clinical Conditions:</strong></th>
<th><strong>Measurement of Improved Performance:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Initial Year of Reward:</strong></th>
<th><strong>Evaluation Component:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Member Incentives:</strong></th>
<th><strong>Not Applicable</strong></th>
</tr>
</thead>
</table>
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: Affiliated Computer Services, Incorporated (ACS)
For All Areas Phased-In: No
Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: April 18, 2000
Implementation Date: October 01, 2000
Waiver Expiration Date: March 31, 2013

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

Sections of Title XIX Costs Not Otherwise Matchable
Granted: None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Audiology, 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

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NEW JERSEY
NJ FamilyCare - 1915(b)

Populations Voluntarily Enrolled:  
None

Populations Mandatorily Enrolled:  
- Blind/Disabled Children and Related Populations
- Foster Care Children
- Medicaid Eligible Blind/Disabled Children Receiving 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 PACE
- Individuals in Out Of State Placements
- Individuals who are Institutionalized in an Inpatient Psychiatric Facility
- Medicare Dual Eligibles
- Reside in Nursing Facility or ICF/MR
- Retroactive Eligibility

Lock-In Provision:  
12 month lock-in

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

Medicare Dual Eligibles Included:  
None

Part D Benefit

MCE has Medicare Contract:  
Yes

Provides Part D Benefits:  
Yes

Scope of Part D Coverage:  
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:  
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- Barbituates
- Benzodiazepines
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:  
Yes

Agencies with which Medicaid Coordinates the Operation of the Program:
- Developmental Disabilities Agency
- Division of Youth and Family Services Agency
- Education Agency
- Family Centered Care Services Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency

Strategies Used to Identify Persons with Complex (Special) Needs:
- Self-Referral
- Surveys medical needs of enrollee to identify members of these groups
- Use of Data Mining
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Developmental Disabilities Agency
- Division of Youth and Family Services Agency
- Education Agency
- Family Centered Care Services Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
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.

AmeriChoice rebranded as UnitedHealthCare Community Plan.

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

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

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

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

Collection: Standardized Forms:
- ANSI ASC X12 837 - transaction set format for transmitting health care claims data

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

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

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
- Adolescent immunization rate
- Adolescent well-care visit rates
- 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
- 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

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
NEW JERSEY
NJ FamilyCare - 1915(b)

<table>
<thead>
<tr>
<th>Ratio of pharmacies to number of beneficiaries</th>
<th>services during the measurement year</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Percentage of enrollees with one or more emergency room visit</td>
<td></td>
</tr>
<tr>
<td>-Percentage of enrollees with one or more inpatient admissions</td>
<td></td>
</tr>
<tr>
<td>-Pharmacy services per member</td>
<td></td>
</tr>
<tr>
<td>-Physician visits per 1000 members</td>
<td></td>
</tr>
</tbody>
</table>

**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

**Beneficiary Characteristics:**
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries who are auto-assigned to MCOs

**Health Plan/ Provider Characteristics:**
None

**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

**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

**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

**Standards/Accreditation**

**MCO Standards:**
- CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

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

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

**Accreditation Required for Participation:**
- Department of Banking and Insurance Certificate of Authority

**EQRO Name:**
- Island Peer Review Organization (IPRO)

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

**EQRO Optional Activities:**
- Calculation of performance measures
- Conduct studies on access that focus on a particular aspect of...
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NJ FamilyCare - 1915(b)

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
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CONTACT INFORMATION

State Medicaid Contact: Paula McGee
NM HSD/Medical Assistance Division
(505) 827-6234

State Website Address: http://www.state.nm.us/hsd/mad/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

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 Practitioners, certified
-Obstetricians/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 injury
- 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
- Reside in Nursing Facility or ICF/MR

Medicare Dual Eligibles Included:
None

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

Lock-In Provision:
12 month lock-in

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Individuals identified by service utilization, clinical assessment, or diagnosis
- Referal by family, a public, or community program
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging and Long Term Services Department
- Children, Youth, and Families Department
- Coordinates with schools
- Department of Health
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- Statewide Entity for Behavioral Health

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Blue Cross Blue Shield of New Mexico</th>
<th>Lovelace Community Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Molina Healthcare of New Mexico</td>
<td>Presbyterian Health Plan</td>
</tr>
</tbody>
</table>

ADDITIONAL INFORMATION

OptumHealth New Mexico provides behavioral services through BH providers through a PIHP waiver. Lovelace Community Health Plan, Molina Health Care, Blue Cross Blue Shield of New Mexico, and Presbyterian Salud! provide physical health services and those BH services provided by non-BH provider/practitioners. Native Americans have the choice of “opt-in” to managed care, but receive benefits under Fee for Service programs by default.

An Individual with Special Health Care Needs (ISHCN) require a broad range of primary, specialized medical, behavioral health and related services. ISHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition and who require health and related services of a type or amount beyond that required by other individuals. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO/SE can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

Native Americans within other covered categories have the option of choosing to participate in managed care due to tribal agreements.

QUALITY ACTIVITIES FOR MCO/HIO

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

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

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Child Medicaid AFDC Questionnaire
  - Child with Special Needs Questionnaire
- Consumer/Beneficiary Focus Groups

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

Encounter Data

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

Collections: Submission Specifications:
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national
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- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission
- 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 data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
- Medical record validation
- Per member per month analysis and comparisons across MCO

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

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

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### Performance Measures

**Process Quality:**
- Adolescent immunization rate
- Adolescent well-care visit rate
- Asthma care - medication use
- Breast Cancer screening rate
- Cervical cancer screening rate
- Dental services
- 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

**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

**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

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

**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,

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### Performance Improvement Projects

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

**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

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

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

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

**EQRO Name:**
- HealthInsight dba New Mexico Medical Review Association

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

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

### Pay for Performance (P4P)

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

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

**Clinical Conditions:**
- Asthma
- Childhood immunizations
- Diabetes
- Well-child visits

**Program Payers:**
Medicaid is the only payer

**Rewards Model:**
- Payment incentives/differentials to reward MCOs
- Preferential auto-enrollment to reward MCOs
- Public reporting to reward MCOs
- Withholds as an incentive

**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,
Initial Year of Reward: 1997

Member Incentives: Not Applicable

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

Salud! Behavioral Health

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### CONTACT INFORMATION

**State Medicaid Contact:**
Paula McGee  
NM HSD/Medical Assistance Division  
(505) 827-6234

**State Website Address:**
http://www.state.nm.us/hsd/HMedicaid.html

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### 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:**
June 30, 2013

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

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

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### 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, 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) Providers  
- Indian Health Service (IHS) Providers  
- Nurse Practitioners  
- Other Addiction Professionals (i.e. Substance Use Disorder counselors, alcohol and drug counselors,  
- Psychiatrists  
- Psychologists  
- Rural Health Clinics (RHCs)

**Contractor Types:**
- Behavioral Health MCO (Private)  
- CMHC Operated Entity (Public)
## NEW MEXICO

### Salud! Behavioral Health

#### Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- Aged and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Blind/Disabled Adults and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Blind/Disabled Children and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Foster Care Children</td>
</tr>
<tr>
<td></td>
<td>- Medicare Dual Eligibles</td>
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<tr>
<td></td>
<td>- Section 1931 Adults and Related Populations</td>
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<td></td>
<td>- Section 1931 Children and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Title XXI CHIP</td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Included:</th>
<th>Medicare Dual Eligibles Excluded:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Only</td>
<td>SLMB, QI, and QDWI</td>
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</tbody>
</table>

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

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

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### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

<table>
<thead>
<tr>
<th>Program Includes People with Complex (Special) Needs:</th>
<th>Agencies with which Medicaid Coordinates the Operation of the Program:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>- Aging Agency</td>
</tr>
<tr>
<td></td>
<td>- Developmental Disabilities Agency</td>
</tr>
<tr>
<td></td>
<td>- Education Agency</td>
</tr>
<tr>
<td></td>
<td>- Housing Agencies</td>
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<tr>
<td></td>
<td>- Mental Health Agency</td>
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<tr>
<td></td>
<td>- Social Services Agencies</td>
</tr>
<tr>
<td></td>
<td>- Substance Abuse Agency</td>
</tr>
</tbody>
</table>

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

OptumHealth New Mexico
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.

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

**Consumer Self-Report Data:**
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Child Medicaid AFDC Questionnaire
  - Child with Special Needs Questionnaire
- Consumer/Beneficiary Focus Groups

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

**Encounter Data**

**Collection: Requirements:**
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for data validation
- Requirements for 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
NEW MEXICO
Salud! Behavioral Health

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

State conducts general data completeness assessments:
Yes

Performance Measures

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

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

Access/Availability of Care:
- Adult's access to preventive/ambulatory health services
- Ratio of 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
- Days in unpaid claims/claims outstanding
- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- Net worth
- Total revenue

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

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

Performance Improvement Projects

Project Requirements:
- PIHPs are required to conduct a project(s) of their own choosing
- Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
- Followup after hospitalization (7day, 30 day)
- RTC Follow-up care/readmissions

Non-Clinical Topics:
Not Applicable - PIHPs are not required to conduct common project(s)

Standards/Accreditation
<table>
<thead>
<tr>
<th><strong>NEW MEXICO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salud! Behavioral Health</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PIHP Standards:</strong></th>
<th><strong>Accreditation Required for Participation:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>NCQA (National Committee for Quality Assurance) Standards</td>
<td>NCQA (National Committee for Quality Assurance)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Non-Duplication Based on Accreditation:</strong></th>
<th><strong>EQRO Name:</strong></th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>HealthInsight dba New Mexico Medical Review Association</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>EQRO Organization:</strong></th>
<th><strong>EQRO Mandatory Activities:</strong></th>
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</thead>
<tbody>
<tr>
<td>Quality Improvement Organization (QIO)</td>
<td>Independent Assessment</td>
</tr>
<tr>
<td></td>
<td>Review of PIHP compliance with structural and operational standards established by the State</td>
</tr>
<tr>
<td></td>
<td>Validation of performance improvement projects</td>
</tr>
<tr>
<td></td>
<td>Validation of performance measures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>EQRO Optional Activities</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical assistance to PIHPs to assist them in conducting quality activities</td>
</tr>
</tbody>
</table>
NEW YORK
Selective Contracting - Bariatric Surgery

CONTACT INFORMATION

State Medicaid Contact: Joseph Anarella
Division of Quality Improvement and Evaluation
(518) 486-9012

State Website Address: http://www.nyhealth.gov

PROGRAM DATA

Program Service Area:
City

Operating Authority:
1915(b) - Waiver Program

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

Solely Reimbursement Arrangement:
Yes

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

Guaranteed Eligibility:
None

ADDITIONAL INFORMATION

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: Initial Waiver Approval Date:
Statewide September 01, 1994

Operating Authority: Implementation Date:
1915(b) - Waiver Program September 01, 1994

Statutes Utilized: Waiver Expiration Date:
1915(b)(1), Freedom of Choice September 30, 2011
1915(b)(4), Selective Contracting

Enrollment Broker: Sections of Title XIX Waived:
No -1902(a)(1) Statewideness

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
Granted:
No -1902(a)(23) Freedom of Choice

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

FFS Transportation Brokers - Fee-for-Service

Service Delivery

Included Services: Allowable PCPs:
Non-Emergency Transportation -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
OREGON
Non-Emergency Transportation

<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
<th>Lock-In Provision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- No populations are excluded</td>
<td>No lock-in</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Included:</th>
<th>Medicare Dual Eligibles Excluded:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include all categories of Medicare Dual Eligibles</td>
<td>None</td>
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</table>

**Part D Benefit**

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
</tr>
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<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
<th></th>
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<tbody>
<tr>
<td>None</td>
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**SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS**

<table>
<thead>
<tr>
<th>Program Includes People with Complex (Special) Needs:</th>
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<tbody>
<tr>
<td>Yes</td>
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<table>
<thead>
<tr>
<th>Strategies Used to Identify Persons with Complex (Special) Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Uses eligibility data to identify members of these groups</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agencies with which Medicaid Coordinates the Operation of the Program:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Does NOT coordinate with any other Agency</td>
</tr>
</tbody>
</table>

**PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS**

| Not Applicable |

**ADDITIONAL INFORMATION**

The State contracts with transportation brokers on a FFS basis. All enrollees under the Oregon Health Plan Plus are enrolled in this program.
PENNSYLVANIA
ACCESS Plus Program

CONTACT INFORMATION

State Medicaid Contact: Jennifer Basom
Pennsylvania Department of Welfare
(717) 772-6149

State Website Address: http://www.state.pa.us

PROGRAM DATA

Program Service Area: County
Operating Authority: 1915(b) - Waiver Program
Statutes Utilized: 1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting
Enrollment Broker: Maximus

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

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

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
-Obstetricians/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)

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

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

Part D - Enhanced Alternative Coverage:
Not Applicable

Provides Part D Benefits:
Not Applicable
Pennsylvania
ACCESS Plus Program

Disease Management PAHP - Risk-based Capitation

Service Delivery

Included Services: Disease Management

Allowable PCPs:
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Independent Medical/Surgical Clinic
- Internists
- Nurse Midwives
- Nurse Practitioners
- Obstetricians/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)

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 Payment (LTCCP)
- Incarcerated Recipients
- Medicare Dual Eligibles
- Reside in Nursing Facility or ICF/MR
- Residence in a State Facility

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only (under age 21)

Medicare Dual Eligibles Excluded:
QMB (age 21 and over)
SLMB, QI, and QDWI (age 21 and over)

Part D Benefit

MCE has Medicare Contract: No

Scope of Part D Coverage: Not Applicable

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

Provides Part D Benefits: Not Applicable

Part D - Enhanced Alternative Coverage: Not Applicable
Program Includes People with Complex
(Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Asks advocacy groups to identify members of these groups
- Department of Public Welfare Offices
- Enrollment Contractor
- Legislative Offices
- Reviews complaints and grievances to identify members of these groups
- Self-Referral
- Surveys medical needs of enrollee to identify members of these groups
- Uses claims to identify special needs
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Education Agency
- Juvenile Justice Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Access Plus Program
APS Healthcare

ADDITIONAL INFORMATION
Under PCCM, the reason for multiple enrollment basis for the included populations: ACCESS Plus is the default; with exceptions. If a voluntary managed care is in a county with ACCESS Plus, the recipient can choose which delivery system they want. If no choice is made, the recipient is auto-assigned to ACCESS Plus. However, in counties where there is no voluntary managed care program, recipients are mandatorily enrolled into ACCESS Plus. Special Needs Children is broadly defined as non-categorical to include all children.

Reimbursement Arrangement: The providers in the network are reimbursed on a FFS basis. The Access Plus contractor receives a capitation for EPCCM Services and capitation for Disease Management Services.

Enrollees are assigned to the Disease Management program if they have one of the following qualifying chronic diseases: Asthma, Diabetes, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, and Congestive Heart Failure. However, enrollees can choose to opt out of this program.

QUALITY ACTIVITIES FOR PAHP
State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Consumer Surveys
- Focused Studies
- Monitoring of PAHP Standards
- On-Site Reviews
- PAHP Standards (see below for details)
- Performance Measures (see below for details)
- Provider Surveys

Use of Collected Data:
- Contract Standard Compliance
- Data Mining
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Target areas for new quality improvement activities
PENNSYLVANIA
ACCESS Plus Program

Consumer Self-Report Data:
- Contractordevelopedsurveyforchronicillnesssatisfaction
- 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 it collects

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
- Chronic Care Satisfaction
- Health Status Reports from Contractors
- Patient satisfaction with care

Access/Availability of Care:
- Adolescent access to preventive/ambulatory health services
- Childhood access to preventive/ambulatory health services

Use of Services/Utilization:
- Call Abandonment
- Call Timeliness
- Emergency room visits/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
- Administrative Costs
- Pay for performance reports on payouts and reserve and withhold
- Total revenue

Health Plan/ Provider Characteristics:
- Geo Mapping Report
- Number of Providers Following Standard Practice Guidelines for Chronic Illnesses
- Number of Providers Participating in Disease Management

Beneficiary Characteristics:
None

Performance Measures - Others:
- Other

Standards/Accreditation

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

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

QUALITY ACTIVITIES FOR PCCM

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

Use of Collected Data:
- Contract Standard Compliance
- Data Mining
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation
- Regulatory Compliance/Federal Reporting
- Target New Areas for Quality Improvement

Consumer Self-Report Data:
- CAHP Survey
- Consumer Complaints

Performance Measures
# PENNSYLVANIA ACCESS Plus Program

<table>
<thead>
<tr>
<th>Process Quality:</th>
<th>Health Status/Outcomes Quality:</th>
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<tbody>
<tr>
<td>None</td>
<td>Patient satisfaction with care</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent well child visits</td>
<td>Call Abandonment</td>
</tr>
<tr>
<td>Adult access to preventive/ambulatory health services</td>
<td>Call Timeliness</td>
</tr>
<tr>
<td>Children's access to primary care practitioners</td>
<td>Emergency room visits/1,000 beneficiaries</td>
</tr>
<tr>
<td>Ratio of primary care case managers to beneficiaries</td>
<td>Hospital Readmission Rates</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Characteristics:</th>
<th>Beneficiary Characteristics:</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
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<thead>
<tr>
<th>Performance Measures - Others:</th>
<th>Performance Improvement Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee Outreach Activities</td>
<td>Non-Clinical Topics:</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Availability of language interpretation services</td>
</tr>
</tbody>
</table>

## Clinical Topics:
- Adolescent Immunization
- Adolescent Well Care/EPSDT
- Asthma management
- Beta Blocker treatment after a heart attack
- Breast cancer screening (Mammography)
- Cervical cancer screening (Pap Test)
- Cervical Cancer Screening initiative to increase screening rates
- Child/Adolescent Dental Screening and Services
- Child/Adolescent Hearing and Vision Screening and Services
- Childhood Immunization
- Cholesterol screening and management
- Coordination of primary and behavioral health care
- Coronary artery disease prevention
- Depression Screening
- Diabetes management
- Domestic violence
- Emergency Room service utilization
- Post-natal Care
- Pre-natal care
- Sexually transmitted disease screening
- Smoking prevention and cessation
- Well Child Care/EPSDT

## Non-Clinical Topics:
- Children's access to primary care practitioners
- ER initiative to reduce ER visit rate
PENNSYLVANIA
HealthChoices

CONTACT INFORMATION

State Medicaid Contact: Joan Morgan
Pennsylvania Department of Welfare
(717) 772-6300

State Website Address: http://www.state.pa.us

PROGRAM DATA

Program Service Area: County
Operating Authority: 1915(b) - Waiver Program
Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Enrollment Broker: Maximus
Initial Waiver Approval Date: December 31, 1996
Implementation Date: February 01, 1997
Waiver Expiration Date: December 31, 2012

For All Areas Phased-In: No
Guaranteed Eligibility: No guaranteed eligibility

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

**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)

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

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

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

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

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

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

**Strategies Used to Identify Persons with Complex (Special) Needs:**
- Asks advocacy groups to identify members of these groups
- Self Reported
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups
PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna Better Health
Community Care Behavioral Health - North Central
Counties of Armstrong/Indiana - Value Behavioral Health of PA
Counties of Carbon/Monroe/Pike - Community Care Behavioral Health
Counties of Franklin/Fulton - Community Behavioral Healthcare Network of PA
County of Adams - Community Care Behavioral Health
County of Beaver - Value Behavioral Health of PA
County of Blair County - Community Behavioral Healthcare Network of PA
County of Butler - Value Behavioral Health of PA
County of Chester - Community Care Behavioral Health
County of Dauphin - Community Behavioral Healthcare Network of PA, Inc.
County of Erie - Value Behavioral Health
County of Lancaster - Community Behavioral Healthcare Network of PA, Inc.
County of Lebanon - Community Behavioral Healthcare Network of PA, Inc.
County of Montgomery - Magellan Behavioral Health
County of Perry - Community Behavioral Healthcare Network of PA, Inc.
County of Washington - Value Behavioral Health of PA
County of York - Community Care Behavioral Health
Gateway Health Plan, Inc.
Keystone Mercy Health Plan
UPMC Health Plan, Inc./UPMC for You
AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan
Community Care Behavioral Health - Northeast
Counties of Bedford/Somerset - Community Behavioral Healthcare Network of PA
Counties of Crawford/Mercer/Venango - Value Behavioral Health
Counties of Lycoming/Clinton - Community Behavioral Healthcare Network of PA
County of Allegheny - Community Care Behavioral Health
County of Berks - Community Care Behavioral Health
County of Bucks - Magellan Behavioral Health
County of Cambria - Value Behavioral Health
County of Cumberland - Community Behavioral Healthcare Network of PA, Inc.
County of Delaware - Magellan Behavioral Health
County of Fayette - Value Behavioral Health of PA
County of Lawrence - Value Behavioral Health of PA
County of Lehigh - Magellan Behavioral Health
County of Northampton - Magellan Behavioral Health
County of Philadelphia - Community Behavioral Health
County of Westmoreland - Value Behavioral Health of PA
Coventry Care
Health Partners of Philadelphia
United Healthcare of PA
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 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 (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)
-Provider Data

Use of Collected Data:
-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision
Consumer Self-Report Data:
- CAHPS
  4.0H adult

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

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

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

Collection: Standardized Forms:
None

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

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

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
- Adolescent immunization rate
- Adolescent well-care visit rates
- Appropriate Testing for Children with Pharyngitis
- Appropriate treatment for Children with Upper Respiratory Infection (URI)
- Asthma care - medication use

Health Status/Outcomes Quality:
- Patient satisfaction with care
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

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

Use of Services/Utilization:
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

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

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

Performance Measures - Others:
None

Performance Improvement Projects

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

Clinical Topics:
-Adolescent Pregnancy
-Asthma management
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Diabetes management
-Hypertension management
-Smoking prevention and cessation
Non-Clinical Topics:
- Adult’s access to dental care
- Children’s access to dental care

Standards/Accreditation

MCO Standards:
- CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
- JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
- NAIC (National Association of Insurance Commissioners) Standards
- State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
- Island Peer Review Organization (IPRO)

EQRO Organization:
- Quality Improvement Organization (QIO)

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

EQRO Optional Activities:
- Conduct of performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of encounter data

Pay for Performance (P4P)

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

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Not Applicable

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

Initial Year of Reward:
2006

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

Member Incentives:
Not Applicable
TEXAS
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact: Sheryl Woolsey
Texas Health and Human Services Commission
(512) 706-4901

State Website Address: http://www.hhsc.state.tx.us/QuickAnswers/index.shtml

PROGRAM DATA

Program Service Area: Statewide
Operating Authority: 1915(b) - Waiver Program
Statutes Utilized: 1915(b)(4), Selective Contracting
Enrollment Broker: No

Initial Waiver Approval Date: January 25, 2011
Implementation Date: April 01, 2011
Waiver Expiration Date: March 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

Other - Fee-for-Service

Service Delivery

Included Services: Non-Emergency Transportation
Allowable PCPs: Not Applicable

Enrollment

Populations Voluntarily Enrolled:
- Aged and Related Populations
- American Indian/Alaska Native
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- 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
TEXAS
Non-Emergency Transportation

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Not Applicable

ADDITIONAL INFORMATION

NEMT services are provided in accordance with the federal regulations 42 CFR §§ 431.53, 440.170. NEMT services are arranged through competitively procured contracts with public and private transportation providers. NEMT also provides mileage reimbursement to persons enrolled as Individual Transportation Provider (ITPs). Eligible beneficiaries through age 20, may receive advance funds for meals and lodging when an overnight stay is medically necessary. The beneficiary's parent or guardian may also qualify for meals and lodging. The beneficiary or the beneficiary's parent or guardian may also receive funds in advance for mileage, when necessary.
TEXAS
NorthSTAR

CONTACT INFORMATION

State Medicaid Contact: Betsy Johnson
Texas Health and Human Services Commission
(512) 491-1199

State Website Address: http://www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
Region November 01, 1999

Operating Authority: Implementation Date:
1915(b) - Waiver Program November 01, 1999

Statutes Utilized: Waiver Expiration Date:
1915(b)(1), Freedom of Choice September 30, 2013
1915(b)(2), Locality as Central Broker
1915(b)(4), Selective Contracting

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

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
Yes Granted:

Guaranteed Eligibility: None

SERVICE DELIVERY

MH/SUD PIHP - Other-FFS/some Risk Based

Service Delivery

Included Services: Allowable PCPs:
Assertive Community Treatment Team, Crisis, Day -Not applicable, contractors not required to identify PCP
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)
TEXAS
NorthSTAR

Enrollment

Populations Voluntarily Enrolled: None

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

Medicare Dual Eligibles Included:
All clients with full Medicare and Medicaid eligibility

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

Lock-In Provision:
No lock-in

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

Part D Benefit

MCE has Medicare Contract: No

Scope of Part D Coverage: Not Applicable

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

Provides Part D Benefits: Not Applicable

Part D - Enhanced Alternative Coverage: Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs: Yes

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

Agencies with which Medicaid Coordinates the Operation of the Program:
- DADS
- DFPS
- DSHS
- Local School Districts
- Protective and Regulatory Agency
- Public Health Agency
- Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ValueOptions
INDIVIDUALS ON SSI AND QMB PLUS ARE THE ONLY MEDICARE DUAL ELIGIBLES THAT ARE ELIGIBLE 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
- 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 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

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
- The State modifies/requires PIHPs to modify some or all NCQA specifications in ways other than continuous enrollment

Encounter Data

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

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)
- Comparisons 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

State conducts general data completeness assessments:
- Yes
Performance Measures

<table>
<thead>
<tr>
<th>Process Quality:</th>
<th>Health Status/Outcomes Quality:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Depression management/care</td>
<td>-Clinical outcomes as measures by clinical assessments</td>
</tr>
<tr>
<td>-Follow-up after hospitalization for mental illness</td>
<td>-Patient satisfaction with care</td>
</tr>
<tr>
<td></td>
<td>-Recidivism to intensive/acute levels of care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Average distance to mental health provider</td>
<td>-Drug Utilization</td>
</tr>
<tr>
<td>-Number and types of providers</td>
<td>-Inpatient admission for MH/SUD conditions/1,000 beneficiaries</td>
</tr>
<tr>
<td>-Ratio of mental health providers to number of beneficiaries</td>
<td>-Re-admission rates of MH/SUD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Plan Stability/Financial/Cost of Care:</th>
<th>Health Plan/Provider Characteristics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Actual reserves held by plan</td>
<td>-Behavioral Health Specialty Network</td>
</tr>
<tr>
<td>-Days in unpaid claims/claims outstanding</td>
<td>-Languages Spoken (other than English)</td>
</tr>
<tr>
<td>-Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)</td>
<td>-Provider turnover</td>
</tr>
<tr>
<td>-Medical loss ratio</td>
<td></td>
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<tr>
<td>-Net income</td>
<td></td>
</tr>
<tr>
<td>-Net worth</td>
<td></td>
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<tr>
<td>-State minimum reserve requirements</td>
<td></td>
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<tr>
<td>-Total revenue</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Performance Improvement Projects

<table>
<thead>
<tr>
<th>Project Requirements:</th>
<th>Clinical Topics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency</td>
<td>-Coordination of primary and behavioral health care</td>
</tr>
</tbody>
</table>

Non-Clinical Topics:

None

Standards/Accreditation

<table>
<thead>
<tr>
<th>PIHP Standards:</th>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare</td>
<td>None</td>
</tr>
<tr>
<td>-NCQA Standards for Treatment Records</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Duplication Based on Accreditation:</th>
<th>EQRO Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>-Institute for Child Health Policy (ICHPP)</td>
</tr>
</tbody>
</table>
TEXAS
NorthSTAR

EQRO Organization:
- QIO-like entity

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

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

CONTACT INFORMATION

State Medicaid Contact: Terri Frazier
Texas Health and Human Services Commission
(512) 491-1832

State Website Address: http://www.hhsc.state.tx.us/medicaid/care_case_pr

PROGRAM DATA

Program Service Area: County
Operating Authority: 1915(b) - Waiver Program
Statutes Utilized: 1915(b)(4), Selective Contracting
Solely Reimbursement Arrangement: Yes

Initial Waiver Approval Date: January 01, 2008
Implementation Date: January 01, 2008
Waiver Expiration Date: February 28, 2012
Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility: None

ADDITIONAL INFORMATION

Negotiated hospital rates by the Texas Medicaid claims administrator, Texas Medicaid & Healthcare Partnership (TMHP).
TEXAS STAR

CONTACT INFORMATION

State Medicaid Contact: Joe Vesowate
Texas Health and Human Services Commission
(512) 491-1379

State Website Address: http://www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area: County
Operating Authority: 1915(b) - Waiver Program
Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(2), Locality as Central Broker
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting

Enrollment Broker: Maximus

Initial Waiver Approval Date: August 01, 1993
Implementation Date: August 01, 1993
Waiver Expiration Date: June 30, 2012

For All Areas Phased-In: No
Guaranteed Eligibility: No guaranteed eligibility

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

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

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

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

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

**Populations Mandatorily Enrolled:**
- Children Under 1 (Poverty 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 Participate in the STAR+PLUS 1915(c) Waiver Program
- Medicare Dual Eligibles
- Reside in Nursing Facility or ICF/MR
- Retroactive Eligibility

**Medicare Dual Eligibles Included:**
None

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

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

**Part D Benefit**

**MCE has Medicare Contract:**
Not Applicable

**Provides Part D Benefits:**
Not Applicable

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

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Aetna</th>
<th>Amerigroup (STAR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community First</td>
<td>Community Health Choice</td>
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<tr>
<td>Cook Children's</td>
<td>Driscoll</td>
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<tr>
<td>El Paso First Premier</td>
<td>First Care</td>
</tr>
<tr>
<td>Molina (STAR)</td>
<td>Parkland Community Health Plan</td>
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<tr>
<td>Superior HealthPlan (STAR)</td>
<td>Texas Children Health Plan</td>
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<tr>
<td>Unicare</td>
<td>United</td>
</tr>
</tbody>
</table>
TEXAS STAR

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

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

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

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

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

Encounter Data

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

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

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

Validation - Methods:
- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to submitted bills)
- Medical record validation
- Per member per month analysis and comparisons across MCOs
MCO/HIO conducts data accuracy check(s) on specified data elements:
- Date of Service
- Date of Payment
- Provider ID
- 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
- Asthma care - medication use
- Cervical cancer screening rate
- Childhood Immunization Status
- Chlamydia 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
- 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
- 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:
- Patient satisfaction with care
- Percentage of low birth weight infants

Access/Availability of Care:
- Adult’s access to preventive/ambulatory health services
- Average distance to PCP
- Average wait time for an appointment with PCP
- Children’s access to primary care practitioners
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

Use of Services/Utilization:
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Percent of beneficiaries accessing 24-hour day/night care at
  MH/SUD facility
- Re-admission rates of MH/SUD

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

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

Non-Clinical Topics:
- Children's access to primary care practitioners

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.

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 Organization:
- QIO-like entity

EQRO Name:
- 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

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

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO, but plans to implement one in the future

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
1% At-risk Premium. HMO at risk for 1% of the capitation
rate(s) dependent on the outcome of pre-identified performance measures
Payment incentives/differentials to reward MCOs
Quality challenge pool award. Based on specific pre-identified clinical performance measures

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
1% At-risk Premium. Standards are established for the SFY time period that must be met in order to retain the point value and percentage of the 1% At-Risk Premium dollars.
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing patient satisfaction measures
Assessing the timely submission of complete and accurate electronic encounter/claims data
Quality Challenge Pool Award is based on a point value and performance standard assigned to the clinical performance measures and overall ranking of managed care organization score.
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
Not Applicable

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

Member Incentives:
Not Applicable
# Texas Medicaid Wellness Program

## Contact Information

| State Medicaid Contact: | Betsy Johnson  
Texas Health and Human Services Commission  
(512) 491-1199 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State Website Address:</td>
<td><a href="http://www.hhsc.state.tx.us/medicaid">http://www.hhsc.state.tx.us/medicaid</a></td>
</tr>
</tbody>
</table>

## Program Data

<table>
<thead>
<tr>
<th>Program Service Area:</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Authority:</td>
<td>1915(b) - Waiver Program</td>
</tr>
</tbody>
</table>
| 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

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Disease Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowable PCPs:</td>
<td>- Not applicable, contractors not required to identify PCPs</td>
</tr>
</tbody>
</table>

### Enrollment

| Populations Voluntarily 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 |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Populations Mandatorily Enrolled:</td>
<td>None</td>
</tr>
</tbody>
</table>

132
Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in Another Managed Care Program
- Enrollees in hospice, STAR, STAR+PLUS, or STARHealth programs, as well as 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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses other means to identify members of these groups
Vendor uses claims data to identify clients

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

McKesson Health Solutions

ADDITIONAL INFORMATION

Only clients enrolled in Primary Care Case Management and 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.
# TEXAS
## Texas Medicaid Wellness Program

<table>
<thead>
<tr>
<th>State Quality Assessment and Improvement Activities:</th>
<th>Use of Collected Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Consumer Self-Report Data (see below for details)</td>
<td>- Contract Standard Compliance</td>
</tr>
<tr>
<td>- Data Analysis</td>
<td>- Monitor Quality Improvement</td>
</tr>
<tr>
<td>- Enrollee Hotlines</td>
<td>- Program Evaluation</td>
</tr>
<tr>
<td>- Independent Assessment</td>
<td>- Program Modification, Expansion, or Renewal</td>
</tr>
<tr>
<td>- Measure Disparities</td>
<td>- Track Health Service provision</td>
</tr>
<tr>
<td>- Network Data</td>
<td></td>
</tr>
<tr>
<td>- On-Site Reviews</td>
<td></td>
</tr>
<tr>
<td>- Performance Improvement Projects (see below for details)</td>
<td></td>
</tr>
<tr>
<td>- Performance Measures (see below for details)</td>
<td></td>
</tr>
<tr>
<td>- Provider Data</td>
<td></td>
</tr>
<tr>
<td>- Utilization Review</td>
<td></td>
</tr>
</tbody>
</table>

### 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 (adult) for: Diabetes (short and long term complications), DOPD, Hypertension, COPD, CHF, uncontrolled Diabetes, and Asthma
- 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
TEXAS
Texas Medicaid Wellness Program

<table>
<thead>
<tr>
<th>PAHP Standards:</th>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Non-Duplication Based on Accreditation:
None
UTAH
Choice Of Health Care Delivery

CONTACT INFORMATION

State Medicaid Contact: Emma Chacon
Utah State Department of Health
(801) 538-6577

State Website Address: http://www.health.utah.gov/medicaid

PROGRAM DATA

Program Service Area: County
Operating Authority: 1915(b) - Waiver Program
Statutes Utilized: 1915(b)(1), 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)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan
Sections of Title XIX Costs Not Otherwise Matchable Granted: None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Diabetes self-management, Durable Medical Equipment, Enhanced Services to Pregnant Women, EPST, ESRD, Family Planning, Hearing, HIV Prevention, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient medical detoxification, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Private Duty Nursing, Speech Therapy, Vision, Well-adult care, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians
## UTAH Choice Of Health Care Delivery

### Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- Aged and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Blind/ Disabled Adults and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Blind/ Disabled Children and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Foster Care Children</td>
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<td>- Medically Needy Children</td>
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<tr>
<td></td>
<td>- Medicare Dual Eligibles</td>
</tr>
<tr>
<td></td>
<td>- Section 1931 Children and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Special Needs Children (State defined)</td>
</tr>
</tbody>
</table>

**Subpopulations Excluded from Otherwise Included Populations:**
- 1931 Adults
- During Retroactive Eligibility Period
- Eligibility Less Than 3 Months
- Eligible only for TB-related Services
- If Approved as Exempt from Mandatory Enrollment
- Medically Needy Adults
- Medicare Dual Eligibles
- Reside in Nursing Facility or ICF/MR
- Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)

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

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

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None
### UTAH
#### Choice Of Health Care Delivery

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

**Service Delivery**

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
</tr>
</thead>
</table>
| 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 | - Family Practitioners  
- Federally Qualified Health Centers (FQHCs)  
- General Practitioners  
- Indian Health Service (IHS) Providers  
- Internists  
- Nurse Midwives  
- Nurse Practitioners  
- Obstetricians/Gynecologists or Gynecologists  
- Other Specialists Approved on a Case-by-Case Basis  
- Pediatricians |

**Enrollment**

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
</table>
| None                            | - 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 spend-down and are aged or disabled  
- Individuals who qualify for Medicaid by paying a spend-down and are under age 19  
- Medicare Dual Eligibles  
- Section 1931 Children and Related Populations  
- Special Needs Children (State defined) |

**Subpopulations Excluded from Otherwise Included Populations:**

- Eligibility Less Than 3 Months  
- Eligible only for TB-related Services  
- Have an eligibility period that is only retroactive  
- Individuals residing in the Utah State Hospital of the Utah Developmental Center  
- Medically Needy Individuals with Spend-down  
- Medicare Dual Eligibles  
- Reside in Nursing Facility or ICF/MR  
- Section 1931 non-pregnant adults age 19 and older and related poverty level populations

**Lock-In Provision:**

- 12 month lock-in

**Medicare Dual Eligibles Included:**

- QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**

- QMB  
- SLMB, QI, and QDWI

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Scope of Part D Coverage:**

- Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**

- Not Applicable
UTAH
Choice Of Health Care Delivery

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

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
- Obstetricians/Gynecologists or Gynecologists
- Other Specialists Approved on a Case-by-Case Basis
- Pediatricians

Enrollment

Populations Voluntarily Enrolled:
None

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

Subpopulations Excluded from Otherwise Included Populations:
- Eligibility Less Than 3 Months
- Eligible only for TB-related Services
- Medically Needy Individuals with Spend-down
- Medicare Dual Eligibles
- Reside in Nursing Facility or ICF/MR
- Retroactive Eligibility

Lock-In Provision:
12 month lock-in

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

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

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
UTAH
Choice Of Health Care Delivery

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Education Agency
- Employment Agencies
- Housing Agencies
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Healthy U Molina Healthcare of Utah (Molina)
Select Access

ADDITIONAL INFORMATION

Children with special 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 special 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.

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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)

Use of Collected Data:
- Beneficiary Plan Selection
Choice Of Health Care Delivery

-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

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

Performance Measures

Process Quality:
-Adolescent immunization rate
-Appropriate Testing for Children with Pharyngitis
-Appropriate treatment for Children with Upper Respiratory Infection (URI)

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of adults 50 and older who received an influenza vaccine

Encounter Data

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

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Collection: 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

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

State conducts general data completeness assessments:
Yes
Choice Of Health Care Delivery

- 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
- 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

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

Health Care Delivery Performance Measures - Others:
- None

Performance Improvement Projects

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

Clinical Topics:
- Diabetes management

Non-Clinical Topics:
- None

Standards/Accreditation

MCO Standards:
- State-Developed/Specified Standards

Accreditation Required for Participation:
- None

Non-Duplication Based on Accreditation:
- None

EQRO Name:
- HCE Quality Quest
- Utah Department of Health's Office of Health Care Statistics

EQRO Organization:
- QIO-like entity
- State entity

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

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

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

Program Payers:  
Not Applicable

Population Categories Included:  
Not Applicable

Rewards Model:  
Not Applicable

Clinical Conditions:  
Not Applicable

Measurement of Improved Performance:  
Not Applicable

Initial Year of Reward:  
Not Applicable

Evaluation Component:  
Not Applicable

Member Incentives:  
Not Applicable

QUALITY ACTIVITIES FOR PAHP

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

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

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/requirements PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Consumer Self-Report Data:  
- CAHPS  
  Adult Medicaid AFDC Questionnaire  
  Child Medicaid AFDC Questionnaire  
  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/requirements 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
### UTAH
#### Choice Of Health Care Delivery

**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
- Chlamydia screening in women
- Diabetes medication management
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Influenza vaccination rate
- 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

#### 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

#### Beneficiary Characteristics:
None

#### Performance Measures - Others:
None

### Performance Improvement Projects

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

**Clinical Topics:**
- Diabetes management

**Non-Clinical Topics:**
None

### Standards/Accreditation
## UTAH
Choice Of Health Care Delivery

<table>
<thead>
<tr>
<th>PAHP Standards:</th>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-State-Developed/Specified Standards</td>
<td>None</td>
</tr>
</tbody>
</table>

Non-Duplication Based on Accreditation:
None

### QUALITY ACTIVITIES FOR PCCM

<table>
<thead>
<tr>
<th>Quality Oversight Activities:</th>
<th>Use of Collected Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

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
Initial Waiver Approval Date: September 19, 2000

Operating Authority: 1915(b) - Waiver Program
Implementation Date: July 01, 2001

Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting
Waiver Expiration Date: June 30, 2013

Enrollment Broker: No

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

For All Areas Phased-In: No

Sections of Title XIX Costs Not Otherwise Matchable
Granted: None

Guaranteed Eligibility: None

SERVICE DELIVERY

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)
Non-Emergency Medical Transportation

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Pick Me Up Transportation

ADDITIONAL INFORMATION

Children with special 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
# UTAH

## Non-Emergency Medical Transportation

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

### Use of Collected Data:
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Track Health Service provision

### Consumer Self-Report Data:
None

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

## Encounter Data

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

### Collections - Submission Specifications:
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Use of "home grown" forms
- Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
None

### Validation - Methods:
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

### PAHP conducts data accuracy check(s) on specified data elements:
None

### State conducts general data completeness assessments:
No

## Standards/Accreditation

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

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None
UTAH
Prepaid Mental Health Program

CONTACT INFORMATION

State Medicaid Contact: Emma Chacon
Division of Medicaid and Health Financing
(801) 538-6577

State Website Address: http://www.health.utah.gov/medicaid

PROGRAM DATA

Program Service Area: County
Initial Waiver Approval Date: July 01, 1991
Operating Authority: 1915(b) - Waiver Program
Implementation Date: July 01, 1991
Statutes Utilized:
1915(b)(1), Freedom of Choice
1915(b)(3), Sharing of Cost Savings
1915(b)(4), Selective Contracting
Waiver Expiration Date: December 31, 2016
Enrollment Broker: No
Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan
For All Areas Phased-In: Yes
Sections of Title XIX Costs Not Otherwise Matchable
Granted: None
Guaranteed Eligibility: None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, Inpatient Mental Health, Mental Health Outpatient,
Mental Health Rehabilitation, Transportation
Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Contractor Types:
-CMHC - some private, some governmental

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
UTAH
Prepaid Mental Health Program

Subpopulations Excluded from Otherwise Included Populations:
- 1925 Adults
- 1931 Adults
- Medically Needy Adults
- Medicare Dual Eligibles
- Outpatient services for foster children
- Resident of the State Developmental Center (DD/MR facility)
- Resident of the Utah State Hospital (IMD)

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

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

Part D Benefit
MCE has Medicare Contract: No
Scope of Part D Coverage: Not Applicable
Part D - Enhanced Alternative Coverage: Not Applicable
Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS
Program Includes People with Complex (Special) Needs: Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Bear River Mental Health Services, Inc
Davis Behavioral Health
Northeastern Counseling Center
Southwest Center Behavioral Health Services
Wasatch Mental Health
Central Utah Counseling Center
Four Corners Community Behavioral Health, Inc.
Salt Lake County Behavioral Health
Valley Mental Health
Weber Human Services

ADDITIONAL INFORMATION
Community Mental Health Centers serve as Prepaid Mental Health Plan (PMHP) contractors to provide/coordinate all mental health services.
services in 9 of the 11 mental health service areas. Under the PMHP foster children receive inpatient services only.

QUALITY ACTIVITIES FOR PIHP

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

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

Consumer Self-Report Data:
- MHSIP satisfaction surveys are used by the PMHPs.
- OQ/YOQ outcomes instruments are used by the PMHPs.

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

Encounter Data

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

Collection: Standardized Forms:
- ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Collection: 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

Validation - Methods:
- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PIHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
- Per member per month analysis and comparisons across PIHPs
- Specification/source code review, such as a programming language used to create an encounter data file for submission
- State monitoring of consistency in encounters over time

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

State conducts general data completeness assessments:
Yes
### Performance Measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Quality:</strong></td>
<td>Health Status/Outcomes Quality: None</td>
</tr>
<tr>
<td><strong>Access/Availability of Care:</strong></td>
<td>Use of Services/Utilization: None</td>
</tr>
<tr>
<td><strong>Health Plan Stability/Financial/Cost of Care:</strong></td>
<td>Health Plan/Provider Characteristics: Information on providers by designated provider groupings</td>
</tr>
<tr>
<td><strong>Beneficiary Characteristics:</strong></td>
<td>Performance Measures - Others: None</td>
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</tbody>
</table>

### Performance Improvement Projects

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project Requirements:</strong></td>
<td>Clinical Topics: Coordination of primary and behavioral health care</td>
</tr>
<tr>
<td><strong>Non-Clinical Topics:</strong></td>
<td>Not Applicable - PIHPs are not required to conduct common project(s)</td>
</tr>
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</table>

### Standards/Accreditation

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
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<tbody>
<tr>
<td><strong>PIHP Standards:</strong></td>
<td>Accreditation Required for Participation: None</td>
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<tr>
<td><strong>Non-Duplication Based on Accreditation:</strong></td>
<td>EQRO Name: HCE Quality Quest</td>
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<tr>
<td><strong>EQRO Organization:</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>EQRO Optional Activities</strong></td>
<td>EQRO Optional Activities: Technical assistance to PIHPs to assist them in conducting quality activities</td>
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</tbody>
</table>
## 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

<table>
<thead>
<tr>
<th>Program Service Area:</th>
<th>Initial Waiver Approval Date:</th>
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<tbody>
<tr>
<td>City</td>
<td>April 01, 2005</td>
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<tr>
<td>County</td>
<td></td>
</tr>
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</table>

**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

**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**

153
<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
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<tbody>
<tr>
<td>None</td>
<td>- Aged and Related Populations</td>
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<td>- Blind/Disabled Adults and Related Populations</td>
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<tr>
<td></td>
<td>- Blind/Disabled Children and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Section 1931 Adults and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Section 1931 Children and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Title XXI CHIP</td>
</tr>
</tbody>
</table>

**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

**Medicare Dual Eligibles Included:**
None

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

**Part D Benefit**

**MCE has Medicare Contract:** Not Applicable

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

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:** None
MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

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

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
- Eligibility Less Than 3 Months
- Enrolled in Another Managed Care Program
- Foster Care
- Hospice
- Medicare Dual Eligibles
- Other Insurance
- Participate in Tech Waiver
- Refugees enrolled in Refugee Medical Assistance
- Reside in Nursing Facility or ICF/MR
- Spend-down
- Subsidized Adoption

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS
VIRGINIA
MEDALLION/Medallion II

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Asks advocacy groups to identify members of these groups
- Initial Interviews with new Medallion II enrollees
- Review claims activity of all new enrollees for special indicators
- Uses eligibility data to identify members of these groups

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Community Care
MEDALLION
Southern Health CareNet
Anthem Healthkeepers Plus
Optima Family Care
Virginia Premier Health Plan

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

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

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

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

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

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
Collection: Standardized Forms: None

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
- Gender-appropriate diagnosis/procedure
- Amount of Payment

State conducts general data completeness assessments: Yes

Performance Measures

Process Quality:
- Adolescent well-care visit rate
- Ambulatory Care
- Antidepressant medication management
- Asthma care - medication use
- Breast Cancer screening rate
- Check-ups after delivery
- Cholesterol screening and management for people with cardiovascular 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

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
## VIRGINIA
### MEDALLION/Medallion II

<table>
<thead>
<tr>
<th>Quality Oversight Activities:</th>
<th>Use of Collected Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Enrollee Hotlines</td>
<td>- Contract Standard Compliance</td>
</tr>
<tr>
<td></td>
<td>- Fraud and Abuse</td>
</tr>
<tr>
<td></td>
<td>- Program Evaluation</td>
</tr>
<tr>
<td></td>
<td>- Track Health Service provision</td>
</tr>
</tbody>
</table>

**Consumer Self-Report Data:**

None
WASHINGTON
The Integrated Mental Health Services

CONTACT INFORMATION

State Medicaid Contact: Cyndi LaBrec
Division 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: Initial Waiver Approval Date:
County Region April 27, 1993

Operating Authority: Implementation Date:
1915(b) - Waiver Program July 01, 1993

Statutes Utilized: Waiver Expiration Date:
1915(b)(1), Freedom of Choice September 30, 2012
1915(b)(4), Selective Contracting

Enrollment Broker: Sections of Title XIX Waived:
No -1902(a)(10)(B) Amount, Duration and Scope

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
No Granted:

Guaranteed Eligibility: None

SERVICE DELIVERY

Mental Health (MH) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Brief Intervention Treatment, Crisis Services, Day Support,
EPSDT, Evaluation and Treatment/Community
Hospitalization, Family Treatment, FQHC, Group Treatment
Services, High Intensity Treatment, Individual Treatment
Services, Inpatient Hospital Psychiatric, 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, Rural Clinic
Services, Special Population Evaluation, Stabilization
Services, Therapeutic Psychoeducation

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

160
### Contractor Types:
- Regional Authority Operated Entity (Public)
- 13 Regional Support Networks

### Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>None</th>
</tr>
</thead>
</table>
| 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
- Washington Medicaid Integration Partnership (WMIP) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lock-In Provision:</td>
<td>No lock-in</td>
</tr>
<tr>
<td>Medicare Dual Eligibles Included:</td>
<td>QMB Plus, SLMB Plus, and Medicaid only</td>
</tr>
</tbody>
</table>
| Medicare Dual Eligibles Excluded: | QMB
SLMB, QI, and QDWI |

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides Part D Benefits:</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Scope of Part D Coverage:</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Part D - Enhanced Alternative Coverage:</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

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

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

| Program Includes People with Complex (Special) Needs: | Yes |
| Strategies Used to Identify Persons with Complex (Special) Needs: | - All Enrollees served by the RSNs meet this criterion |
| Agencies with which Medicaid Coordinates the Operation of the Program: | - Aging Agency
- Dental Providers
- Education Agency
- HIS - Indian Health Services
- Maternal and Child Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency |
WASHINGTON
The Integrated Mental Health Services
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
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)
- Performance Measures (see below for details)
- PIHP Standards (see below for details)
- Quality Review Team

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

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

Consumer Self-Report Data:
- Consumer/Beneficiary Focus Groups
- MHSIP Child, Family, and Adult Survey

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)
WASHINGTON
The Integrated Mental Health Services

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 Partnership in Treatment Planning
- Decrease in the Days to Medication Evaluation Appointment After Request for Service
- Employment Outcomes for Adult Consumers
- Follow-up Appointment Within Seven Days of Discharge from Eastern State Hospital
- Impact of Implementing the PACT Model on the Use of Inpatient Treatment
- Improved Access to Children's Long-Term Inpatient Care
- Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder
- Metabolic Syndrome Screening and Intervention
- Multisystemic Therapy
- Permanent Supported Housing
- Using Dialectical Behavioral Therapy to Decrease Inpatient Psychiatric Admissions

Non-Clinical Topics:
- Improved Access to Community-Based Least Restrictive Care for Children with Intensive Needs
- Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization
- Improving Coordination of Care and Outcomes
- Improving Early Engagement in Outpatient Services
WASHINGTON
The Integrated Mental Health Services

- Increased Incident Reporting Compliance
- Increased Penetration Rate for Older Adults Enrolled in the Medicaid Program
- Increasing Percentage of Medicaid Clients who receive an Intake Service within 14 days of service request
- Reauthorization Timelines
- Resident Satisfaction in Transfer to Integrated Permanent Housing

**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:**
- EQRO Contractor/QIO

**Non-Duplication Based on Accreditation:**
- Compliance with Performance Measurements
- Compliance with QAPI and Program Integrity
- Encounter Data Validation

**EQRO Name:**
- Acumentra Health

**EQRO Organization:**
- External quality 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

**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
-Obstetricians/Gynecologists or Gynecologists
-Pediatricians
-Rural Health Clinics (RHCs)

Enrollment

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# WEST VIRGINIA
## Mountain Health Trust

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
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<tbody>
<tr>
<td>- Section 1931 Adults and Related Populations</td>
<td>- Poverty-Level Pregnant Women</td>
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<tr>
<td>- Section 1931 Children and Related Populations</td>
<td>- Special Needs Children (State defined)</td>
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<th>Subpopulations Excluded from Otherwise Included Populations:</th>
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<tr>
<td>- Medicare Dual Eligibles</td>
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<tr>
<td>- Participate in HCBS Waiver</td>
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<td>- Reside in Nursing Facility or ICF/MR</td>
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<td>- Title CHIP XXI</td>
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<td>1 month lock-in</td>
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<td>None</td>
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## Part D Benefit

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WEST VIRGINIA
Mountain Health Trust

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
-Obstetricians/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

Populations Mandatorily Enrolled:
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

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

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Included:
None

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

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

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WEST VIRGINIA
Mountain Health Trust

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Carelink Health Plan</th>
<th>Health Plan of the Upper Ohio Valley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Assured Access System</td>
<td>Unicare Health Plan of WV</td>
</tr>
</tbody>
</table>

ADDITIONAL INFORMATION

Any child who is enrolled in the States Children 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 continuous enrollment requirement for some or all of the measures

**Encounter Data**

**Collection: Requirements:**
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for data validation
- 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
WEST VIRGINIA
Mountain Health Trust

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
- Chlamydia 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 member 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

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

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable
West Virginia
Mountain Health Trust

<table>
<thead>
<tr>
<th>Initial Year of Reward:</th>
<th>Evaluation Component:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Member Incentives:</th>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
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</tbody>
</table>

## Quality Activities for PCCM

### Quality Oversight Activities:
- Performance Measures (see below for details)
- Provider Data

### Use of Collected Data:
- Beneficiary Provider Selection
- Program Evaluation
- Provider Profiling

### Consumer Self-Report Data:
None

### Performance Measures

#### Process Quality:
None

#### Health Status/Outcomes Quality:
None

#### Access/Availability of Care:
- Average distance to primary care case manager

#### Use of Services/Utilization:
None

#### Provider Characteristics:
None

#### Beneficiary Characteristics:
None

#### Performance Measures - Others:
None
ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

CONTACT INFORMATION

State Medicaid Contact: Tom Betlach
AHCCCS
(602) 417-4483

State Website Address: http://www.AZAHCCCS.gov

PROGRAM DATA

Program Service Area: Statewide
Initial Waiver Approval Date: July 13, 1982
Operating Authority: 1115(a) - Demonstration Waiver Program
Implementation Date: October 01, 1982
Statutes Utilized: Not Applicable
Waiver Expiration Date: September 30, 2016
Enrollment Broker: No

Sections of Title XIX Waived:
-1902(a)(10) Non Covered Activities
-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 Simplification and Delivery Systems
-Expenditures Related to Benefits
-Expenditures Related to Expansion of Existing Eligibility Groups base on Eligibility Simplification

For All Areas Phased-In: No

Guaranteed Eligibility:
12 months guaranteed eligibility for deemed newborns, 6 months guaranteed eligibility for first-time AHCCCS enrollees

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery
### ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
</tr>
</thead>
</table>
| Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Maternity, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplantation of Organs and Tissue and Related Immunosuppressant Drugs, Transportation, Vision, X-Ray | - Family Practitioners  
- General Practitioners  
- Indian Health Service (IHS) Providers  
- Internists  
- Nurse Practitioners  
- Obstetricians/Gynecologists  
- Pediatricians  
- Physician Assistants |

### Enrollment

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<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
</table>
| None                              | - 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 |

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<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
<th>Lock-In Provision:</th>
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<tr>
<td>- No populations are excluded</td>
<td>12 month lock-in</td>
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<tr>
<td>- None - managed care entity provides standard prescription drug coverage</td>
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</tr>
</tbody>
</table>
**ARIZONA**

**Arizona Health Care Cost Containment System (AHCCCS)**

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
- Obstetricians/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

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

**Medicare Dual Eligibles Excluded:**
- None

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

### Part D Benefit

**MCE has Medicare Contract:**
- Yes

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

**Provides Part D Benefits:**
- No

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

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
- None - managed care entity provides standard prescription drug coverage

---

**SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS**

174
Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Acute uses health risk assessment form to identify members
- ALTCS considers all members special needs

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

| AZ Physicians IPA (Family Planning Extension) | 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) | Cochise Co. Dept. of Health Services (PC) |
| Department of Economic Security/Childrens Medical and Dental Program (Family Planning Extension) | Department of Economic Security/Childrens Medical and Dental Program (HP) |
| Department of Economic Security/Division of Developmental Disabilities (PC) | Department of Health Services (Behavioral Health) |
| 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) |
| Pima Health System (Family Planning Extension) | Pima Health System (HP) |
| Pima Health System (PC) | Pinal County Long Term Care (PC) |
| SCAN | University Family Care (Family Planning Extension) |
| University Family Care (HP) | Yavapai County Long Term Care (PC) |

ADDITIONAL INFORMATION

12 months guaranteed eligibility for deemed newborns/born to mothers receiving Medicaid (Title XIX). Otherwise, 6 months eligibility guarantee for individuals enrolled with a health plan for the first time and become ineligible prior to 6 months of enrollment. This 6 month guarantee does not apply to members receiving Long Term Care services.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
- 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

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

- Quality Management/Quality Improvement Annual Plans and Annual Evaluations

**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. NCPDP, ASC X12 837)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

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

**Validation - Methods:**
- Automated analysis of encounter data submission to help determine 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

**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

**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 home health visits per beneficiary
- Number of PCP visits per beneficiary
- Percentage of beneficiaries with at least one dental visit
- Re-admission rates of MH/SUD

## Health Plan Stability/Financial/Cost of Care:
- Agency performance bond requirements
- Financial Viability Ratios (i.e., Current Ratio, Medical Expense, Administrative, Equity/Member)
- Net income
- Total revenue

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

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

### Clinical Topics:
- Childhood Immunization
- Diabetes management
- Medical problems of the elderly
- 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 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

### Accreditation Required for Participation:
None
**Arizona Health Care Cost Containment System (AHCCCS)**

- Healthcare Organizations Standards
- Managed Care Rules (BBA)
- NCQA (National Committee for Quality Assurance) Standards
- State-Developed/Specified Standards
- URAC Standards

<table>
<thead>
<tr>
<th>Non-Duplication Based on Accreditation:</th>
<th>EQRO Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- Health Services Advisory Group</td>
</tr>
<tr>
<td></td>
<td>- Healthcare Excel</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>EQRO Organization:</th>
<th>EQRO Mandatory Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Quality Improvement Organization (QIO)</td>
<td>- Review of MCO compliance with structural and operational standards established by the State</td>
</tr>
<tr>
<td></td>
<td>- Validation of some performance improvement projects</td>
</tr>
<tr>
<td></td>
<td>- Validation of some performance measures</td>
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</tbody>
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<table>
<thead>
<tr>
<th>EQRO Optional Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Ad hoc QM reviews</td>
</tr>
<tr>
<td>- Administration or validation of consumer or provider surveys</td>
</tr>
<tr>
<td>- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services</td>
</tr>
</tbody>
</table>

**Pay for Performance (P4P)**

<table>
<thead>
<tr>
<th>Implementation of P4P:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The State HAS NOT implemented a Pay-for-Performance program with the MCO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Payers:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
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</table>

<table>
<thead>
<tr>
<th>Population Categories Included:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Rewards Model:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
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</table>

<table>
<thead>
<tr>
<th>Clinical Conditions:</th>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
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</table>

<table>
<thead>
<tr>
<th>Measurement of Improved Performance:</th>
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<tr>
<td>Not Applicable</td>
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</table>

<table>
<thead>
<tr>
<th>Initial Year of Reward:</th>
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<tr>
<td>Not Applicable</td>
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<thead>
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<th>Evaluation Component:</th>
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<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Member Incentives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
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</tbody>
</table>

**QUALITY ACTIVITIES FOR PIHP**

<table>
<thead>
<tr>
<th>State Quality Assessment and Improvement Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Consumer Self-Report Data (see below for details)</td>
</tr>
<tr>
<td>- Encounter Data (see below for details)</td>
</tr>
<tr>
<td>- Enrollee Hotlines</td>
</tr>
<tr>
<td>- Focused Studies</td>
</tr>
<tr>
<td>- Monitoring of PIHP Standards</td>
</tr>
<tr>
<td>- Ombudsman</td>
</tr>
<tr>
<td>- On-Site Reviews</td>
</tr>
<tr>
<td>- Performance Improvement Projects (see below for details)</td>
</tr>
<tr>
<td>- Performance Measures (see below for details)</td>
</tr>
<tr>
<td>- Physician Survey</td>
</tr>
<tr>
<td>- PIHP Standards (see below for details)</td>
</tr>
<tr>
<td>- Provider Data</td>
</tr>
<tr>
<td>- Quality Management/Quality Improvement Annual Plans and Annual Evaluations</td>
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</table>

<table>
<thead>
<tr>
<th>Use of Collected Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Contract Standard Compliance</td>
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<tr>
<td>- Fraud and Abuse</td>
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<tr>
<td>- Health Services Research</td>
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<tr>
<td>- Monitor Quality Improvement</td>
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<td>- Plan Reimbursement</td>
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<tr>
<td>- Program Evaluation</td>
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<td>- Program Modification, Expansion, or Renewal</td>
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<tr>
<td>- Regulatory Compliance/Federal Reporting</td>
</tr>
<tr>
<td>- Track Health Service provision</td>
</tr>
</tbody>
</table>
## ARIZONA
### Arizona Health Care Cost Containment System (AHCCCS)

### 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/require PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

### Encounter Data

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

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

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

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

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

#### State conducts general data completeness assessments:
- Yes

### Performance Measures

#### Process Quality:
- Appropriateness of services
- Coordination of care with acute contractors/pcp's
- Member/Family involvement
- Percentage of beneficiaries who are satisfied with their

#### Health Status/Outcomes Quality:
- Coordination of Care
- Patient satisfaction with care
- Symptomatic and functional improvement
- Transition of Care
# ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Access to care/appointment availability</td>
<td>- Drug Utilization</td>
</tr>
<tr>
<td>- Appointment Standards</td>
<td>- Inpatient admission for MH/SUD conditions/1,000 beneficiaries</td>
</tr>
<tr>
<td>- Ratio of mental health providers to number of beneficiaries</td>
<td>- Inpatient admissions/1,000 beneficiary</td>
</tr>
<tr>
<td></td>
<td>- Re-admission rates of MH/SUD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Plan Stability/ Financial/Cost of Care:</th>
<th>Health Plan/ Provider Characteristics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Agency performance bond requirements</td>
<td>- Languages Spoken (other than English)</td>
</tr>
<tr>
<td>- Financial Viability Ratios (i.e., Current Ratio, Medical Expense, Administrative, Equity/Member)</td>
<td></td>
</tr>
<tr>
<td>- Net income</td>
<td></td>
</tr>
<tr>
<td>- State minimum reserve requirements</td>
<td></td>
</tr>
<tr>
<td>- Total revenue</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Geographic</td>
<td>None</td>
</tr>
<tr>
<td>- Information of beneficiary ethnicity/race</td>
<td></td>
</tr>
<tr>
<td>- Percentage of beneficiaries who are auto-assigned to PIHPs</td>
<td></td>
</tr>
<tr>
<td>- PIHP/PCP-specific disenrollment rate</td>
<td></td>
</tr>
</tbody>
</table>

## Performance Improvement Projects

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

### Clinical Topics:
- Access to Care
- Behavior health assessment - birth to 5 years of age
- Coordination of primary and behavioral health care
- Follow-up after hospitalization
- Informed consent for psychotropic medication prescription
- Pharmacy management
- Reducing the use of seclusion & restraint
- Transition of Care

### Non-Clinical Topics:
- Availability of language interpretation services

## Standards/Accreditation

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

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

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

### EQRO Name:
Health Care Excel

### EQRO Mandatory Activities:
- Review of PIHP compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures
ARIZONA
Arizona Health Care Cost Containment System (AHCCCS)

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
Connectcare

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)(23) Freedom of Choice

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

SERVICE DELIVERY

PCCM Provider - Primary Care Case Management Fee

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
-Obstetricians/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
ARKANSAS
Connectcare

Subpopulations Excluded from Otherwise Included Populations:
- Eligibility Period that is Retroactive
- family planning waiver
- Medically Needy "Spenddown" Categories
- Medicare Dual Eligibles
- Particpate in HCBS Waiver
- Poverty Level Pregnant Woman
- Reside in Nursing Facility or ICF/MR

Medicare Dual Eligibles Included:
None

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

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Connect Care

ADDITIONAL INFORMATION
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**

<table>
<thead>
<tr>
<th>Process Quality:</th>
<th>Health Status/Outcomes Quality:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- Number of children with diagnosis of rubella (measles)/1,000 children</td>
</tr>
<tr>
<td></td>
<td>- Percentage of low birth weight infants</td>
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<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Ratio of primary care case managers to beneficiaries</td>
<td>- Inpatient admissions/1,000 beneficiaries</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Provider Characteristics:</th>
<th>Beneficiary Characteristics:</th>
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<tr>
<td>None</td>
<td>None</td>
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<table>
<thead>
<tr>
<th>Performance Measures - Others:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
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</tbody>
</table>
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:
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)(5) Guaranteed Eligibility
-1902(a)(6) Advance Payment
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13) Payment to Providers
-1902(a)(23) Freedom of Choice

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

SERVICE DELIVERY

HIO - Risk-based Capitation

Service Delivery

Included Services:
Acute ICF Visits, Comprehensive Case Management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education and Counseling, Health Risk Assessment (HRA), Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Long Term Care, 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, 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 or Gynecologists
-Pediatricians
-Specialty Providers (MD)
### CALIFORNIA

**Bridge to Reform Demonstration: COHS Model**

#### Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>None</th>
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</thead>
<tbody>
<tr>
<td><strong>Populations Mandatorily Enrolled:</strong></td>
<td></td>
</tr>
<tr>
<td>-Aged and Related Populations</td>
<td></td>
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<tr>
<td>-Blind/Disabled Adults and Related Populations</td>
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<tr>
<td>-Blind/Disabled Children and Related Populations</td>
<td></td>
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<tr>
<td>-Breast and Cervical Cancer Preventive Treatment</td>
<td></td>
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<tr>
<td>-Children with Accelerated Eligibility</td>
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<tr>
<td>-Foster Care Children</td>
<td></td>
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<tr>
<td>-Medi-Cal Eligibles with Share Cost</td>
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<tr>
<td>-Medically Needy</td>
<td></td>
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<tr>
<td>-Medicare Dual Eligibles</td>
<td></td>
</tr>
<tr>
<td>-Section 1931 Adults and Related Populations</td>
<td></td>
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<tr>
<td>-Section 1931 Children and Related Populations</td>
<td></td>
</tr>
<tr>
<td>-Title XXI CHIP (non-State only Healthy Families)</td>
<td></td>
</tr>
</tbody>
</table>

| Subpopulations Excluded from Otherwise Included Populations: |
| -CHIP Title XXI (State-only Healthy Families) |
| -Enrolled in another Medicaid Managed Care program |
| -Medicare Dual Eligibles |
| **Lock-In Provision:** |
| Does not apply because State only contracts with one managed care entity |

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

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

| QMB |

#### Part D Benefit

| MCE has Medicare Contract: |
| No |

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

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

#### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

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

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

#### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

| Caloptima-Orange |
| Central California Alliance For Health |
| Gold Coast Health Plan |
| Health Plan of San Mateo |
| Partnership Health Plan |
| Santa Barbara San Luis Obispo Regional Health Authority |
CALIFORNIA
Bridge to Reform Demonstration: COHS Model

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)
- Enrollee Hotlines
- Focused Studies
- MCO Standards (see below for details)
- Ombudsman
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

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

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

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

Encounter Data

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

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

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

<table>
<thead>
<tr>
<th>MCO/HIO conducts data accuracy check(s) on specified data elements:</th>
<th>State conducts general data completeness assessments:</th>
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<tr>
<td>- Date of Service</td>
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<tr>
<td>- Date of Processing</td>
<td></td>
</tr>
<tr>
<td>- Date of Payment</td>
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<tr>
<td>- Provider ID</td>
<td></td>
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<tr>
<td>- Medicaid Eligibility</td>
<td></td>
</tr>
<tr>
<td>- Procedure Codes</td>
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</tbody>
</table>

### Performance Measures

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

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

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

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

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

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

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

#### Performance Measures - Others:
- None

### Performance Improvement Projects

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

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

**Bridge to Reform Demonstration: COHS Model**

Project(s) prescribed by State Medicaid agency

**Non-Clinical Topics:**
None

### Standards/Accreditation

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

**Accreditation Required for Participation:**
None

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

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

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

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

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

### Pay for Performance (P4P)

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

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Not Applicable

**Initial Year of Reward:**
Not Applicable

**Evaluation Component:**
Not Applicable

**Member Incentives:**
Not Applicable
CALIFORNIA
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

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

For All Areas Phased-In:
No
Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Acute ICF, Comprehensive Case Management, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, FQHCs, Health Education, Health Risk Assessment (HRA), Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Long Term Care Services for Month of Admission Plus one Additional Month, Nurse Practitioner, Optometry, Outpatient Hemodialysis, Outpatient Hospital, Outpatient Mental Health, Outpatient Rehab, Pharmacy, Physical Therapy, Physician, 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 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
- Foster Care/Medically Indigent Child
- 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

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

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

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

Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Developmental Disabilities Agency
- Education Agency
- Home and Community Based Care
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency
- Title V
PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem Blue Cross Partnership Plan - Sacramento
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
- Focused Studies
- MCO Standards (see below for details)
- Ombudsman
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

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

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

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

Collection: Requirements:
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- 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

Validation - Methods:
- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency
CALIFORNIA
Bridge to Reform Demonstration: Geographic Managed Care Model

-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.

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

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

State conducts general data completeness assessments:
Yes

Performance Measures

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

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

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

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

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

Health Plan/ Provider Characteristics:
-Board Certification
-Languages Spoken (other than English)
CALIFORNIA
Bridge to Reform Demonstration: Geographic Managed Care Model

Beneficiary Characteristics:
- Information on primary languages spoken by beneficiaries
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCO

Performance Measures - Others:
None

Performance Improvement Projects

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

Clinical Topics:
- Cervical cancer screening among seniors and persons with disabilities
- Childhood obesity
- Emergency Room service utilization
- Hypertension management
- Postpartum care

Non-Clinical Topics:
None

Clinical Topics:
- Cervical cancer screening among seniors and persons with disabilities
- Childhood obesity
- Emergency Room service utilization
- Hypertension management
- Postpartum care

Non-Clinical Topics:
None

Standards/Accreditation

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

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
- Quality Improvement Organization (QIO)

EQRO Name:
- Health Services Advisory Group

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

EQRO Optional Activities:
- 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
California Bridge to Reform Demonstration: Geographic Managed Care Model

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
Initial Waiver Approval Date: November 01, 2010

Operating Authority: 1115(a) - Demonstration Waiver Program
Implementation Date: November 01, 2010

Statutes Utilized: Not Applicable
Waiver Expiration Date: October 31, 2015

Enrollment Broker: No
Sections of Title XIX Waived:

For All Areas Phased-In: Yes
Sections of Title XIX Costs Not Otherwise Matchable

Guaranteed Eligibility: None
Granted: None

SERVICE DELIVERY

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

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 Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists or Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)
-Specialized Providers (MDs)
Enrollment

**Populations Voluntarily Enrolled:**
- HCCI: Individuals between 19-64 (not enrolled in Medicaid with incomes between above 133% up to 200%)
- MCE: Individuals between 19-64 (not enrolled in Medicaid with incomes at or below 133% FPL)

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

**Medicare Dual Eligibles Included:**
None

**Populations Mandatorily Enrolled:**
None

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

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

Part D Benefit

**MCE has Medicare Contract:**
Yes

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

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

**Provides Part D Benefits:**
Yes

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

- Access Coverage Enrollment Program
- Health Way LA
- Kern Medical Center Health Plan
- San Diego LIHP
- SF Path
- Contra Costa Health Plan
- HealthyPAC
- Medical Services Initiative
- San Mateo Access & Care
- Valley Care

ADDITIONAL INFORMATION

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

QUALITY ACTIVITIES FOR PIHP
**State Quality Assessment and Improvement Activities:**
- Encounter Data  (see below for details)
- Performance Measures (see below for details)

**Use of Collected Data:**
- Plan Reimbursement
- 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

**Consumer Self-Report Data:**
None

**Use of Collected Data:**

**Encounter Data**

**Collection: Requirements:**
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Requirements for data validation
- 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)
- Plans submit encounter data quarterly

**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

**Performance Measures**

**Process Quality:**
None

**Health Status/Outcomes Quality:**
None

**Access/Availability of Care:**
- Timely access

**Use of Services/Utilization:**
- Rate of service utilization 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**

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### Bridge to Reform Demonstration: LIHP Model

<table>
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<th>PIHP Standards:</th>
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<td>-NA (Exempt)</td>
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| 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: Count

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, EPSDT, Health Education, Prevention, Screening

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
CALIFORNIA
Bridge to Reform Demonstration: Sacramento Dental PAHP

- Pregnant/Medically Indigent-Adult

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

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

Lock-In Provision:
No lock-in

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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

Community Dental Services/Sacramento
Liberty Dental Plan of CA/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)

Use of Collected Data:
- Contract Standard Compliance
- Track Health Service provision
CALIFORNIA
Bridge to Reform Demonstration: Sacramento Dental PAHP

-Performance Measures (see below for details)

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

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

Guaranteed Eligibility: No guaranteed eligibility

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), Home Health, 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, 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

**Subpopulations Excluded from Otherwise Included Populations:**
- Eligibility Period Less Than 3 Months
- Enrolled in Another Managed Care Program
- Medicare Dual Eligibles
- Other Insurance
- Participate in HCBS Waiver
- Poverty Level Pregnant Woman
- Reside in Nursing Facility or ICF/MR
- Title XXI CHIP (State only Healthy Families)

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

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

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

**Part D Benefit**

**MCE has Medicare Contract:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

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

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- California Childrens Services
- Department of Managed Health Care
- Developmental Disabilities Agency
- Early Periodic Screening Diagnosis and Treatment Program
- Education Agency
- Mental Health Agency
program linkage and/or family contact
-Uses provider referrals to identify members of these groups
-Utilization data (TAR, FFS, AC)

-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Plan/Partnership Plan/TPMP</th>
<th>Plan/Partnership Plan/TPMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda Alliance for Health</td>
<td>Anthem Blue Cross Partnership Plan-TPMP</td>
</tr>
<tr>
<td>CalViva Health</td>
<td>Contra Costa Health Plan</td>
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<td>Health Net Community Solutions, Inc.-TPMP</td>
<td>Health Plan of San Joaquin</td>
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<td>Inland Empire Health Plan</td>
<td>Kern Family Health Care</td>
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<td>LA Care Health Plan</td>
<td>Molina Healthcare of California Partner Plan, Inc.-TPMP</td>
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<tr>
<td>San Francisco Health Plan</td>
<td>Santa Clara Family Health Plan</td>
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</tbody>
</table>

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

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

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

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

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
-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
### CALIFORNIA

**Bridge to Reform Demonstration: Two-Plan Model**

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

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

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

#### State conducts general data completeness assessments:
- Yes

### Performance Measures

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

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

#### Access/Availability of Care:
- Average distance to PCP
- Average wait time for an appointment with PCP
- Percent of PCPs with open or closed patient assignment panels
- Ratio of PCPs to beneficiaries

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

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

#### Health Plan/Provider Characteristics:
- Languages Spoken (other than English)
- Provider turnover
CALIFORNIA
Bridge to Reform Demonstration: Two-Plan Model

State minimum reserve requirements
-Total revenue

Beneficiary Characteristics:
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCO

Performance Measures - Others:
None

Performance Improvement Projects

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

Clinical Topics:
-Adolescent obesity
-Asthma management
-Attention deficit hyperactivity disorder management
-Cervical cancer screening among seniors and persons with disabilities
-Childhood obesity
-Comprehensive diabetic quality improvement
-Diabetic testing & retinal exam screening
-Emergency Room service utilization
-Hypertension management
-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 Organization:
-Quality Improvement Organization (QIO)

EQRO Name:
-Health Services Advisory Group

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

EQRO Optional Activities:
-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

Rewards Model:
 Preferential auto-enrollment to reward MCOs
Eligibility

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

<table>
<thead>
<tr>
<th>State Medicaid Contact</th>
<th>Glyne Williams</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Division of Medicaid and Medical Services</td>
</tr>
<tr>
<td></td>
<td>(302) 255-9628</td>
</tr>
<tr>
<td>State Website Address</td>
<td><a href="http://www.dmap.state.de.us">http://www.dmap.state.de.us</a></td>
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### PROGRAM DATA

<table>
<thead>
<tr>
<th>Program Service Area</th>
<th>Initial Waiver Approval Date:</th>
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<tr>
<td>Statewide</td>
<td>May 17, 1995</td>
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<thead>
<tr>
<th>Operating Authority</th>
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<tr>
<td>1115(a) - Demonstration Waiver Program</td>
<td>January 01, 1996</td>
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<tr>
<th>Statutes Utilized</th>
<th>Waiver Expiration Date:</th>
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<table>
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<tr>
<th>Enrollment Broker</th>
<th>Sections of Title XIX Waived:</th>
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<tbody>
<tr>
<td>HP Enterprise Services, LLC</td>
<td>-1902(a)(1) Statewidensss</td>
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<tr>
<td></td>
<td>-1902(a)(10)(B) Amount, Duration and Scope</td>
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<td>-1902(a)(23) Freedom of Choice</td>
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<td>-1902(a)(34)</td>
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<td>-1902(a)(43)</td>
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<table>
<thead>
<tr>
<th>For All Areas Phased-In</th>
<th>Sections of Title XIX Costs Not Otherwise Matchable Granted:</th>
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<tbody>
<tr>
<td>No</td>
<td>-1902(a)(43)</td>
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<tr>
<td></td>
<td>-Budget Neutrality</td>
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<tr>
<td></td>
<td>-Eligibility Expansion</td>
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<tr>
<td></td>
<td>-Family Planning Expenditures</td>
</tr>
</tbody>
</table>

| Guaranteed Eligibility    |                                                               |
|----------------------------|                                                               |
| No guaranteed eligibility |                                                               |

### SERVICE DELIVERY

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

**Service Delivery**

<table>
<thead>
<tr>
<th>Included Services</th>
<th>Allowable PCPs</th>
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</thead>
<tbody>
<tr>
<td>Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Mental Health, Inpatient Substance Use Disorders, Integrated Services, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Podiatry, Private Duty Nursing, Skilled Nursing Facility, Speech Therapy, Vision, X-Ray</td>
<td>-Addictionologists</td>
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<td></td>
<td>-Clinical Social Workers</td>
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<td>-Family Practitioners</td>
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<td>-Federally Qualified Health Centers (FQHCs)</td>
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<td>-General Practitioners</td>
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<td>-Internists</td>
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<td>-Nurse Practitioners</td>
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<td>-Obstetricians/Gynecologists or Gynecologists</td>
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<td>-Pediatricians</td>
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<td>-Psychiatrists</td>
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<tr>
<td></td>
<td>-Psychologists</td>
</tr>
<tr>
<td></td>
<td>-Rural Health Clinics (RHCs)</td>
</tr>
</tbody>
</table>
## 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

**Medicare Dual Eligibles Included:** None

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

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

## Part D Benefit

**MCE has Medicare Contract:** No

**Provides Part D Benefits:** Not Applicable

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

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

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:** None
# DELAWARE DIAMOND STATE HEALTH PLAN

## Fee for Service Model - Risk-based Capitation

### Service Delivery

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
</tr>
</thead>
</table>
| 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 | -Addictionologists  
-Physical Social Workers  
-Family Practitioners  
-Federally Qualified Health Centers (FQHCs)  
-General Practitioners  
-Internists  
-Nurse Midwives  
-Nurse Practitioners  
-Obstetricians/Gynecologists  
-Pediatricians  
-Psychiatrists  
-Psychologists  
-Rural Health Clinics (RHCs) |

### 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

### Medicare Dual Eligibles Included:
None

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

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

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
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<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

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**SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS**

---

211
Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Asks advocacy groups to identify members of these groups
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Delaware Physicians Care, Inc
UnitedHealthcare Community Plan

ADDITIONAL INFORMATION
The Diamond State Health Plan (DSHP) is a state-wide mandatory managed care program. Approximately 80% of the Delaware Medicaid population is included in this program with the exception of member in other community-based waivers and Medicare dual eligibles. The DSHP includes an expansion population of adults with incomes below 100% of FPL.

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

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/requirements MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous enrollment requirement for some or all of the measures
DELAWARE
DIAMOND STATE HEALTH PLAN

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

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

MCO/HIO conducts data accuracy check(s) on specified data elements:
- Provider ID
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
- Adolescent immunization rate
- Adolescent well-care visit rate
- Antidepressant medication management
- Appropriate treatment for Children with Upper Respiratory Infection (URI)
- Asthma care - medication use
- Breast Cancer screening rate
- Cervical cancer screening rate
- Cholesterol screening and management
- Controlling high blood pressure
- Immunizations for two year olds
- Lead screening rate
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
- Blood tests results for diabetes
- Obesity rates for adolescents
- Patient satisfaction with care
- Percentage of low birth weight infants
- Provider surveys

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

Use of Services/Utilization:
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
## DELAWARE
### DIAMOND STATE HEALTH PLAN

<table>
<thead>
<tr>
<th>Children's access to primary care practitioners</th>
<th>Inpatient admissions/1,000 beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of PCPs with open or closed patient assignment panels</td>
<td>Number of PCP visits per beneficiary</td>
</tr>
<tr>
<td>Ratio of PCPs to beneficiaries</td>
<td></td>
</tr>
</tbody>
</table>

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

### Health Plan/ Provider Characteristics:
None

### Beneficiary Characteristics:
None

### Performance Measures - Others:
None

### Performance Improvement Projects

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

#### Clinical Topics:
- Breast cancer screening (Mammography)
- Cervical cancer screening (Pap Test)
- Childhood Immunization
- Coordination of care for persons with physical disabilities
- Diabetes management
- Emergency Room service utilization
- Low birth-weight baby
- Pharmacy management
- Pre-natal care

#### Non-Clinical Topics:
- Availability of language interpretation services
- Health information technology (e.g. state implementation of immunization and other registries, telemedicine initiatives, etc...)
- Reducing health care disparities via health literacy, education campaigns, or other initiatives

### Standards/Accreditation

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

#### Accreditation Required for Participation:
None

#### 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

#### 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
Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO, but plans to implement one in the future.

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

Clinical Conditions:
Possible clinical conditions not yet identified.

Initial Year of Reward:
Not Applicable.

Member Incentives:
Not Applicable.

Program Payers:
Medicaid has collaborated with a private sector entity to support the P4P program.

Rewards Model:
To be determined.

Measurement of Improved Performance:
To be determined.

Evaluation Component:
Not Applicable.
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
- Obstetricians/Gynecologists or Gynecologists
- Other Addiction Professionals (i.e. Substance Use Disorder counselors, alcohol and drug counselors,
- Pediatricians
- Physician Assistants
- Psychiatrists
- Psychologists
DISTRIBUTION OF COLUMBIA
Childless Adults 1115 Demonstration

Enrollment

Populations Voluntarily Enrolled: None

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)

Medicare Dual Eligibles Included: None

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

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

Lock-In Provision:
- 12 month lock-in

Part D Benefit

MCE has Medicare Contract:
- No

Provides Part D Benefits:
- Not Applicable

Scope of Part D Coverage:
- Not Applicable

Part D - Enhanced Alternative Coverage:
- Not Applicable

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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
DISTRICT OF COLUMBIA
Childless Adults 1115 Demonstration

**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**

<table>
<thead>
<tr>
<th>Collection: Requirements:</th>
<th>Collections: Submission Specifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Requirements for MCOs to collect and maintain encounter data</td>
<td>- Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)</td>
</tr>
<tr>
<td>- Specifications for the submission of encounter data to the Medicaid agency</td>
<td>- Guidelines for frequency of encounter data submission</td>
</tr>
<tr>
<td>- Standards to ensure complete, accurate, timely encounter data submission</td>
<td>- Use of Medicaid Identification Number for beneficiaries</td>
</tr>
</tbody>
</table>

**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 allowble range)

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
- 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**

<table>
<thead>
<tr>
<th>Process Quality:</th>
<th>Health Status/Outcomes Quality:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- Mortality rates</td>
</tr>
<tr>
<td></td>
<td>- Patient satisfaction with care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Plan Stability/ Financial/Cost of Care:</th>
<th>Health Plan/ Provider Characteristics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)</td>
<td>None</td>
</tr>
<tr>
<td>- Medical loss ratio</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Standards/Accreditation**

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## District of Columbia
### Childless Adults 1115 Demonstration

<table>
<thead>
<tr>
<th>MCO Standards:</th>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- NCQA (National Committee for Quality Assurance) Standards</td>
<td>- NCQA (National Committee for Quality Assurance)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Duplication Based on Accreditation:</th>
<th>EQRO Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- Delmarva Foundation for Medical Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EQRO Organization:</th>
<th>EQRO Mandatory Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Quality Improvement Organization (QIO)</td>
<td>- Validation of performance measures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EQRO Optional Activities:</th>
<th>Pay for Performance (P4P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Calculation of performance measures</td>
<td>Program Payers:</td>
</tr>
</tbody>
</table>

**Program Payers:**
- Medicaid is the only payer

### 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:
- 2010

### Member Incentives:
- Not Applicable

### Program Payers:
- Medicaid is the only payer

### Rewards Model:
- Withholds as an incentive

### 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.)

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

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-enrollemnt Expenditures
-Expenditures for employee costs of insurance for individuals who have opted out of Medicaid
-Expenditures for enhanced benefit accounts
-Expenditures for health care services provided under the Low Income Pool

Guaranteed Eligibility: No guaranteed eligibility

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
-Obstetricians/Gynecologists or Gynecologists
Florida Medicaid Reform

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

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- None - managed care entity provides standard prescription drug coverage
**FLORIDA**

**Florida Medicaid Reform**

Medical-only PIHP (risk or non-risk, non-comprehensive) - FFS w/ Some Risk Capitation

**Service Delivery**

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

**Allowable PCPs:**
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Internists
- Nurse Practitioners
- Obstetricians/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
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**Subpopulations Excluded from Otherwise Included Populations:**
- Family Planning Waiver Eligibles
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- Other Insurance
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- Reside in Nursing Facility or ICF/MR
- Women with Breast or Cervical Cancer

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

**Medicare Dual Eligibles Excluded:**
None

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

**Part D Benefit**

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

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

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

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

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**SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS**

**Program Includes People with Complex (Special) Needs:**
Yes
FLORIDA
Florida Medicaid Reform

Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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

ADDITIONAL INFORMATION

The Provider Service Networks are reimbursed on a fee-for-service basis for all Florida state plan covered services. Under Reform, the fee-for-service PSN must cover transportation, which is done on a capitated basis.

The Childrens Medical Services Network is classified as a Provider Service Network and a speciality plan under Medicaid Reform. This plan was developed to serve children with special health care needs as defined by Florida statutes on a voluntary basis.

AIDS Healthcare Foundation of Florida (AHF MCO), 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.

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
- Regulatory Compliance/Federal Reporting

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## Florida Medicaid Reform

### Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire (Modified)
  - Adult Medicaid SSI Questionnaire (Modified)
  - Children Medicaid AFDC Questionnaire (Modified)
  - Children Medicaid SSI Questionnaire (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 continuous enrollment requirement for some or all of the measures

### Encounter Data

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

#### Collection: Standardized Forms:
- 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.

#### 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

#### 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

### Validation - Methods:
- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
- Per member per month analysis and comparisons across MCO

### 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
- Cervical cancer screening rate
- Childhood Immunization Status-Combo 2 and 3
- Chlamydia Screening for Women
- Controlling high blood pressure

#### Health Status/Outcomes Quality:
- Comprehensive Diabetes Care
- 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
-Well-child care visit rates in first 15 months of life

Access/Availability of Care:
-Annual dental visit

Use of Services/Utilization:
-Adolescent 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

Clinical Topics:
-Adolescent Well Care/EPSDT
-Asthma management
-Child Health Checkups
-Childhood Immunization
-CLAS - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
-Clinical Health Care Disparities - Blood Lead Screening in African American Children
-Clinical Health Care Disparities: Oral Health (Annual Dental Visit)
-Coordination of care for persons with physical disabilities
-Depression management
-Follow-up After Discharge From Mental Health Acute Care Facility
-Improving Ambulatory Follow-up Appointments After Discharge From Inpatient Mental Health Treatment
-Improving Annual Dental Visits
-Inpatient maternity care and discharge planning
-Lead toxicity
-Sexually transmitted disease treatment
-Use of Appropriate Asthma Drug Therapy
-Well Child Care/EPSDT
-Well-Child Visits in the First 15 Months of Life - Six or More Visits

Non-Clinical Topics:
-Adolescent Child Health Check-up Participation Rates within and Across Racial Groups
Florida Medicaid Reform

- Behavioral Health Discharge Planning
- Disparity in Well-Checkup Visits between Younger and Older Children
- Improving Member Satisfaction With Customer Service
- Language and Culturally Appropriate Access to Preventive Health Care Services
- Member Service Call Answer Timeliness and Call Abandonment Rate
- Quality Assessment and Performance Improvement (QAIP)

Standards/Accreditation

MCO Standards:
- CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
- Standards for Medicaid and Medicare
- State-Developed/Specified Standards

Accreditation Required for Participation:
- AAAHC (Accreditation Association for Ambulatory Health Care)
- NCQA (National Committee for Quality Assurance)
- URAC

Non-Duplication Based on Accreditation:
None

EQRO Name:
- Health Systems Advisory Group (HSAG)

EQRO Organization:
- Health Systems Advisory Group (HSAG)
- Private accreditation organization

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

EQRO Optional Activities:
- Assessment of MCO information systems
- Calculation of performance measures
- Conduct of performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Technical Assistance
- 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
**FLORIDA**

**Florida Medicaid Reform**

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

### Use of Collected Data:
- Contract Standard Compliance
- Monitor Quality Improvement

### Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid SSI Questionaire (Modified)
  - Adult Medicaid TANF Questionaire (Modified)
  - Children Medicaid SSI Questionaire (Modified)
  - Children Medicaid TANF Questionaire (Modified)

### Use of HEDIS:
- The State uses SOME of the HEDIS measures listed for Medicaid
- State uses/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous enrollment requirement for some or all of the measures

### Performance Measures

#### Process Quality:
- Adolescent well-care visit rate
- Ambulatory Care
- Annual Dental Visit
- Cervical cancer screening rate
- Controlling high blood pressure
- Diabetes medication management
- Follow-up After Hospitalization for Mental Illness
- Follow-up after hospitalization for mental illness
- Mental Health Readmission Rate
- Mental Health Utilization
- Prenatal and Postpartum Care
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

#### Access/Availability of Care:
- Annual Dental Visit
- Prenatal and Postpartum Care

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

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

#### Use of Services/Utilization:
- Adolescent 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/ 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

#### Clinical Topics:
- Adolescent Immunization
FLORIDA
Florida Medicaid Reform

choosing
- 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

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

Initial Waiver Approval Date: July 16, 1993

Implementation Date: August 01, 1994

Waiver Expiration Date: June 30, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(10)(C)
-1902(a)(17)
-1902(a)(17)(D)
-1902(a)(23) Freedom of Choice
-1902(a)(34)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-HCBS
-MCO Definition 1903(m)(1)(A)
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)
-MCO Payments in non-rural areas to the extent necessary if a plan exceeds its enrollment cap 1903(m)(2)(A)(xii)

Guaranteed Eligibility: No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Cornea and Kidney Transplants and Bone Grafts, Dental,
Dietary, Durable Medical Equipment, EPSDT, HCBS,
Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient
Mental Health, Inpatient Substance Use Disorders,
Intermediate Care Facility, Laboratory, Language/Interpreter,
Long Term Care, Maternity, Occupational Therapy,
Optometry, Certified Nurse Midwife, Nurse Practitioner,
Physician Assistant, Outpatient Hospital, Outpatient Mental
Health, Outpatient Substance Use Disorders, Pharmacy,
Physical Therapy, Physician, Preventive, Skilled Nursing
Facility, Speech Therapy, Sterilization/Hysterectomies,

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

Populations Voluntarily Enrolled:
None

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

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

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-None - managed care entity provides standard prescription drug coverage

Program Includes People with Complex (Special) Needs:
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
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

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

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

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

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

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

Encounter Data
HAWAII
Hawaii QUEST Expanded (QEx)

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

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

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
- Adolescent immunization rate
- Adolescent well-care visit rates
- Annual monitoring for patients on persistent medication
- Antidepressant medication management
- Appropriate treatment for Children with Upper Respiratory Infection (URI)
- Asthma care - medication use
- Avoidance of antibiotic treatment in adults with acute bronchitis
- Beta-blocker treatment after heart attack
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Childhood immunizations
- Chlamydia 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

Use of Services/Utilization:
- Ambulatory care
- Drug Utilization
- Emergency room visits/1,000 beneficiary
# Hawaii QUEST Expanded (QEx)

## Health Plan Stability/ Financial/Cost of Care:
- Actual reserves held by plan
- Days cash on hand
- Days in unpaid claims/claims outstanding
- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Net income
- Net worth
- Relative resource use for people with asthma
- Relative resource use for people with diabetes
- State minimum reserve requirements
- Total revenue

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

## Non-Clinical Topics:
None

## Clinical Topics:
- Adolescent Well Care/EPSDT
- Asthma management
- Childhood Immunization
- Childhood obesity
- Diabetes management
- Emergency Room service utilization
- Well Child Care/EPSDT

## 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

## Performance Measures - Others:
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

**EQRO Organization:**
- Private accreditation organization
- Quality Improvement Organization (QIO)

**EQRO Name:**
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
HAWAII
Hawaii QUEST Expanded (QEx)

- Validation of performance measures

**EQRO Optional Activities:**
- Administration or validation of consumer or provider surveys
- Conduct of performance improvement projects
- Validation of encounter data

**Pay for Performance (P4P)**

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

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

**Clinical Conditions:**
5 conditions are measured 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

**Program Payers:**
Medicaid is the only payer

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

State Website Address:  
http://www.in.gov/fssa/2408.htm

PROGRAM DATA

Program Service Area:  
Statewide

Operating Authority:  
1115(a) - Demonstration Waiver Program

Statutes Utilized:  
Not Applicable

Enrollment Broker:  
Maximus

Initial Waiver Approval Date:  
December 14, 2007

Implementation Date:  
January 01, 2008

Waiver Expiration Date:  
December 31, 2012

Sections of Title XIX Waived:  
-1902(a)(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)(13)(A) Disproportionate Share Hospital (DSH)  
-1902(a)(23) Freedom of Choice  
-1902(a)(3)/1902(a)(8) Reasonable Promptness  
-1902(a)(34) Retroactive Eligibility  
-1902(a)(37)(B) Prepayment Review  
-1902(a)(4) Methods of Administration: Transportation  
-1902(a)(43) Dental and Vision Coverage for Certain HIP Caretakers and HIP Adults  
-1916(a)(1) Premiums

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

For All Areas Phased-In:  
No

Guaranteed Eligibility:  
No guaranteed eligibility

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,

Allowable PCPs:  
-Members are not required to select a primary care provider
## INDIANA
### Healthy Indiana Plan

**Smoking Cessation, Speech Therapy, X-Ray**

### Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>None</th>
</tr>
</thead>
</table>
| **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) |
| Populations Mandatorily Enrolled: | - Uninsured Adults Under 200% FPL |
| **Lock-in Provision:** | 12 month lock-in |
| **Medicare Dual Eligibles Included:** | None |
| **Medicare Dual Eligibles Excluded:** | Exclude all categories of Medicare Dual Eligibles |

### Part D Benefit

| MCE has Medicare Contract: | No |
| **Scope of Part D Coverage:** | Not Applicable |
| **Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:** | None |
| **Provides Part D Benefits:** | Not Applicable |
| **Part D - Enhanced Alternative Coverage:** | Not Applicable |

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

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

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

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

| Anthem-Healthy Indiana Plan | Enhanced Services Plan (ESP)-Healthy Indiana Plan |
| 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
- Focused Studies
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

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

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

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

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

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

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
**INDIANA**

**Healthy Indiana Plan**

<table>
<thead>
<tr>
<th><strong>electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.</strong></th>
<th><strong>language used to create an encounter data file for submission</strong></th>
</tr>
</thead>
</table>

**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 Organization:
- Independent Consultant

## EQRO Name:
- Burns & Associates, Inc.

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

## EQRO Optional Activities:
- An Independent Annual Report which documents accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstrations.
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

## Pay for Performance (P4P)

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

### Program Payers:
Not Applicable

### Population Categories Included:
Not Applicable

### Rewards Model:
Not Applicable

### Clinical Conditions:
Not Applicable

### Measurement of Improved Performance:
Not Applicable

### Initial Year of Reward:
Not Applicable

### Evaluation Component:
Not Applicable

### Member Incentives:
Not Applicable
INDIANA
Hoosier Healthwise (1115)

CONTACT INFORMATION

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

State Website Address: http://www.in.gov/fssa/2408.htm

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
Statewide December 14, 2007

Operating Authority: Implementation Date:
1115(a) - Demonstration Waiver Program January 01, 2008

Statutes Utilized: Waiver Expiration Date:
Not Applicable December 31, 2012

Enrollment Broker: Sections of Title XIX Waived:
Maximus -1902(a)(1) Statewidens/Uniformity

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
No -1902(a)(10)(B) Amount, Duration and Scope

Guaranteed Eligibility: Granted:
No guaranteed eligibility -1902(a)(13)(A) DSH Payments
-1902(a)(23) Freedom of Choice

-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
-Obstetricians/Gynecologists or Gynecologists
-Pediatricians

Enrollment

240
### INDIANA
**Hoosier Healthwise (1115)**

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- Poverty-Level Pregnant Women</td>
</tr>
<tr>
<td></td>
<td>- Section 1931 Adults and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Section 1931 Children and Related Populations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Enrolled in Another Managed Care Program</td>
</tr>
<tr>
<td>- Hospice</td>
</tr>
<tr>
<td>- Medicare Dual Eligibles</td>
</tr>
<tr>
<td>- Reside in Nursing Facility or ICF/MR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Included:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Excluded:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclude all categories of Medicare Dual Eligibles</td>
</tr>
</tbody>
</table>

**Part D Benefit**

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

**SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS**

<table>
<thead>
<tr>
<th>Program Includes People with Complex (Special) Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies Used to Identify Persons with Complex (Special) Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Uses Health Needs Screening</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agencies with which Medicaid Coordinates the Operation of the Program:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Eligibility Agency</td>
</tr>
<tr>
<td>- Enrollment Broker</td>
</tr>
<tr>
<td>- Health Plans</td>
</tr>
<tr>
<td>- PBM</td>
</tr>
<tr>
<td>- State Actuary</td>
</tr>
</tbody>
</table>

**PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS**

<table>
<thead>
<tr>
<th>Anthem-Hoosier Healthwise</th>
<th>Managed Health Services (MHS)-Hoosier Healthwise</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDwise-Hoosier Healthwise</td>
<td></td>
</tr>
</tbody>
</table>

**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
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

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

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 provisions

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

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.

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

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

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

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

**Hoosier Healthwise (1115)**

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Procedure Codes</th>
<th>Revenue Codes</th>
<th>Age-appropriate diagnosis/procedure</th>
<th>Gender-appropriate diagnosis/procedure</th>
</tr>
</thead>
</table>

### 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
- Controlling high blood pressure
- Depression management/care
- Diabetes Management
- Follow-up after hospitalization for mental illness
- Follow-Up for Children Prescribed ADHD Medications
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation and engagement of SUD treatment
- Initiation of Prenatal Care
- Lead screening rate
- Use of Imaging Studies for Low Back Pain
- Utilization for Ambulatory, Inpatient, and Mental Health Treatment
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

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

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

**Use of Services/Utilization:**
- Average number of visits to MH/SUD providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
- Re-admission rates of MH/SUD

**Health Plan Stability/ Financial/Cost of Care:**
- Administrative Cost Ratio
- Claims Payable per Member
- Cost per Member
- Days cash on hand
- Days in Claims Receivable
- Days in unpaid claims/claims outstanding
- Equity per Member
- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income

**Health Plan/ Provider Characteristics:**
- Grievance and Appeal Timeliness
- Languages Spoken (other than English)
- Provider Complaints
- Provider turnover
- Net worth
- Ratio Assets to Liabilities
- Revenue per Member
- State minimum reserve requirements
- Total revenue

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

Performance 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

Performance Measures - Others:
None

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

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

Pay for Performance (P4P)

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

Program Payers:
Medicaid is the only payer
INDIANA
Hoosier Healthwise (1115)

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

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

Initial Year of Reward:
2008

Member Incentives:
Not Applicable

Rewards Model:
Payment incentives/differentials 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
KENTUCKY
Kentucky Health Care Partnership Program

CONTACT INFORMATION

State Medicaid Contact: April Lowery
Kentucky Department for Medicaid Services
(502) 564-8196

State Website Address: http://www.chfs.ky.gov/dms

PROGRAM DATA

Program Service Area: Region
Operating Authority: 1115(a) - Demonstration Waiver Program
Statutes Utilized: Not Applicable
Enrollment Broker: No
For All Areas Phased-In: Yes

Guaranteed Eligibility: 6 months guaranteed eligibility

Initial Waiver Approval Date: October 06, 1995
Implementation Date: November 01, 1997
Waiver Expiration Date: 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
**KENTUCKY**

**Kentucky Health Care Partnership Program**

- Physician Assistants
- Rural Health Centers (RHCs)

## Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
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<tbody>
<tr>
<td>None</td>
<td>Aged and Related Populations</td>
</tr>
<tr>
<td></td>
<td>Blind/Disabled Adults and Related Populations</td>
</tr>
<tr>
<td></td>
<td>Blind/Disabled Children and Related Populations</td>
</tr>
<tr>
<td></td>
<td>Foster Care Children</td>
</tr>
<tr>
<td></td>
<td>Medicare Dual Eligibles</td>
</tr>
<tr>
<td></td>
<td>Section 1931 Adults and Related Populations</td>
</tr>
<tr>
<td></td>
<td>Section 1931 Children and Related Populations</td>
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<tr>
<td></td>
<td>Title XXI CHIP</td>
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<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
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<tbody>
<tr>
<td>Eligibility for Spend down</td>
</tr>
<tr>
<td>Medicare Dual Eligibles</td>
</tr>
<tr>
<td>Participate in HCBS Waiver</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility PRTF</td>
</tr>
<tr>
<td>Reside in Nursing Facility or ICF/MR</td>
</tr>
<tr>
<td>Residents of Institutions for Mental Disease</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Included:</th>
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</thead>
<tbody>
<tr>
<td>QMB Plus, SLMB Plus, and Medicaid only</td>
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</tbody>
</table>

<table>
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<th>Medicare Dual Eligibles Excluded:</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB</td>
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<tr>
<td>SLMB, Qi, and QDWI</td>
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## Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
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<tbody>
<tr>
<td>Yes</td>
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<table>
<thead>
<tr>
<th>Provides Part D Benefits:</th>
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<tbody>
<tr>
<td>No</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Part D - Enhanced Alternative Coverage:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None - managed care entity provides standard prescription drug coverage</td>
</tr>
</tbody>
</table>

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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<th>Program Includes People with Complex (Special) Needs:</th>
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<tbody>
<tr>
<td>Yes</td>
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<table>
<thead>
<tr>
<th>Strategies Used to Identify Persons with Complex (Special) Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asks advocacy groups to identify members of these groups</td>
</tr>
<tr>
<td>Reviews complaints and grievances to identify members of these groups</td>
</tr>
<tr>
<td>Uses claims data to identify members of these groups</td>
</tr>
<tr>
<td>Uses provider referrals to identify members of these groups</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agencies with which Medicaid Coordinates the Operation of the Program:</th>
</tr>
</thead>
<tbody>
<tr>
<td>KY Commission for Children with Special Health Care Needs</td>
</tr>
<tr>
<td>Maternal and Child Health Agency</td>
</tr>
<tr>
<td>Mental Health Agency</td>
</tr>
<tr>
<td>Public Health Agency</td>
</tr>
<tr>
<td>Social Services Agency</td>
</tr>
<tr>
<td>Substance Abuse Agency</td>
</tr>
<tr>
<td>Transportation Agency</td>
</tr>
</tbody>
</table>
State Quality Assessment and Improvement
Activities:
- Accreditation for Participation
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- Ombudsman
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

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

Consumer Self-Report Data:
None

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

Encounter Data

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

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

Collection: Standardized Forms:
None

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

**Beneficiary Characteristics:**
None

**Health Plan/ Provider 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**

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# KENTUCKY
Kentucky Health Care Partnership Program

<table>
<thead>
<tr>
<th>MCO Standards:</th>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare</td>
<td>- Plan required to obtain MCO accreditation by NCQA or other accrediting body</td>
</tr>
<tr>
<td>- JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards</td>
<td></td>
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<tr>
<td>- NCQA (National Committee for Quality Assurance) Standards</td>
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<tr>
<td>- Standards for Medicaid and Medicare</td>
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</table>

<table>
<thead>
<tr>
<th>Non-Duplication Based on Accreditation:</th>
<th>EQRO Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- Island Peer Review Organization (IPRO)</td>
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<table>
<thead>
<tr>
<th>EQRO Organization:</th>
<th>EQRO Mandatory Activities:</th>
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</thead>
<tbody>
<tr>
<td>- Quality Improvement Organization (QIO)</td>
<td>- Review of MCO compliance with structural and operational standards established by the State</td>
</tr>
<tr>
<td></td>
<td>- Validation of performance improvement projects (PIPs)</td>
</tr>
<tr>
<td></td>
<td>- Validation of performance measures reported by MCO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EQRO Optional Activities:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Administration or validation of consumer or provider surveys</td>
<td></td>
</tr>
<tr>
<td>- Conduct of performance improvement projects</td>
<td></td>
</tr>
<tr>
<td>- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services</td>
<td></td>
</tr>
<tr>
<td>- Review of high cost services and procedures</td>
<td></td>
</tr>
<tr>
<td>- Technical assistance to MCOs to assist them in conducting quality activities</td>
<td></td>
</tr>
<tr>
<td>- Validation of client level data, such as claims and encounters</td>
<td></td>
</tr>
</tbody>
</table>

## Pay for Performance (P4P)

<table>
<thead>
<tr>
<th>Implementation of P4P:</th>
<th>Program Payers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The State HAS NOT implemented a Pay-for-Performance program with the MCO</td>
<td>Not Applicable</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Population Categories Included:</th>
<th>Rewards Model:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Conditions:</th>
<th>Measurement of Improved Performance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Initial Year of Reward:</th>
<th>Evaluation Component:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Member Incentives:</th>
<th></th>
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<tbody>
<tr>
<td>Not Applicable</td>
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</tbody>
</table>
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: Initial Waiver Approval Date:
Parish September 22, 2010

Operating Authority: Implementation Date:
1115(a) - Demonstration Waiver Program October 01, 2010

Statutes Utilized: Waiver Expiration Date:
Not Applicable December 31, 2013

Enrollment Broker: Sections of Title XIX Waived:
No

-1902(a)(1) Statewidiness
-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: Sections of Title XIX Costs Not Otherwise Matchable
No Granted:

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

All-Inclusive Encounter-Based Rates - Other

Service Delivery

Included Services:
Basic behavioral care services include mental health 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
LOUISIANA  
Greater New Orleans Community Health Connection (GNOCHC)

-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

**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)

**Medicare Dual Eligibles Included:**  
None

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

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

Part D Benefit

**MCE has Medicare Contract:**  
No

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

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

**Provides Part D Benefits:**  
Not Applicable

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Greater New Orleans Community Health Connection (GNOCHC)  
Non-Applicable

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:  Nadine Smith
Department of Health and Mental Hygiene
(410) 767-1483

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

PROGRAM DATA

Program Service Area:  Initial Waiver Approval Date:
Statewide  October 30, 1996

Operating Authority:  Implementation Date:
1115(a) - Demonstration Waiver Program  June 02, 1997

Statutes Utilized:  Waiver Expiration Date:
Not Applicable  December 31, 2013

Enrollment Broker:  Sections of Title XIX Waived:
(PSI) Policy Studies, Inc

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

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:
254
MARYLAND
HealthChoice

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligibles

Medicare Dual Eligibles Included:
None

Lock-In Provision:
12 month lock-in

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

-Individuals ages 19 and over with incomes < 116% of FPL
# MARYLAND HealthChoice

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

### Service Delivery

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
</tr>
</thead>
</table>
| 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 | - Family Practitioners  
- Federally Qualified Health Centers (FQHCs)  
- General Practitioners  
- Gynecologists  
- Internists  
- Nurse Practitioners  
- Rural Health Clinics (RHCs) |

### Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
</table>
| None                             | - 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 |

<table>
<thead>
<tr>
<th>Populations Excluded from Otherwise Included Populations:</th>
<th>Lock-In Provision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Medicare Dual Eligibles</td>
<td>12 month lock-in</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Included:</th>
<th>Medicare Dual Eligibles Excluded:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Exclude all categories of Medicare Dual Eligibles</td>
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</tbody>
</table>

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

| Yes |

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

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

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

| Developmental Disabilities Agency  
- Education Agency  
- Maternal and Child Health Agency |
MARYLAND
HealthChoice

- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups
  Mental Health Agency
  Public Health Agency
  Social Services Agency
  Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

| AMERIGROUP - PAC          | AMERIGROUP Maryland Inc.        |
| JAI Medical System        | JAI Medical Systems - PAC       |
| Maryland Physicians Care  | Maryland Physicians Care - PAC  |
| Medstar Family Choice     | Priority Partners - PAC         |
| Priority Partners MCO     | The Diamond Plan                |
| United Health Care        | United HealthCare - PAC        |

ADDITIONAL INFORMATION

An eligible HealthChoice enrollee may be permitted to disenroll "for cause" from an MCO and enroll in another MCO outside of his/her annual right to change period if he/she is not hospitalized. The Department is responsible for purchase, examination, or fitting of hearing aids and supplies, tinnitus maskers, dental services provided for enrollees under 21 years old and pregnant women of any age, OT, PT, and ST for children under 21. There are additional optional services that some MCOs provide for their enrollees such as dental services for adults. Pregnant women in the Maryland Childrens Health Program are guaranteed eligibility for the duration of the pregnancy and 2 months postpartum. PAC enrollees with diabetes receive DME, podiatry and vision services.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement

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

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

Consumer Self-Report Data:
- CAHPS
  - Medicaid Adult/ Version 4.0
  - Medicaid Children/Version 3.0
  - Special Needs Children with Chronic Conditions

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

Encounter Data

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

Collections: Submission Specifications:
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837)
## MARYLAND HealthChoice

- Standards to ensure complete, accurate, timely encounter data submission
- ADA)
- Guidelines for frequency of encounter data submission
- Use of Medicaid Identification Number for beneficiaries

### Collection: Standardized Forms:
- ANSI ASC X12 837 - transaction set format for transmitting health care claims data

### Validation - Methods:
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
- Medical record validation
- Per member per month analysis and comparisons across MCOs

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

### State conducts general data completeness assessments:
- Yes

## Performance Measures

### Process Quality:
- Adolescent immunization rate
- Adolescent well-care visit rate
- Ambulatory Care for SSI Children and Adults
- Appropriate Testing for Children with Pharyngitis
- Appropriate treatment for Children with Upper Respiratory Infection (URI)
- Asthma care - medication use
- Breast Cancer screening rate
- Cervical cancer screening rate
- Chlamydia screening in women
- Diabetes Management
- Frequency of on-going prenatal care
- HEDIS-Prenatal and Postpartum Care
- Immunizations for two year olds
- Initiation and engagement of SUD treatment
- Lead screening rate
- Well-child care visit rates in first 15 months of life
- Well-child care visits rates in 3, 4, 5, and 6 years of life

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

### Access/Availability of Care:
- Adult's access to preventive/ambulatory health services
- Call Abandonment
- Call Answer Timeliness
- Children’s access to primary care practitioners
- Ratio of PCPs to beneficiaries

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

### Health Plan Stability/ Financial/Cost of Care:
- Actual reserves held by plan
- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income

### Health Plan/ Provider Characteristics:
- None
MARYLAND
HealthChoice

- Net worth
- State minimum reserve requirements
- Total revenue

Beneficiary Characteristics:
- Information of beneficiary ethnicity/race
- Percentage of beneficiaries who are auto-assigned to MCO

Performance Measures - Others:
None

Performance Improvement Projects

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

Clinical Topics:
- Cervical cancer screening (Pap Test)
- Initiation and Engagement of Alcohol and Other Drug Services

Non-Clinical Topics:
None

Standards/Accreditation

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

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
- Quality Improvement Organization (QIO)

EQRO Name:
Delmarva Foundation for Medical Care

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

EQRO Optional Activities:
- Calculation of performance measures
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of encounter data

Pay for Performance (P4P)

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

Program Payers:
Medicaid is the only payer

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

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Adolescent Well Care
Ambulatory Care for SSI Adults
Ambulatory Care for SSI Children
Asthma
Cervical Cancer Screening
Childhood immunizations
Diabetes Eye Exam

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

Lead Screening
Postpartum Care
Well-child visits

Initial Year of Reward: 2002

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

Member Incentives: Not Applicable

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Monitoring of PAHP Standards
- Network Data
- PAHP Standards (see below for details)
- Performance Measures (see below for details)

Use of Collected Data:
- Beneficiary Plan Selection
- Fraud and Abuse
- Plan Reimbursement
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting

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

Consumer Self-Report Data:
- State-developed Survey

Use of Collected Data:
- Beneficiary Plan Selection
- Fraud and Abuse
- Plan Reimbursement
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting

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

Validation - Methods:
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
- Medical record validation

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

State conducts general data completeness assessments:
Yes
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

**Beneficiary Characteristics:**
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries who are auto-assigned to PAHPs

**Health Plan/Provider Characteristics:**
- None

**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
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

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

Guaranteed Eligibility: No guaranteed eligibility

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

General Practitioners
Internists
Nurse Practitioners
Obstetricians/Gynecologists or Gynecologists
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

Medicare Dual Eligibles Included:
None

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

Lock-In Provision:
No lock-in

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

Scope of Part D Coverage:
Not Applicable
MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Crisis, Detoxification, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Intermediate or Day/Night and Substance Use Disorder Treatment, Mental Health Intermediate or Day/Night, Mental Health Outpatient, Opioid Treatment Programs, Outpatient Substance Use Disorders, Substance Use Disorders Support

Contractor Types:
- Managed Behavioral Health Organization (Private)

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

Enrollment

Populations Voluntarily Enrolled:
- Foster Care Children
- Special Needs Children (BBA defined)

Populations Mandatory Enrolled:
- American Indian/Alaska Native
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Foster Care Children
- Medicare Dual Eligibles
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
- Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in Another Managed Care Program
- Medicare Dual Eligibles
- Other Insurance
- Over 65
- Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only (children under age 21)
QMB (children under age 21)
SLMB, QI, and QDWI (children under age 21)

Medicare Dual Eligibles Excluded:
QMB Plus, SLMB Plus, and Medicaid only (age 21 and over)
QMB (age 21 and over)
SLMB, QI, and QDWI (age 21 and over)

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
MASSACHUSETTS
Mass Health

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Abortion, Audiologist, Case Management, Chiropractic,
Dental - Emergency Related Dental in and Ambulatory
Surgery/Outpatient Hospital Care, Diabetes Self-
Management Training, Dialysis, Disease Management,
Durable Medical Equipment, Early Intervention, Emergency,
Emergency Services Program (ESP), EPSDT, Family
Planning, Flouride Varnish, Hearing Aids, Home Health,
Hospice, Immunization, Inpatient Hospital, Inpatient Mental
Health, Inpatient Substance Use Disorders, Institutional
Care - for all Levels of Care Provided at either a Nursing
Facility, Chronic, Laboratory, Medical Nutrition Therapy,
Mental Health Diversionary, Orthotics, Outpatient Hospital,
Outpatient Mental Health, Outpatient Substance Use
Disorders, Oxygen and Respiratory Therapy Equipment,
Pharmacy, Physician, Podiatry, Prosthetics, Radiology and
Diagnostic Tests - Magnetic Resonance Imagery and other
Radiological and Diagnostic, Tobacco Cessation,
Transportation (Emergency) - 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).

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

Enrollment

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

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

Medicare Dual Eligibles Included:
HIV/AIDS Dual Eligibles
Severely Physically Disabled Dual Eligibles

Populations Mandatorily Enrolled:
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Medicare Dual Eligibles
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
- Special Needs Children (BBA defined)
- Title XXI CHIP

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
All categories of Medicare Dual Eligibles other than
"grandfathered HIV/AIDS Dual Eligibles and Severely
Physically Disabled dual Eligibles"

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Provides Part D Benefits:
Yes

Part D - Enhanced Alternative Coverage:
Not Applicable
MASSACHUSETTS
Mass Health

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- Barbituates
- Benzodiazepines
- Nonprescription drugs

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

Agencies with which Medicaid Coordinates the Operation of the Program:
- Department of Mental Retardation
- Department of Youth Services
- Developmental Disabilities Agency
- Education Agency
- Housing Agencies
- Massachusetts Rehabilitation Commission
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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

ADDITIONAL INFORMATION

PCCM:
The PCC Plan Reimbursement arrangement is fee-for-service with enhanced office visit claim - no case management fee paid for each member each month.

PIHP:
Mass Health has a behavioral carve-out for PCCM enrollees and for children in the care or custody of the Commonwealth and other members under 21 with other insurance who are eligible for CBHI services. Regarding the MH/SUD PIHP included services, there is no long-term care in mental health residential or residential substance abuse treatment programs. The Outpatient Day programs are defined as full or part-time substance abuse or mental health services provided in an ambulatory setting.

Massachusetts Behavioral Health Partnership, the MH SUD PIHP is financed using actuarially sound capitation payments to fund the delivery and provision of behavioral health covered services. The aggregate capitation payments are assessed against actual BH service expenditures by the PIHP. Actual spending is then applied to the established risk-sharing corridors/the financial parameters which limited the extent to which the PIHP may experience earnings or losses. After those parameters are accounted for the State conducts a final financial reconciliation to address "surplus funding" recovery from the PIHP or to cover the cost of excess expenditures. CBHI capitated services are excluded from the risk arrangement.
Childrens Behavioral Health Initiative (CBHI) is an interagency undertaking by the Massachusetts Executive Office of Health and Human Services (EOHHS) and MassHealth whose mission is to strengthen, expand and integrate behavioral health services for MassHealth Members under the age of 21 into a community-based, culturally competent care.

Under the PIHP: Excluded Populations data element: Persons with other insurance with the exception for youth and adolescents under 21 receiving or eligible for CBHI services are excluded.

MCO Programs - 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.

As of 07/01/2010, Neighborhood Health Plan's (NHP) previous years' two special programs for HIV/AIDS members and severely disabled dual eligible members were transitioned and grandfathered into MassHealth's managed care disabled categories. These grandfathered dual members have the option to enroll in any of the five contracted MCOs. Most of these members continue to be enrolled in NHP. These dual members get their pharmacy benefit from Medicare Part D Drug Plan which includes OTCs, Barbiturates and Benzodiazepines and legislatively mandated drugs. As of 7/01/2011 NHP served approximately 148 dually eligibles.

Effective 1/01/2011, Neighborhood Health Plan (NHP) was awarded the MassHealth 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 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. This program is offered state-wide and as of 7/01/2011, NHP served approximately 125 children in SK/SC program.

The MCO Program's previous P4P Program was not extended for this reporting period. It will be evaluated for possible Implementation in the future.

APS, the current EQRO Vendor's contract was extended and MassHealth is in the process of rebidding this 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)
- 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

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 continuous enrollment

Encounter Data

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

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

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Massachusetts
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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

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 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
-Chlamydia screening in women
-Controlling high blood pressure
-Dental services
-Depression management/care
-Diabetes medication management
-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

Health Status/Outcomes Quality:
-Mortality rates
-Patient satisfaction with care
-Pediatric behavioral health (BH) screens with potential BH need identified
-Pediatric behavioral health (BH) screens with potential BH need identified ad follow-up received
-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 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

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 a PCCM

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

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
- Substance Use Disorders treatment after detoxification service
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
- State-Developed/Specified 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

EQRO Optional Activities:
None

Pay for Performance (P4P)

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

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR 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

Use of Collected Data:
- Contract Standard Compliance
- Data Mining
- Fraud and Abuse
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
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-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:
-MHQPM 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 ALL of the HEDIS measures listed for Medicaid
-State use/requirements 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 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

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.

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

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

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

State conducts general data completeness assessments:
Yes

Performance Measures
### Mass Health

#### Process Quality:
- 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
- Identification of Alcohol and other Drug Services
- 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

#### 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 conditions
- Substance Use Disorders treatment after detoxification service

##### Non-Clinical Topics:
- Member Access to Behavioral Health Services
- Reducing health care disparities via health literacy, education campaigns, or other initiatives

#### Standards/Accreditation

##### PIHP Standards:
- Timely availability and access to Behavioral Health services following BH hospitalizations

##### Accreditation Required for Participation:
None

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

##### EQRO Name:
- APS Healthcare

##### EQRO Organization:
- QIO-like entity

##### EQRO Mandatory Activities:
- Review of PIHP compliance with structural and operational standards established by the State
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
- Children's access to primary care practitioners
- Percent of PCPs with open or closed patient assignment panels

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

Provider Characteristics:
None

Beneficiary Characteristics:
- Disenrollment rate
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries auto-assigned to PCP
- Percentage of beneficiaries who are auto-assigned to PCCM
Performance 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: Gretchen Ulbee
Minnesota Department of Human Services
(651) 431-2192

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

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
County July 27, 1995

Operating Authority: Implementation Date:
1115(a) - Demonstration Waiver Program July 01, 1995

Statutes Utilized: Waiver Expiration Date:
Not Applicable December 31, 2013

Enrollment Broker: Sections of Title XIX Waived:
No -1902(a)(1) Statewidness

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable

Guaranteed Eligibility: -1902(a)(10)(B) - Amount, Duration & Scope
No guaranteed eligibility -1902(a)(17) Comparability of Eligibility Standards

-1902(a)(23)(A) Freedom of Choice

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:
Case Management, Chiropractic, Dental, Durable Medical -Not applicable, contractors not required to identify PCPs
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

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

Enrollment

Populations Voluntarily Enrolled: None

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

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

Lock-In Provision: 12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only
Under 65 and not using a disabled basis of eligibility

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

Part D Benefit

MCE has Medicare Contract: No

Scope of Part D Coverage: Not Applicable

Provides Part D Benefits: Not Applicable

Part D - Enhanced Alternative Coverage: Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

| Blue Plus                  | Health Partners                |
| Itasca Medical Care       | Medica                         |
| Metropolitan Health Plan  | PrimeWest Health System        |
| South Country Health Alliance | UCARE                       |

ADDITIONAL INFORMATION

PCP provider types are designated by MCO, not the State. County staff perform enrollment function.

Included Population- SED/SPMI- Servere Emotional Disturbance/Serious and Persistent Mental Illness

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- Non-Duplication Based on Accreditation
- Ombudsman
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data:
- Assess Program Results
- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Access and Utilization

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Adult Medicaid SSI Questionnaire
  - Adult with Special Needs Questionnaire
  - Child with Special Needs Questionnaire
  - Disenrollment Survey

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

Encounter Data

Collection: Requirements:
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries
MINNESOTA
Minnesota Prepaid Medical Assistance Project Plus-1115(a)

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
- Chlamydia 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 Visits - 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

Beneficiary Characteristics:
- 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 Optional Activities:
- Administration or validation of consumer or provider surveys

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

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

Initial Year of Reward:
1999

Member Incentives:
- Not Applicable

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.)

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

<table>
<thead>
<tr>
<th>State Medicaid Contact:</th>
<th>Paula McGee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NM HSD/Medical Assistance Division</td>
</tr>
<tr>
<td></td>
<td>(505) 827-6234</td>
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| State Website Address:           | http://www.insurenewmexico.state.nm.us/scihome.htm |

## PROGRAM DATA

<table>
<thead>
<tr>
<th>Program Service Area:</th>
<th>Initial Waiver Approval Date:</th>
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<tr>
<td>Statewide</td>
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<th>Operating Authority:</th>
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<td>1115(a) - Demonstration Waiver Program</td>
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<th>Sections of Title XIX Waived:</th>
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<tr>
<td>No</td>
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<td>-1902(a)(17) Financial Eligibility Standards</td>
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<td>-1902(a)(23) Freedom of Choice</td>
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<td>-1902(a)(34) Retroactive Eligibility</td>
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<td>-1902(a)(4) Proper and Efficient Administration of the State Plan</td>
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<th>For All Areas Phased-In:</th>
<th>Sections of Title XIX Costs Not Otherwise Matchable Granted:</th>
</tr>
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<tbody>
<tr>
<td>No</td>
<td>-Eligibility Expansion</td>
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<td>-MCO Choice {1932(a)(3)}</td>
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<td></td>
<td>-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)</td>
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<table>
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<th>Guaranteed Eligibility:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>12 months guaranteed eligibility</td>
<td></td>
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</tbody>
</table>

## 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
- Obstetricians/Gynecologists or Gynecologists
- Other providers who meet the MCO credentialing requirements for PCP.
- Other Specialists Approved on a Case-by-Case Basis
- Physician Assistants
- Primary care teams at teaching facilities.
- Rural Health Clinics (RHCs)
NEW MEXICO
New Mexico State Coverage Insurance Section 1115 Demonstration

Enrollment

Populations Voluntarily Enrolled:
- Non-pregnant childless adults age 19-64 with incomes < 200% FPL

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)

Medicare Dual Eligibles Included:
None

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

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Part D Benefit

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Lovelace Community Health Plan
Presbyterian Health Plan
Molina Healthcare of New Mexico

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 verified, 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 continuous enrollment requirement for some or all of the measures

Encounter Data

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

Collection: Standardized Forms:
- 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.

Collection: 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

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

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

State conducts general data completeness assessments:
Yes
Performance Measures

Process Quality:
- Asthma care - medication use
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Diabetes medication management
- Frequency of on-going prenatal care
- Initiation of prenatal care - timeliness of

Access/Availability of Care:
- Adult's access to preventive/ambulatory health services
- Average distance to PCP
- Ratio of PCPs to beneficiaries

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

Use of Services/Utilization:
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary

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

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 dba New Mexico Medical Review Association
NEW MEXICO
New Mexico State Coverage Insurance Section 1115 Demonstration

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

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

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

---

**Pay for Performance (P4P)**

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

**Program Payers:**
Medicaid is the only payer

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

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

**Clinical Conditions:**
Diabetes

**Measurement of Improved Performance:**
Assessing levels of technology adoption
Assessing the adoption of systematic quality improvement processes
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
2010

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

**Member Incentives:**
Not Applicable
NEW YORK
F-SHRP - Medicaid Advantage

CONTACT INFORMATION

State Medicaid Contact: Jennifer Dean
Division of Health Plan Contracting & Oversight
(518) 473-1134

State Website Address: http://www.nyhealth.gov

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
County

Operating Authority:
1115(a) - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

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

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
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
- Eligible 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 permanent
- Residents of State operated Psych facilities or residents of State certified treatment facilities for children and youth
- Spend downs

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

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

Part D Benefit

**MCE has Medicare Contract:**
- Yes

**Provides Part D Benefits:**
- Yes

**Scope of Part D Coverage:**
- Standard Prescription Drug

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

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
- Analgesic and Antipyretic
- Antacid
- Anti-diarrheal
- Antihistamine
- Anti-vertigo
- Artificial tears and ocular/oral lubricants
- Chronic renal disease
- Cough and cold
- Dermatological
- Family Planning
- Fecal softener and laxative
- Hematinic
- Insulin
- Insulin Biosynthetic Human
- Pediculocide
- Smoking cessation agents
# NEW YORK
## F-SHRP - Medicaid Advantage

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

**Strategies Used to Identify Persons with Complex (Special) Needs:**
- Requires MCOs to identify through assessments

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

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
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<tr>
<th>Affinity/Medicaid Advantage</th>
<th>ElderPlan/Medicaid Advantage</th>
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<td>GHI/Medicaid Advantage</td>
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<td>Liberty Health Advantage/Medicaid Advantage</td>
<td>Managed Health Inc/Medicaid Advantage</td>
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<td>MetroPlus/Medicaid Advantage</td>
<td>NYS Catholic Health Plan/Fidelis/Medicaid Advantage</td>
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<td>Senior Whole Health/ Medicaid Advantage</td>
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<td>United Health Plan/Medicaid Advantage</td>
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</table>

### ADDITIONAL INFORMATION

The Medicaid Advantage program strictly serves dual eligibles. Transportation and dental services are optional outside of NYC. Within NYC, these services are required.

### QUALITY ACTIVITIES FOR MCO/HIO

#### State Quality Assessment and Improvement Activities:
- Encounter Data (see below for details)
- MCOs must comply with Medicare requirements for quality in 42 CFR 422

#### Use of Collected Data:
- Program Evaluation
- Regulatory Compliance/Federal Reporting

#### Consumer Self-Report Data:
None

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

### Encounter Data

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

#### 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
NEW YORK
F-SHRP - Medicaid Advantage

data submission

Collection: Standardized Forms:
None

Validation - Methods:
- Automated analysis of encounter data submission to help determine 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

IQRO Name:
Island Peer Review Organization

EQRO Mandatory Activities:
Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities:
Validation of encounter data

Pay for Performance (P4P)

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

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable
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
Initial Waiver Approval Date: September 29, 2006

Operating Authority: 1115(a) - Demonstration Waiver Program
Implementation Date: October 01, 2006

Statutes Utilized: Not Applicable
Waiver Expiration Date: September 30, 2011

Enrollment Broker: MAXIMUS

For All Areas Phased-In: No
Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice
-1902(a)(25) Third Party Liability
-1902(a)(4)(a) MEQC

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Designated State Health Programs
-Dual-Eligible Appeals
-Exemption from MEQC disallowances {1903(u)}
-Facilitated Enrollment Services
-Institute For Mental Disease Expenditures
-Twelve Months Continuous Coverage

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Qualified Obstetricians/Gynecologists
Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Admitted to hospice at the time of enrollment
-Eligible less than 6 Months
-Eligible only for TB related services
-Enrolled in Another Managed Care Program
-Enrolled in the Restricted Recipient Program
-Foster children in direct care
-Infants weighing less than 1200 grams or infants who meet SSI criteria
-Medicare Dual Eligibles
-Other Insurance
-Participation 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

Medicare Dual Eligibles Included:
None

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

Lock-In Provision:
12 month lock-in

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

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

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

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
NEW YORK
F-SHRP - Medicaid Managed Care

PCCM Provider - Risk-based Capitation

Service Delivery

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
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<tbody>
<tr>
<td>Case Management, Dental, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray</td>
<td>- Family Practitioners</td>
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<tr>
<td></td>
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<td></td>
<td>- Other Specialists Approved on a Case-by-Case Basis</td>
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<tr>
<td></td>
<td>- Pediatricians</td>
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<tr>
<td></td>
<td>- Qualified Obstetricians/Gynecologists</td>
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</tbody>
</table>

Included Services:
- Case Management, Dental, Durable Medical Equipment
- EPSDT, Home Health, Immunization, Inpatient Hospital
- Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray
- Family Practitioners
- General Practitioners
- Internists
- Nurse Practitioners
- Other Specialists Approved on a Case-by-Case Basis
- Pediatricians
- Qualified Obstetricians/Gynecologists

Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Blind/Disabled Adults and Related Populations</td>
</tr>
<tr>
<td>- Blind/Disabled Children and Related Populations</td>
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<table>
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<th>Subpopulations Excluded from Otherwise Included Populations:</th>
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<tr>
<td>- Admitted to hospice at the time of enrollment</td>
</tr>
<tr>
<td>- Eligible Less Than 6 Months</td>
</tr>
<tr>
<td>- Eligible only for TB-related Services</td>
</tr>
<tr>
<td>- Enrolled in Another Managed Care Program</td>
</tr>
<tr>
<td>- Enrolled in the Restricted Recipient Program</td>
</tr>
<tr>
<td>- Foster Care Children in direct care</td>
</tr>
<tr>
<td>- Medicare Dual Eligibles</td>
</tr>
<tr>
<td>- Other Insurance</td>
</tr>
<tr>
<td>- Participation in LTC Demonstration</td>
</tr>
<tr>
<td>- Reside in Nursing Facility or ICF/MR</td>
</tr>
<tr>
<td>- Reside in Residential Treatment Facility for children and youth</td>
</tr>
<tr>
<td>- Reside in State Operated Psychiatric Facility</td>
</tr>
<tr>
<td>- Special Needs Children (State defined)</td>
</tr>
<tr>
<td>- Spend downs</td>
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<table>
<thead>
<tr>
<th>Lock-In Provision:</th>
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</thead>
<tbody>
<tr>
<td>12 month lock-in</td>
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</tbody>
</table>

Medicare Dual Eligibles Included:
None

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

Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
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</thead>
<tbody>
<tr>
<td>No</td>
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<table>
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<tbody>
<tr>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
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<td>Not Applicable</td>
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<tr>
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<td>None</td>
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<tr>
<th>Part D - Enhanced Alternative Coverage:</th>
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<td>Not Applicable</td>
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SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

<table>
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<tr>
<th>Program Includes People with Complex (Special) Needs:</th>
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<tr>
<td>Yes</td>
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NEW YORK
F-SHRP - Medicaid Managed Care

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Agency</th>
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<tbody>
<tr>
<td>Affinity Health Plan</td>
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<tr>
<td>AmidaCare Special Needs</td>
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<tr>
<td>Excellus</td>
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<tr>
<td>Health Now</td>
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<td>Hudson Health Plan</td>
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<tr>
<td>MetroPlus Health Plan Special Needs</td>
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<tr>
<td>Neighborhood Health Providers</td>
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<tr>
<td>NYS Catholic Health Plan 1199</td>
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<tr>
<td>Physician Case Management Program</td>
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<tr>
<td>Southern Tier Pediatrics</td>
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<tr>
<td>United Healthcare</td>
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<tr>
<td>Wellcare</td>
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<td>Amerigroup</td>
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<td>Capital District Physicians Health Plan</td>
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<td>Health First</td>
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<td>HealthPlus</td>
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<td>MetroPlus Health Plan</td>
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<td>MVP Health Plan</td>
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<td>NYPS Select Health Special Needs</td>
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<td>NYS Catholic Health Plan/Fidelis</td>
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<td>SCHC TotalCare</td>
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<tr>
<td>Southern Tier Priority</td>
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<tr>
<td>Univera Community Health</td>
</tr>
</tbody>
</table>

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

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F-SHRP - Medicaid Managed Care

Encounter Data

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

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 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

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of low birth weight infants
NEW YORK
F-SHRP - Medicaid Managed 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

### 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

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NEW YORK
F-SHRP - Medicaid Managed Care

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

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

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

**Pay for Performance (P4P)**

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

**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

**Program Payers:**
Medicaid is the only payer

**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)

**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
**NEW YORK**  
**F-SHRP - Medicaid Managed Care**

<table>
<thead>
<tr>
<th>Provider Characteristics:</th>
<th>Beneficiary Characteristics:</th>
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<tbody>
<tr>
<td>None</td>
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</table>

**Performance Measures - Others:**  
None
NEW YORK
Partnership Plan - Family Health Plus

CONTACT INFORMATION

State Medicaid Contact: Kathleen Johnson
Division of Coverage & Enrollment
(518) 474-8887

State Website Address: http://www.nyhealth.gpv

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
Statewide June 29, 2001

Operating Authority: Implementation Date:
1115(a) - Demonstration Waiver Program September 04, 2001

Statutes Utilized: Waiver Expiration Date:
Not Applicable December 31, 2013

Enrollment Broker: Sections of Title XIX Waived:
MAXIMUS

-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

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
No 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

Guaranteed Eligibility: Guaranteed Eligibility
6 months guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:
Case Management, Chemical Dependence, Dental, Diabetic -Family Practitioners
supplies and equipment, Durable Medical Equipment, -General Practitioners
EPSDT, Family Planning, Hearing, Home Health, Hospice, -Internists
Immunization, Inpatient Hospital, Inpatient Mental Health, -Nurse Practitioners
Inpatient Substance Use Disorders, Laboratory, Medically -Other Specialists Approved on a Case-by-Case Basis

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NEW YORK
Partnership Plan - Family Health Plus

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

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

Medicare Dual Eligibles Included:
None

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

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity Health Plan
Capital District Physicians Health Plan
Health First
HealthPlus
Hudson Health Plan
MetroPlus Health Plan
Neighborhood Health Providers
NYS Catholic Health Plan/Fidelis
United Healthcare
Wellcare

Amerigroup
Excellus
Health Now
HIP Combined
Independent Health/Hudson Valley&WNY
MVP Health Plan
NYS Catholic Health Plan 1199
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
- 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

**State conducts general data completeness assessments:**
Yes
NEW YORK
Partnership Plan - Family Health Plus

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

Performance Measures

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

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

Access/Availability of Care:
- Ratio of PCPs to beneficiaries

Use of Services/Utilization:
- Average number of visits to MH/SUD providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary

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

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

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
NEW YORK
Partnership Plan - Family Health Plus

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

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

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

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Qualified Obstetricians/Gynecologists
Enrollment

Populations Voluntarily Enrolled:
- Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
- Admitted to hospice at the time of enrollment
- Eligible less than 6 Months
- Eligible only for TB related services
- Enrolled in Another Managed Care Program
- Enrolled in the Restricted Recipient Program
- Foster children in direct care
- Infants weighing less than 1200 grams or infants who meet SSI criteria
- Medicare Dual Eligibles
- Other Insurance
- Participation 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

Medicare Dual Eligibles Included:
None

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

Lock-in Provision:
12 month lock-in

Populations Mandatorily Enrolled:
- Safety Net Adults
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
NEW YORK
Partnership Plan Medicaid Managed Care Program

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

Included Services:

Enrollment

Populations Voluntarily Enrolled:
- Foster Care Children

Populations Mandatorily Enrolled:
- Safety Net Adults
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- Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
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- Eligible only for TB related services
- Enrolled in Another Managed Care Program
- Enrolled in the Restricted Recipient Program
- Foster care children in direct care
- Medicare Dual Eligibles
- Other Insurance
- Participation in a LTC Demonstration Program
- Reside in Nursing Facility or ICF/MR
- Reside in Residential Treatment Facility for children and youth
- Reside in State Operated Psychiatric Facility
- Special Needs Children (State defined)
- Spend downs

Lock-in Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
NEW YORK
Partnership Plan Medicaid Managed Care Program

Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Affinity Health Plan
AmidaCare Special Needs
Excellus
Health Now
Hudson Health Plan
MetroPlus Health Plan
MVP Health Plan
NYPS Select Health Special Needs
NYS Catholic Health Plan/Fidelis
SCHC TotalCare
Southern Tier Priority
Univera Community Health
Amerigroup
Capital District Physicians Health Plan
Health First
HealthPlus
Independent Health/Hudson Valley&WNY
MetroPlus Health Plan Special Needs
Neighborhood Health Providers
NYS Catholic Health Plan 1199
Physician Case Management Program
Southern Tier Pediatrics
United Healthcare
Wellcare

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

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

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
NEW YORK
Partnership Plan Medicaid Managed Care Program

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

Collection: Standardized Forms:
None

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

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

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

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
**NEW YORK**

**Partnership Plan Medicaid Managed Care Program**

- 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

**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 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
NEW YORK
Partnership Plan Medicaid Managed Care Program

- Validation of performance measures

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

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, 2012

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

PCCM Provider - Fee-for-Service

Service Delivery

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

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

Populations Voluntarily Enrolled:
- American Indian/Alaska Native

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

Medicare Dual Eligibles Included:
None

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

Lock-in Provision:
No lock-in

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
American Indian PCCM - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Disease Management, Durable Medical Equipment, 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

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

Medicare Dual Eligibles Included:
None

Lock-in Provision:
No lock-in

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

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Asks advocacy groups to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
OKLAHOMA
SoonerCare

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

| 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

<table>
<thead>
<tr>
<th>Quality Oversight Activities:</th>
<th>Use of Collected Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
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</table>

Consumer Self-Report Data:
None
OREGON
Oregon Health Plan Plus

CONTACT INFORMATION

State Medicaid Contact: Jon Pelkey
Division of Medical Assistance Programs
(503) 947-2315

State Website Address: http://www.oregon.gov/DHS/healthplan/index.shtml

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
Statewide March 19, 1993

Operating Authority:
1115(a) - Demonstration Waiver Program Implementation Date:
February 01, 1994

Statutes Utilized:
Not Applicable Waiver Expiration Date:
October 31, 2013

Enrollment Broker:
No Sections of Title XIX Waived:
-1902(a)(1) Statewidenss
-1902(a)(10)(A) Eligibility Procedures
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(13)(A) DSH
-1902(a)(17) Eligibility Standards
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Coverage
-1902(a)(4) Proper and Efficient Administration of the State Plan
-1902(a)(43)(c) EPSDT
-1902(a)(8) Reasonable Promptness
-2103 Benefits
-2103(e) Cost-Sharing

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable Granted:
No -1903(f)
-Chemical Dependency Treatment 1905(a)(13)
-Eligibility Expansion
-Employer Sponsored Insurance
-Guaranteed Eligibility Expenditures
-MCO Definition 1903(m)(1)(A)
-MCO Limits Disenrollment Rights 1903(m)(2)(A)(vi)

Guaranteed Eligibility:
6 months guaranteed eligibility

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Allowable PCPs:
OREGON
Oregon Health Plan Plus

Crisis, IMD, Inpatient Mental Health, Mental Health Support, Opioid Treatment Programs, Outpatient Substance Use Disorders, Screening, Identification, and Brief -Not applicable, contractors not required to identify PCPs

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

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

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

Medicare Dual Eligibles Excluded:
None

Lock-in Provision:
No lock-in

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
OREGON
Oregon Health Plan Plus

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Physician

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

Enrollment

Populations Voluntarily Enrolled:
- Aged and Related Populations
- American Indian/Alaska Native
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Foster Care Children
- Medicare Dual Eligibles
- Poverty-Level Pregnant Women
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
- Title XXI CHIP

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

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

Medicare Dual Eligibles Excluded:
None

Lock-In Provision:
No lock-in

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
OREGON
Oregon Health Plan Plus

Dental PAHP - Risk-based Capitation

Service Delivery

Included Services: Dental

Allowable PCPs: -Does not apply

Enrollment

Populations Voluntarily Enrolled: None

Populations Mandatorily Enrolled:
- Aged and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Medicare Dual Eligibles
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
- Title XXI CHIP

Lock-In Provision: 6 month lock-in

Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in Another Managed Care Program
- Other Insurance
- QMB and MN Spenddown

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

Medicare Dual Eligibles Excluded: None

Part D Benefit

MCE has Medicare Contract: No

Provides Part D Benefits: Not Applicable

Scope of Part D Coverage: Not Applicable

Part D - Enhanced Alternative Coverage: Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: None
OREGON Health Plan Plus

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

**Included Services:**
- Durable Medical Equipment, EPSDT, Family Planning,
- Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

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

Enrollment

**Populations Voluntarily Enrolled:**
None

**Populations Mandatorily Enrolled:**
- Aged and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Medicare Dual Eligibles
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
- Title XXI CHIP

**Subpopulations Excluded from Otherwise Included Populations:**
- Enrolled in Another Managed Care Program
- Other Insurance
- QMB and MN Spenddown

**Lock-in Provision:**
6 month lock-in

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

**Medicare Dual Eligibles Excluded:**
None

Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
No

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

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

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes
OREGON
Oregon Health Plan Plus

Strategies Used to Identify Persons with Complex (Special) Needs:
- Asks advocacy groups to identify members of these groups
- Health Plans use multiple means to identify such members
- Reviews complaints and grievances to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses provider referrals to identify members of these groups

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan
Advantage Dental Services
CareOregon
Clackamas County Mental Health
Douglas County IPA
FamilyCare (Mental Health)
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)

Accountable Behavioral Health
Capitol Dental Care, Inc.
Cascade Comprehensive Care
Doctors of the Oregon Coast South
Family Dental Care
FamilyCare Health Plans
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

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.

Under age one is guaranteed 12 months continuous eligibility.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- On Site Reviews 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
OREGON
Oregon Health Plan Plus

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 data submission

Collections: Submission Specifications:
- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
- ADA - American Dental Association dental claim form
- ANSI ASC X12 837 - transaction set format for transmitting health care claims data
- CMS 1500
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form
- UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

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

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

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
- 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

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with obtaining care
OREGON
Oregon Health Plan Plus

- 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 within 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
- 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
OREGON
Oregon Health Plan Plus

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

EQRO Optional Activities:
- Administration or validation of consumer or provider surveys
- Conduct of performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Rapid Cycle Review
- Validation of encounter data

Pay for Performance (P4P)

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

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Monitoring of PIHP Standards
- On Site Reviews 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
OREGON
Oregon Health Plan Plus

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/require 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 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

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

Health Status/Outcomes Quality:
- Patient satisfaction with care

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

- 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:
- 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

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
OREGON
Oregon Health Plan Plus

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 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)
- 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)
OREGON
Oregon Health Plan Plus

Beneficiary Characteristics:
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- PAHP/PCP-specific disenrollment rate

Performance Measures - Others:
None

Standards/Accreditation

PAHP Standards:
- State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

QUALITY ACTIVITIES FOR PCCM

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

Use of Collected Data:
- Health Services Research
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

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 Institutional/
(401) 462-0140

State Website Address: http://www.ohhs.ri.gov

PROGRAM DATA

Program Service Area: Statewide
Initial Waiver Approval Date:

Operating Authority:
1115(a) - Demonstration Waiver Program
Implementation Date:

Statutes Utilized:
Not Applicable
Waiver Expiration Date:

Enrollment Broker:
No
Sections of Title XIX Waived:

For All Areas Phased-In:
No
Sections of Title XIX Costs Not Otherwise Matchable

Guaranteed Eligibility:
No guaranteed eligibility
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
RHODE ISLAND
Connect Care Choice

Enrollment

Populations Voluntarily Enrolled: None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles
-Other Health Insurance

Medicare Dual Eligibles Included: None

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

Lock-In Provision: No lock-in

Part D Benefit

MCE has Medicare Contract: No

Scope of Part D Coverage: Not Applicable

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

Provides Part D Benefits: Not Applicable

Part D - Enhanced Alternative Coverage: Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs: Yes

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

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Developmental Disabilities Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency
-Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Connect Care Choice

ADDITIONAL INFORMATION

Connect Care Choice is a primary care case management program for adults with Medicaid coverage who are 21 years old or older. The goal is to provide improved access to a person's 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.
RHODE ISLAND
Connect Care Choice

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: Initial Waiver Approval Date:
Statewide January 16, 2009

Operating Authority: Implementation Date:
1115(a) - Demonstration Waiver Program January 16, 2009

Statutes Utilized: Waiver Expiration Date:
Not Applicable December 31, 2013

Enrollment Broker: Sections of Title XIX Waived:
No -1092(a)(32) Payment for Self-Directed Care

For All Areas Phased-In: -1092(a)(8) Reasonable Promptness
No -1902(a)(10)(B) Amount, Duration and Scope

Guaranteed Eligibility: -1902(a)(14) Cost-Sharing Requirements
No guaranteed eligibility -1902(a)(17) Comparability of Eligibility Standards

-1902(a)(23) Freedom of Choice

-1902(a)(34) Retroactive Eligibility

-1902(a)(37)(B) Payment Review

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

-HCBS

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)
### RHODE ISLAND

#### Rhody Health Partners

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### Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Populations Mandatorily Enrolled:</td>
<td>- Aged and Related Populations</td>
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<tr>
<td></td>
<td>- Blind/Disabled Adults and Related Populations</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Access to Cost Effective, Comprehensive, Employer-Sponsored Coverage</td>
</tr>
<tr>
<td>- Enrolled in Another Managed Care Program</td>
</tr>
<tr>
<td>- Medicare Dual Eligibles</td>
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<tr>
<td>- Other Insurance</td>
</tr>
<tr>
<td>- Reside in Nursing Facility or ICF/MR</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Included:</th>
</tr>
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<tbody>
<tr>
<td>None</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Excluded:</th>
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</thead>
<tbody>
<tr>
<td>Exclude all categories of Medicare Dual Eligibles</td>
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</table>

<table>
<thead>
<tr>
<th>Lock-in Provision:</th>
</tr>
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<tbody>
<tr>
<td>12 month lock-in</td>
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### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
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</table>

<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
</tr>
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<tbody>
<tr>
<td>None</td>
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### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

<table>
<thead>
<tr>
<th>Program Includes People with Complex (Special) Needs:</th>
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<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Strategies Used to Identify Persons with Complex (Special) Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Uses eligibility data to identify members of these groups</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Agencies with which Medicaid Coordinates the Operation of the Program:</th>
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<tbody>
<tr>
<td>- Aging Agency</td>
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<tr>
<td>- Social Services Agencies</td>
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<tr>
<td>- Substance Abuse Agency</td>
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<tr>
<td>- Transportation Agencies</td>
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</tbody>
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### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Neighborhood Health Plan of Rhode Island</th>
<th>United HealthCare of New England</th>
</tr>
</thead>
</table>

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### ADDITIONAL INFORMATION

331
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
- Network Data
- Non-Duplication Based on Accreditation
- On-Site Reviews
- Performance Measures (see below for details)
- Provider Data

**Consumer Self-Report Data:**
- CAHPS Adult Medicaid AFDC Questionnaire
- Consumer Advisory Committee

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

**Use of HEDIS:**
- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS 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-specific 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 submission processes from providers to health plans to assure complete and timely submissions
- Per member per month analysis and comparisons across
MCO/HIO conducts data accuracy check(s) on specified data elements:
- Date of Service
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
- Adult BMI Assessment
- Antidepressant medication management
- Asthma care - medication use
- Cervical cancer screening rate
- Check-ups after delivery
- Chlamydia screening in women
- Diabetes medication management
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Initiation of prenatal care - timeliness of
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Smoking prevention and cessation

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

Access/Availability of Care:
- Adult's access to preventive/ambulatory health services
- Complaint Resolution Statistics
- Patient/Member Satisfaction with Access to Care

Use of Services/Utilization:
- Average number of visits to MH/SUD providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Inpatient days per 1,000
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Prescriptions per 1,000 population by category (name brand, generic, OTC)
- Re-admission rates of MH/SUD

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

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

Beneficiary Characteristics:
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries who are auto-assigned to MCO

Performance Measures - Others:
None
RHODE ISLAND
Rhody Health Partners

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

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 Organization:
-Quality Improvement Organization (QIO)

EQRO Name:
-IPRO, Inc.

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

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of encounter data

Pay for Performance (P4P)

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

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by disease and medical condition
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Adult preventive care
Cervical Cancer screening
Depression
Diabetes
Obesity
Smoking and Tobacco Use

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing patient satisfaction measures

Initial Year of Reward:
2010

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

Member Incentives:
Not Applicable
RHODE ISLAND
Rite 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: Initial Waiver Approval Date:
Statewide January 16, 2009

Operating Authority: Implementation Date:
1115(a) - Demonstration Waiver Program January 16, 2009

Statutes Utilized: Waiver Expiration Date:
Not Applicable December 31, 2013

Enrollment Broker: Sections of Title XIX Waived:
No -1902(a)(10)(B) Amount, Duration and Scope

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
No Grants: -1902(a)(14) Cost-Sharing Requirements

Guaranteed Eligibility: -1902(a)(17) Comparability of Eligibility Standards
No guaranteed eligibility -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

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

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### RHODE ISLAND

#### Rite Care

- 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

**Medicare Dual Eligibles Included:**
- None

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

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

#### Part D Benefit

**MCE has Medicare Contract:**
- Not Applicable

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

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

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

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Aging Agency
- Child Welfare Agency
- Developmental Disabilities Agency
- Education Agency
- Maternal and Child Health Agency
RHODE ISLAND
Rite Care

- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Neighborhood Health Plan of Rhode Island
United HealthCare of New England

ADDITIONAL INFORMATION

Since September 2003, Children with Special Health Care Needs are offered enrollment in RItc 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. RItc 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/require MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects
### RHODE ISLAND

**Rite Care**

#### Encounter Data

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

**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-specific 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 submission 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
- Chlamydia 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

**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
RHODE ISLAND
Rite Care

- 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

Access/Availability of Care:
- Adolescents' Access to PCPs
- Adult's access to preventive/ambulatory health services
- Children's access to primary care practitioners
- Complaint Resolution Statistics
- Patient/Member Satisfaction with Access to Care

Use of Services/Utilization:
- Average number of visits to MH/SUD providers per beneficiary
- Discharges from Neonatal Intensive Care Unit per 1,000 live births
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Inpatient days per 1,000
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Prescriptions per 1,000 population by category (name brand, generic and OTC)
- Re-admission rates of MH/SUD

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

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

Beneficiary Characteristics:
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries who are auto-assigned to MCOs
- Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

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

Clinical Topics:
- Antidepressant Medication Management
- ED Visits for Ambulatory Care Sensitive Conditions
- Follow-up for Children Prescribed ADHD Medications
- Notification of TPL

Non-Clinical Topics:
- Notifying the State of TPL Data within Five Days
- Work Distribution in the Grievance and Appeals Unit

Standards/Accreditation

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

Accreditation Required for Participation:
- NCQA (National Committee for Quality Assurance)
RHODE ISLAND
Rite Care

Standards

Non-Duplication Based on Accreditation:
- None

EQRO Organization:
- Quality Improvement Organization (QIO)

EQRO Name:
- IPRO, Inc.

EQRO Mandatory Activities:
- Detailed technical report for each MCO
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

EQRO Optional Activities:
- Administration or validation of consumer or provider surveys
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Validation of encounter data

Pay for Performance (P4P)

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

Program Payers:
Medicaid is the only payer

Population Categories Included:
A subset of MCO members, defined by disease and medical condition
A subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
ADHD
Adolescent Immunizations
Adult preventive care
Cervical Cancer Screening
Childhood immunizations
Chlamydia Screening
Depression
Diabetes
Lead Screening
Obesity
Perinatal Care
Smoking Cessation
Well-child visits

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
Assessing patient satisfaction measures
Using clinically-based outcome measures (e.g., HEDIS, etc.)

Initial Year of Reward:
1999

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

Member Incentives:
Not Applicable
RHODE ISLAND
RIt 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
Initial Waiver Approval Date: January 16, 2009
Operating Authority: 1115(a) - Demonstration Waiver Program
Implementation Date: January 16, 2009
Statutes Utilized: Not Applicable
Waiver Expiration Date: December 31, 2013
Enrollment Broker: No
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

For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable Granted: None

Guaranteed Eligibility: None

SERVICE DELIVERY

Dental PAHP - Risk-based Capitation

Service Delivery

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

Enrollment

Populations Voluntarily Enrolled: None
Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medicare Dual Eligibles
-Section 1931 Children and Related Populations
RHODE ISLAND
Rite Smiles

Subpopulations Excluded from Otherwise Included Populations:
-Children born before 5/1/2000
-Children residing out of state
-Other Dental Insurance
-Reside in Nursing Facility or ICF/MR

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

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

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

United HealthCare Dental - Rite Smiles

ADDITIONAL INFORMATION

Rite Smiles is a children's dental program only covering those born on or after May 1, 2000. It was originally implemented on May 1, 2006 under 1915(b) authority and was subsumed into the Rhode Island Global Consumer Choice Compact 1115(a) Demonstration, as of 1/16/2009.

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

QUALITY ACTIVITIES FOR PAHP

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

Use of Collected Data:
-Contract Standard Compliance
**RHODE ISLAND**  
**RIte Smiles**

- 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)  

**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

**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 prophylactic 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

**Use of Services/Utilization:**
- Annual Dental Visit by age
RHODE ISLAND
RItte Smiles

- Call Abandonment Rate
- Complaint Resolution Statistics
- Ratio of dental providers to beneficiaries

Health Plan Stability/Financial/Cost of Care:
- Risk Share Reporting

Beneficiary Characteristics:
None

Performance Improvement Projects

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

Non-Clinical Topics:
Not Applicable - PAHPs are not required to conduct common project(s)

Clinical Topics:
- Annual Dental Visit for 2-3, 4-6 and 7-10 year olds
- Postcard Outreach to Parents of Non-Utilizing Children

Standards/Accreditation

PAHP Standards:
- State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

Accreditation Required for Participation:
None
TENNESSEE
TennCare II

CONTACT INFORMATION

State Medicaid Contact: Darin J. Gordon
TennCare
(615) 507-6443

State Website Address: http://www.tn.gov/tenncare

PROGRAM DATA

Program Service Area: Statewide
Initial Waiver Approval Date: May 30, 2002
Operating Authority: 1115(a) - Demonstration Waiver Program
Implementation Date: July 01, 2002
Statutes Utilized: Not Applicable
Waiver Expiration Date: June 30, 2013
Enrollment Broker: No
Sections of Title XIX Waived:

-1902(a)(1) Statewidensness/Uniformity
-1902(a)(10) Access to FQHCs and RHCs
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(17) Comparability and Amount, Duration, and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(34) Retroactive Eligibility
-1902(a)(4)(A) Proper and Efficient Administration
-1902(a)(54) Payment for Outpatient Drugs
-1902(a)(8) Reasonable Promptness
For All Areas Phased-In: No

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-CHIP-Related Medicaid Expansion Demonstration Population Children
-Continuing Receipt of Home and Community-Based Services
-Continuing Receipt of Nursing Facility Care
-Expenditures for Expanded Benefits and Coverage of Cost-Effective Alternative Services
-Expenditures for Pool Payments
-Expenditures Related to Eligibility Expansion
-Expenditures Related to Expansion of Existing Eligibility Groups
-Expenditures related to MCO Enrollment and Disenrollment
-HCBS Services for SSI-Eligibles
-Indirect Payment of Graduate Medical Education
-LTC Partnership
-Payments for Non-Risk Contractor
-The 217-Like HCBS Group

Guaranteed Eligibility: No guaranteed eligibility

SERVICE DELIVERY
TENNESSEE
TennCare II

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Bariatric Surgery, Case Management, Chiropractic, Community Health Services, Crisis, Detoxification, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Medical Supplies, Mental Health Rehabilitation, Mental Health Residential, Methadone Clinic Services Under Age 21 Only, Occupational Therapy, Organ & Tissue Transplant Services and Donor Organ/Tissue Procurement Services, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Physician Inpatient Services, Physician Outpatient Services/Community Health Clinics/Other Clinical Services, Podiatry, Private Duty Nursing, Psychiatric Inpatient Facility Services, Psychiatric Rehabilitation Services, Psychiatric Residential Treatment Services, Reconstructive Breast Surgery, Renal Dialysis Clinic Services, Residential Substance Use Disorders Treatment Programs, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
- Aged and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Foster Care Children
- Institutionalized adults
- Institutionalized children
- Medically Needy (Pregnant Women and Children)
- Medicare Dual Eligibles
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
- SSI eligible children
- Uninsurable children (Title XIX)
- Uninsured children (Title XXI)

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligibles

Lock-In Provision:
No lock-in

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

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable
## TennCare II

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

### Prepaid Inpatient Health Plan (partial risk, comprehensive) - Partial Capitation

#### Service Delivery

<table>
<thead>
<tr>
<th>Included Services</th>
<th>Allowable PCPs</th>
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</thead>
<tbody>
<tr>
<td>Bariatric Surgery, Case Management, Chiropractic, Community Health Services, Crisis, Detoxification, Disease Management, Donor Organ/Tissue Procurement Services, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Medical Supplies, Mental Health Rehabilitation, Mental Health Residential, Methadone Clinic Services (under age 21 only), Occupational Therapy, Organ and Tissue Transplant Services, Outpatient Hospital, Outpatient Substance Use Disorders, Physical Therapy, Physical Outpatient Services, Physician, Physician Inpatient Services, Podiatry, Private Duty Nursing, Psychiatric Inpatient Facility Services, Psychiatric Rehabilitation Services, Psychiatric Residential Treatment Services, Reconstructive Breast Surgery, Renal Dialysis Clinic Services, Residential Substance Use Disorders Treatment Programs, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray</td>
<td>Not applicable, contractors not required to identify PCPs</td>
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</table>

### Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>-Children and Adults in HCBS</td>
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<tr>
<td></td>
<td>-Foster Care Children</td>
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<tr>
<td></td>
<td>-Medicare Dual Eligibles</td>
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<td>-SSI Eligible Children</td>
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<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
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<tr>
<td>-Medicare Dual Eligibles</td>
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<tr>
<th>Medicare Dual Eligibles Included:</th>
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<tr>
<td>QMB Plus, SLMB Plus, and Medicaid only (under age 21)</td>
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<tr>
<th>Medicare Dual Eligibles Excluded:</th>
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<tbody>
<tr>
<td>QMB</td>
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<tr>
<td>SLMB, QI, and QDWI</td>
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### Part D Benefit

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<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
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<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
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<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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**Pharmacy Benefit Manager PAHP - Administrative Services Fee**

### Service Delivery

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<th>Included Services:</th>
<th>Allowable PCPs:</th>
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<tbody>
<tr>
<td>Pharmacy</td>
<td>-Not applicable, contractors are not required to identify PCPs</td>
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### Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
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<tbody>
<tr>
<td>None</td>
<td>-Aged and Related Populations</td>
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<td>-Foster Care Children</td>
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<td>-Institutionalized Adults</td>
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<td>-Institutionalized Children</td>
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<td>-Medically Needy (Pregnant Women and Children)</td>
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<td>-Medicare Dual Eligibles</td>
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<td>-Section 1931 Adults and Related Populations</td>
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<td>-Uninsurable Children (Title XIX)</td>
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<td>-Uninsured Children (Title XXI)</td>
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#### Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligibles

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<th>Medicare Dual Eligibles Included:</th>
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<tbody>
<tr>
<td>QMB Plus, SLMB Plus, and Medicaid only (under age 21)</td>
<td>SLMB, QI, and QDWI</td>
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<td>QMB</td>
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<td></td>
<td>QMB Plus, SLMB Plus, and Medicaid only (age 21 and older)</td>
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### Lock-In Provision:
Does not apply because State only contracts with one managed care entity

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
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<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
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<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
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<tr>
<td>Not Applicable</td>
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<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
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<td>None</td>
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**TENNESSEE**  
**TennCare II**

## Dental Benefit Manager PAHP - Administrative Services Fee

### Service Delivery

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>-Not applicable, contractors not required to identify PCPs</td>
</tr>
</tbody>
</table>

### Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>-All TENNCARE Standard and TENNCARE Medicaid under age 21</td>
</tr>
<tr>
<td></td>
<td>-Medicare Dual Eligibles</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
<th>Lock-In Provision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Medicare Dual Eligibles</td>
<td>Does not apply because State only contracts with one managed care entity</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Included:</th>
<th>Medicare Dual Eligibles Excluded:</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB Plus, SLMB Plus, and Medicaid only (under age 21)</td>
<td>QMB SLMB, QI, and QDWI QMB Plus, SLMB Plus, and Medicaid only (age 21 and older)</td>
</tr>
</tbody>
</table>

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
</tr>
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<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
<th></th>
</tr>
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<td>None</td>
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</table>

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

| Yes |

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

- Reviews complaints and grievances to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups

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

- Aging Agency
- Developmental Disabilities Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Social Services Agencies
- Substance Abuse Agency
### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>AmeriChoice - East TN</th>
<th>AmeriChoice - Middle TN</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriChoice - West TN</td>
<td>AmeriGroup Community Care</td>
</tr>
<tr>
<td>DentaQuest</td>
<td>SXC Health Solutions Corporation</td>
</tr>
<tr>
<td>Volunteer State Health Plan (Bluecare) - East</td>
<td>Volunteer State Health Plan (Bluecare) - West</td>
</tr>
<tr>
<td>Volunteer State Health Plan (TennCare Select)</td>
<td></td>
</tr>
</tbody>
</table>

### ADDITIONAL INFORMATION

1. **Phased-In:** As of July 1, 2010, the CHOICES program in TennCare was NOT fully phased in. On July 1, 2010, Nursing Facility (NF) services and Home and Community Based Services (HCBS) for persons considered to be institutionalized were provided through the MCOs and the PIHP (TennCare Select) in Middle Tennessee. NF services and HCBS in East and West Tennessee continued to be provided on a fee-for-service basis until August 1, 2010, when the CHOICES program was implemented statewide.

2. **Guaranteed Eligibility** is offered to Pregnant Women only - 60 days post delivery. The total period of eligibility will vary depending on the number of months the enrollees was pregnant at the time eligibility was granted.

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

4. MCO/PIHP included Services: Chiropractic, Hearing, and Methadone Clinic Services are covered as medically necessary for under 21. Private Duty Nursing services are subject to specific limitations and medical necessity. Emergency Air and Ground Transportation is covered. Non-Emergency Transportation including Ambulance services is covered.

5. **PIHP:** TennCare Select is a prepaid inpatient health plan (PIHP) (as defined in 42 CFR 438.2) which operates in all areas of the State and covers the same services as the MCOs for the individuals described in paragraph 7 below. The State's TennCare Select contractor is reimbursed on a partial risk basis for services rendered to covered populations, and in addition receives fees from the State to offset administrative costs. TennCare Select is at risk for meeting EPSDT Screening Rate targets as reported annually on the CMS 416 report. TennCare Select is also at risk for medical and mental health services.

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

7. **Lock-in:** PIHP: Children eligible for SSI, children receiving care in a NF or Intermediate Care Facility for Persons with Mental Retardation, and children and adults in a Home and Community Based Services 1915(c) Waiver for individuals with mental retardation are not locked into TennCare Select and may enroll in an MCO if one is available. Children in State custody and children leaving State custody for six months post-custody who remain eligible and enrollees living in areas where there is insufficient capacity to serve them are locked into TennCare Select.

8. MCO/PIHP: Full Benefit Medicare Dual Eligibles are enrolled in managed care programs. QMB only, SLMB only, QI and QDWI are not enrolled in managed care.

9. The Dental Benefits Manager (DBM) and Pharmacy Benefits Manager (PBM) are PAHPs and are paid an Administrative Services Fee. The managers handle claims administrative and are reimbursed for the claims amount(s). The DBM and PBM are currently non-risk but may be renegotiated at as risk. Provider rates are established in accordance with the State plan.

10. In both the DBM and the PBM, full benefit dual eligibles under age 21 are included. Partial benefit dual eligibles of any age and full benefit dual eligibles age 21 and older are excluded.

11. Some of our managed care entities have separate Medicare Advantage Plans, but these are independent of the Medicaid Program. The Bureau of TennCare does not have separate contracts with these plans for passive enrollment of dual eligibles into their Medicare Advantage Plans.

### QUALITY ACTIVITIES FOR MCO/PIHP

350
**TENNESSEE**
**TennCare II**

**State Quality Assessment and Improvement Activities:**
- Accreditation for Participation
- Consumer Self-Report Data (see below for details)
- Development of Quality Strategy for Tennessee
- Encounter Data (see below for details)
- Enrollee Hotlines
- MCO/PIHP Standards
- Monitoring of MCO/PIHP Standards
- Network Data
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

**Use of Collected Data:**
- ANOVA (Analysis of Variance)
- Contract Standard Compliance
- Data Mining
- Enhanced/Revise State managed care Medicaid Quality Strategy
- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

**Consumer Self-Report Data:**
- CAHPS
  - Health Plan Survey Adult Version (CPA)
  - Health Plan Survey Child Version: Children with Chronic Conditions (CCC)
  - Health Plan Survey Child Version: General Population (CPC)
  - Medicaid Adult Questionnaire
  - Medicaid Child Questionnaire

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

**Encounter Data**

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

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

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

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

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

**State conducts general data completeness assessments:**
- Yes
TENNESSEE
TennCare II

Performance Measures

Process Quality:
- Adolescent immunization rate
- Adolescent well-care visit rate
- Appropriate Testing for Children with Pharyngitis
- Appropriate treatment for Children with Upper Respiratory Infection (URI)
- Asthma care - medication use
- Beta-blocker treatment after heart attack
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Chlamydia screening in women
- Cholesterol screening and management
- Controlling high blood pressure
- Dental services
- Diabetes medication management
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds
- Initiation of prenatal care - timeliness of
- Lead screening rate
- Percentage of beneficiaries with at least one dental visit
- Smoking prevention and cessation
- Vision services for individuals less than 21 years of age
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
- Breast Cancer and Cervical Cancer rates
- Infant Mortality
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of low birth weight infants

Access/Availability of Care:
- Adult's access to preventive/ambulatory health services
- Average distance to PCP
- Children's and adolescents access to primary care practitioners
- Percent of PCPs with open or closed patient assignment panels
- Prenatal and Postpartum Care
- Ratio of dental providers to beneficiaries
- Ratio of PCPs to beneficiaries

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

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

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

Beneficiary Characteristics:
- Beneficiary need for interpreter

Performance Measures - Others:
None
Performance Improvement Projects

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

**Clinical Topics:**
- Cholesterol screening and management
- Diabetes management
- Emergency Room service utilization
- Inpatient maternity care and discharge planning
- Low birth-weight baby
- Post-natal Care
- Pre-natal care

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

Standards/Accreditation

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

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

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

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

**EQRO Name:**
- Q-Source

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

**EQRO Optional Activities:**
- Administration or validation of consumer or provider surveys
- Assessment of MCO/PIHP information systems
- Calculation of performance measures
- Technical assistance to MCOs/PIHPs to assist them in conducting quality activities

Pay for Performance (P4P) for MCO

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

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
Covers all MCO members

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness
**TENNESSEE**

**TennCare II**

<table>
<thead>
<tr>
<th><strong>Initial Year of Reward:</strong></th>
<th><strong>2006</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Incentives:</strong></td>
<td><strong>Not Applicable</strong></td>
</tr>
</tbody>
</table>

**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.

### Quality Activities for Dental Benefit Manager PAHP

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

#### Consumer Self-Report Data:
None

#### Use of Collected Data:
- Contract Standard Compliance
- Data Mining
- Fraud and Abuse
- Monitor Quality Improvement
- Plan Reimbursement
- Program Modification, Expansion, or Renewal
- Track Health Service provision

#### 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

#### 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.

#### 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

#### Validation - Methods:
- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
- Medical record validation
- Specification/source code review, such as a programming language used to create an encounter data file for submission
PAHP conducts data accuracy check(s) on specified data elements:
- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure
- Amount of Payment

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
-Dental services

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

Access/Availability of Care:
-Dental Screening ratio (observed/expected)
-Ratio of dental providers to beneficiaries

Use of Services/Utilization:
-Percentage of beneficiaries with at least one dental visit

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

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

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

Performance Measures - Others:
None

Performance Improvement Projects

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

Clinical Topics:
-Child/Adolescent Dental Screening and Services

Non-Clinical Topics:
Not Applicable - PAHPs are not required to conduct common project(s)

Standards/Accreditation

PAHP Standards:
-State-Developed/Specified Standards

Accreditation Required for Participation:
None
<table>
<thead>
<tr>
<th>QUALITY ACTIVITIES FOR PHARMACY BENEFIT MANAGER PAHP</th>
</tr>
</thead>
</table>

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

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

**Consumer Self-Report Data:**
None

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

**Encounter Data**

**Collection: Requirements:**
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
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- Requirements for PAHPs to collect and maintain encounter data
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**PAHP conducts data accuracy check(s) on specified data elements:**
- Date of Service
- Date of Processing
- Date of Payment
- Provider ID

**State conducts general data completeness assessments:**
Yes
TENNESSEE
TennCare II

- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure
- Amount of Payment

Performance Measures

Process Quality: None
Health Status/Outcomes Quality: None

Access/Availability of Care: None
Use of Services/Utilization: - Drug Utilization

Health Plan Stability/ Financial/Cost of Care: Net Worth, Total Revenue
Health Plan/ Provider Characteristics: Pharmacy Taxonomy (retail vs. specialty vs. LTC, etc), Valid Pharmacy License

Beneficiary Characteristics: None
Performance Measures - Others: None

Performance Improvement Projects

Project Requirements: PAHPs are required to conduct a project(s) of their own choosing
Clinical Topics: None

Non-Clinical Topics: Network Access, Trends in Pharmacy Appeals

Standards/Accreditation

PAHP Standards: State-Developed/Specified Standards
Accreditation Required for Participation: None

Non-Duplication Based on Accreditation: None
CONTACT INFORMATION

State Medicaid Contact: Emma Chacon
Utah State Department of Health
(801) 538-6577

State Website Address: http://www.health.utah.gov/medicaid

PROGRAM DATA

Program Service Area: Statewide

Operating Authority: 1115(a) - Demonstration Waiver Program

Statutes Utilized: Not Applicable

Enrollment Broker: No

For All Areas Phased-In: No

Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: February 08, 2002

Implementation Date: July 01, 2002

Waiver Expiration Date: June 30, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(14) Enrollment Fee
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-Eligibility Expansion
-Restrictions on Coverage

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Crisis, Inpatient Mental Health, Mental Health Outpatient,
Mental Health Rehabilitation, Transportation

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
-Section 1931 Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
Lock-In Provision:
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UTAH
Primary Care Network (PCN)

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Diabetes self-management, Durable Medical Equipment, Emergency Room, ESRD, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Medical Detoxification, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Primary Care, Speech Therapy, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
- American Indian/Alaska Native
- Medically Needy (not aged, blind, or disabled) Adults
- Medicare Dual Eligibles
- Section 1931 Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
- Reside in Nursing Facility or ICF/MR
- Resident of the State Developmental Center (DD/MR facility)
- Resident of the Utah State Hospital (IMD)

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

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
Medical-only PAHP (risk or non-risk, non-comprehensive) - Non-risk Capitation

Service Delivery

Included Services:
- Case Management, Diabetes self-management, Durable Medical Equipment, ESRD, Family Planning, Hearing, HIV Prevention, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient medical detoxification, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Speech Therapy, Vision, X-Ray

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

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
- American Indian/Alaska Native
- Medically Needy (not aged, blind, or disabled) Adults
- Medicare Dual Eligibles
- Section 1931 Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
- Demonstration Population I, under the Waiver III, IV, V, VI
- During Retroactive Eligibility Period
- Eligibility Less Than 3 Months
- Eligible only for TB-related Services
- If approved as exempt from mandatory enrollment
- Medicare Dual Eligibles
- Reside in Nursing Facility or ICF/MR
- Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)

Lock-in Provision:
12 month lock-in

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

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

Program Includes People with Complex (Special) Needs:
Yes
UTAH
Primary Care Network (PCN)

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

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

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy U
Select Access
Molina Healthcare of Utah (Molina)

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)
- Monitoring of MCO Standards
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

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

Use of Collected Data:
- Contract Standard Compliance
- Fraud and Abuse
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting

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

Encounter Data

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

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

Collection: Standardized Forms:
- ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Validation - Methods:
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Per member per month analysis and comparisons across MCO
UTAH
Primary Care Network (PCN)

MCO/HIO conducts data accuracy check(s) on specified data elements:
- Date of Service
- Provider ID
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Possible duplication of encounter.

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
- Asthma care - medication use
- Breast Cancer screening rate
- Cervical cancer screening rate
- Chlamydia screening in women
- Cholesterol screening and management
- Colorectal Cancer Screening
- Diabetes medication management
- Immunizations for two year olds
- Influenza vaccination rate

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

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

Use of Services/Utilization:
- Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
- Actual reserves held by plan
- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- Total revenue

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

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

Clinical Topics:
- Diabetes management

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
- State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
-HCE Quality Quest
UTAH
Primary Care Network (PCN)

EQRO Organization:
- QIO-like entity

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

EQRO Optional Activities:
None

Pay for Performance (P4P)

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

Program Payers:
Not Applicable

Population Categories Included:
Not Applicable

Rewards Model:
Not Applicable

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Not Applicable

Initial Year of Reward:
Not Applicable

Evaluation Component:
Not Applicable

Member Incentives:
Not Applicable

QUALITY ACTIVITIES FOR PAHP

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

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

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

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

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:
None

Accreditation Required for Participation:
None
## QUALITY ACTIVITIES FOR PCCM

### Quality Oversight Activities:
- Consumer Self-Report 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:
- State-developed Survey

### Performance Measures

#### Process Quality:
None

#### Health Status/Outcomes Quality:
None

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

#### Use of Services/Utilization:
None

#### Provider Characteristics:
None

#### Beneficiary Characteristics:
None

### Performance Measures - Others:
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)

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
-Expenditures 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

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# VERMONT Global Commitment to Health

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
</tr>
</thead>
</table>
| 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 | - Family Practitioners  
- Federally Qualified Health Centers (FQHCs)  
- General Practitioners  
- Indian Health Service (IHS) Providers  
- Internists  
- Nurse Practitioners  
- Obstetricians/Gynecologists or Gynecologists  
- Other Specialists Approved on a Case-by-Case Basis  
- Pediatricians  
- Rural Health Clinics (RHCs) |

## Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
</table>
| None | - 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

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Included:</th>
<th>Medicare Dual Eligibles Excluded:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include all categories of Medicare Dual Eligibles</td>
<td>None</td>
</tr>
</tbody>
</table>

## Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Scope of Part D Coverage:

- Standard Prescription Drug

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

- Agents when used for anorexia, weight loss, weight gain  
- Barbituates  
- Benzodiazepines  
- Nonprescription drugs  
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
VERMONT
Global Commitment to Health

Yes

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

Agencies with which Medicaid Coordinates the Operation of the Program:
- Department for Children and Families (DCF)
- Department of Disability, Aging and Independent Dept. of Disability, Aging and Independent Living (D
- Department of Education (DOE)
- Department of Mental Health (DMH)
- Vermont Department of Health (VDH)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Global Commitment to Health

ADDITIONAL INFORMATION

Under Vermont's Global Commitment to Health 1115 Demonstration, the single State agency (Agency of Human Services (AHS)) has entered into an agreement with the Division of Vermont Health Access (DVHA). DVHA is a public agency. The AHS pays DVHA on a capitated basis (fixed rate multiplied by member months).

For the purposes of mental health: Children with severe emotional disturbance 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

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

Consumer Self-Report Data:
None

Use of Encounter Data

Collection: Requirements:
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Requirements for MCOs to collect and maintain encounter

Collections: Submission Specifications:
None
## Collection: Standardized Forms:
None

## Validation - Methods:
- Automated analysis of encounter data submission to help determine 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 Medication 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

<table>
<thead>
<tr>
<th>MCO/HIO conducts data accuracy check(s) on specified data elements:</th>
<th>State conducts general data completeness assessments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Date of Service</td>
<td>No</td>
</tr>
<tr>
<td>- Date of Processing</td>
<td></td>
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<tr>
<td>- Date of Payment</td>
<td></td>
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<tr>
<td>- Provider ID</td>
<td></td>
</tr>
<tr>
<td>- Type of Service</td>
<td></td>
</tr>
<tr>
<td>- Medicaid Eligibility</td>
<td></td>
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<tr>
<td>- Plan Enrollment</td>
<td></td>
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<tr>
<td>- Diagnosis Codes</td>
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<tr>
<td>- Procedure Codes</td>
<td></td>
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<tr>
<td>- Revenue Codes</td>
<td></td>
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<tr>
<td>- Age-appropriate diagnosis/procedure</td>
<td></td>
</tr>
<tr>
<td>- Gender-appropriate diagnosis/procedure</td>
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</tbody>
</table>

## 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 Practitioners
- 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:
None

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

### Use of Services/Utilization:
- Adolescent well-care visits utilization
- Drug Utilization
- Inpatient admissions/1,000 beneficiary
- Well-child visits in first 15 months of life
- Well-child visits in the 3, 4, 5, and 6 years of life

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

### Health Plan/Provider Characteristics:
None
## VERMONT
### Global Commitment to Health

<table>
<thead>
<tr>
<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
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</tbody>
</table>

### Performance Improvement Projects

<table>
<thead>
<tr>
<th>Project Requirements:</th>
<th>Clinical Topics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- MCOs are required to conduct a project(s) of their own choosing</td>
<td>- Increasing adherence to Evidence Based Guidelines in Members with Congestive Heart failure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Clinical Topics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Fostering Healthy Families</td>
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</tbody>
</table>

### Standards/Accreditation

<table>
<thead>
<tr>
<th>MCO Standards:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare</td>
</tr>
<tr>
<td>- State-Developed/Specified Standards</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
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<table>
<thead>
<tr>
<th>EQRO Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Health Services Advisory Group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EQRO Mandatory Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Review of MCO compliance with structural and operational standards established by the State</td>
</tr>
<tr>
<td>- Validation of performance measures</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>EQRO Optional Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Technical assistance to MCOs to assist them in conducting quality activities</td>
</tr>
</tbody>
</table>

### Pay for Performance (P4P)

<table>
<thead>
<tr>
<th>Implementation of P4P:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The State HAS NOT implemented a Pay-for-Performance program with the MCO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Payers:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
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</table>

<table>
<thead>
<tr>
<th>Population Categories Included:</th>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Rewards Model:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Conditions:</th>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurement of Improved Performance:</th>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial Year of Reward:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Evaluation Component:</th>
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</thead>
<tbody>
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</table>

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<thead>
<tr>
<th>Member Incentives:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
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://hraa.dhs.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 been determined to be eligible for Medicaid or CHIP, and who are currently enrolled, or become newly enrolled in Medical Care Services

**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

**Medicare Dual Eligibles Included:**
None

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

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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

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

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

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

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Aging Agency
- Developmental Disabilities Agency
- Economic Services Administration which does eligibility determinations
- Housing Agencies
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Transportation Agencies

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

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Health Plan
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.

**QUALITY ACTIVITIES FOR MCO/HIO**

**State Quality Assessment and Improvement**

**Activities:**
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- 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
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- State Medicaid Managed care Quality Strategy
- Track Health Service provision

**Consumer Self-Report Data:**

None

**Use of HEDIS:**
- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
- State use/requires MCOs 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
- 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:**
- Not Applicable
WASHINGTON
Bridge to Reform: Medical Care Services

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:
- Diabetes medication management

Health Status/Outcomes Quality:
None

Access/Availability of Care:
None

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

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
- Information of beneficiary ethnicity/race

Performance Measures - Others:
None

Performance Improvement Projects

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

Clinical Topics:
- Not Applicable

Non-Clinical Topics:
- Not Applicable

Standards/Accreditation

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

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
- Accumentra

EQRO Organization:
- EQRO

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
## Pay for Performance (P4P)

<table>
<thead>
<tr>
<th>Implementation of P4P:</th>
<th>Program Payers:</th>
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<tbody>
<tr>
<td>The State HAS NOT implemented a Pay-for-Performance program with the MCO</td>
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<table>
<thead>
<tr>
<th>Population Categories Included:</th>
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<tr>
<th>Clinical Conditions:</th>
<th>Measurement of Improved Performance:</th>
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<tr>
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<tr>
<th>Initial Year of Reward:</th>
<th>Evaluation Component:</th>
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<tr>
<th>Member Incentives:</th>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
## 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

<table>
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<tr>
<th>Program Service Area:</th>
<th>Initial Waiver Approval Date:</th>
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<tr>
<td>Statewide</td>
<td>January 01, 2011</td>
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<th>Operating Authority:</th>
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<td>1115(a) - Demonstration Waiver Program</td>
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<th>Waiver Expiration Date:</th>
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<td>December 31, 2013</td>
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<th>Enrollment Broker:</th>
<th>Sections of Title XIX Waived:</th>
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<tbody>
<tr>
<td>No</td>
<td>-1902(a)(10)(B) Amount, Duration and Scope</td>
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<td></td>
<td>-1902(a)(10)(b)(i) Waiting Period for Pre-existing Conditions</td>
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<td>-1902(a)(13)(A) Public Process for Hospital Payments</td>
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<td>-1902(a)(14) Cost-Sharing Requirements</td>
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<td>-1902(a)(17)(D) Comparability for Eligibility Standards</td>
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<tr>
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<td>-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 of sufficient information</td>
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<tr>
<td></td>
<td>-1902(a)(23) Freedom of Choice</td>
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<td>-1902(a)(3) Fair Hearings (Restricted Period)</td>
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<td>-1902(a)(34) Retroactive Eligibility</td>
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<td></td>
<td>-1902(a)(43) EPSDT</td>
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<td></td>
<td>-1902(a)(8) Reasonable Promptness</td>
</tr>
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<table>
<thead>
<tr>
<th>For All Areas Phased-In:</th>
<th>Sections of Title XIX Costs Not Otherwise Matchable Granted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>-1903(m)(2)(A)(xii), but only insofar as it requires compliance with section 1932(a)(3)(A)</td>
</tr>
<tr>
<td></td>
<td>-MCO Limits Disenrollment Rights {1903(m)(2)(A)(vi)}</td>
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</table>

<table>
<thead>
<tr>
<th>Guaranteed Eligibility:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No guaranteed eligibility</td>
<td></td>
</tr>
</tbody>
</table>

## SERVICE DELIVERY

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

#### Service Delivery

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
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</thead>
<tbody>
<tr>
<td>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</td>
<td>-Clinical Social Workers</td>
</tr>
<tr>
<td></td>
<td>-Family Practitioners</td>
</tr>
<tr>
<td></td>
<td>-Federally Qualified Health Centers (FQHCs)</td>
</tr>
<tr>
<td></td>
<td>-General Practitioners</td>
</tr>
<tr>
<td></td>
<td>-Indian Health Service (IHS) Providers</td>
</tr>
</tbody>
</table>
WASHINGTON
Bridge to Reform: The Basic Health Plan

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

- Internists
- Nurse Midwives
- Nurse Practitioners
- Obstetricians/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

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)

Populations Mandatorily Enrolled:
- Must be age 19 to 64, U.S. citizen or qualified non U.S. citizen, not eligible or enrolled in free or purchased Medicare, not eligible or enrolled in Medicaid, not enrolled in Washington Health Program and not living in the U.S. on student visa

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

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

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

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

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes
WASHINGTON
Bridge to Reform: The Basic Health Plan

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Developmental Disabilities Agency
-Mental Health Agency
-Private Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Columbia United Providers
Group Health Cooperative

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 Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

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 continuous enrollment requirement for some or all of the measures

Consumer Self-Report Data:
-Use the most recent HEDIS version of the commercial adult questionnaire or as instructed by NCQA for 2011 CAHPS™ surveys

Use of HEDIS:
-Use the most recent HEDIS version of the commercial adult questionnaire or as instructed by NCQA for 2011 CAHPS™ surveys
Performance Measures

**Process Quality:**
- Antidepressant medication management
- Cholesterol screening and management
- Controlling high blood pressure
- Diabetes 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:**
- 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
- 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
- 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
- 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:**
- The contractor should conduct at least one Clinical Performance Improvement Topic as specified in the CMS protocol at http://www.cms.gov/medicaidchipqualprac/07_tools_tips_and_protocol cols.asp

**Non-Clinical Topics:**
- The contractor should conduct at least one Non-clinical Performance Improvement Topic as specified in the CMS protocol at http://www.cms.gov/medicaidchipqualprac/07_tools_tips_and_protocol cols.asp

**Standards/Accreditation**
# WASHINGTON
## Bridge to Reform: The Basic Health Plan

<table>
<thead>
<tr>
<th>MCO Standards:</th>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards</td>
<td>None</td>
</tr>
<tr>
<td>- NCQA (National Committee for Quality Assurance) Standards</td>
<td></td>
</tr>
<tr>
<td>- State-Developed/Specified Standards</td>
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<tr>
<td>- URAC Standards</td>
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<table>
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<tr>
<th>Non-Duplication Based on Accreditation:</th>
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<td>Accumentra</td>
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<table>
<thead>
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<th>EQRO Organization:</th>
<th>EQRO Mandatory Activities:</th>
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<tr>
<td>- EQRO</td>
<td>- Validation of performance improvement projects</td>
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<td></td>
<td>- Validation of performance measures</td>
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<th>EQRO Optional Activities:</th>
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<tbody>
<tr>
<td>- 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 Contractor</td>
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## Pay for Performance (P4P)

<table>
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<tr>
<th>Implementation of P4P:</th>
<th>Program Payers:</th>
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## CONTACT INFORMATION

**State Medicaid Contact:**
Jerry Smallwood  
Department of Health Care Policy and Financing  
303-866-5947

**State Website Address:**
http://www.colorado.gov/hcpf

## PROGRAM DATA

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<tr>
<th>Program Service Area:</th>
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<tr>
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<tr>
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<td>MAXIMUS, INC.</td>
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<tr>
<th>For All Areas Phased-In:</th>
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</thead>
<tbody>
<tr>
<td>No guaranteed eligibility</td>
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</tbody>
</table>

## SERVICE DELIVERY

### PCCM Provider - Fee-for-Service

**Service Delivery**

**Included Services:**
- Case Management  
- EPSDT  
- Hearing  
- Immunization  
- Inpatient Hospital  
- Inpatient Substance Use Disorders  
- Laboratory  
- Outpatient Hospital  
- Pharmacy  
- Physician  
- X-Ray

**Allowable PCPs:**
- Family Practitioners  
- Federally Qualified Health Centers (FQHCs)  
- General Practitioners  
- Internists  
- Nurse Practitioners  
- Obstetricians/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
COLORADO
Accountable Care Collaborative (ACC) Program

- 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

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

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

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

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

Agencies with which Medicaid Coordinates the Operation of the Program:
- Developmental Disabilities Agency
- Public Health Agency
- Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Accountable Care Collaborative Program

ADDITIONAL INFORMATION

Program is a PCCM that closely resembles a 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:
- 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
**COLORADO**
Accountable Care Collaborative (ACC) Program

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

---

## Performance Measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Measures</th>
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<tr>
<td><strong>Process Quality:</strong></td>
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<tr>
<td><strong>Health Status/Outcomes Quality:</strong></td>
<td>Patient satisfaction with care</td>
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<td>Percentage of beneficiaries who are satisfied with their ability to obtain care</td>
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<tr>
<td><strong>Access/Availability of Care:</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Use of Services/Utilization:</td>
</tr>
<tr>
<td></td>
<td>- Emergency room visits/1,000 beneficiaries</td>
</tr>
<tr>
<td></td>
<td>- Inpatient admission for MH/SUD conditions/1,000 beneficiaries</td>
</tr>
<tr>
<td></td>
<td>- Use of high cost imaging</td>
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<tr>
<td><strong>Provider Characteristics:</strong></td>
<td>None</td>
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<td>Beneficiary Characteristics:</td>
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<td>None</td>
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<tr>
<td><strong>Performance Measures - Others:</strong></td>
<td>None</td>
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</table>

COLORADO
Primary Care Physician Program

CONTACT INFORMATION

State Medicaid Contact: Valerie baker-Easley
Department of Health Care Policy and Financing
303-866-3830

State Website Address: http://www.colorado.gov/hcpf

PROGRAM DATA

Program Service Area: Statewide
Operating Authority: 1932(a) - State Plan Option to Use Managed Care
Statutes Utilized: Not Applicable
Enrollment Broker: Maximus, INC.
For All Areas Phased-In: No
Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: Not Applicable
Implementation Date: June 30, 2003
Waiver Expiration Date: Not Applicable
Sections of Title XIX Waived: Not Applicable
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
- EPSDT, Hearing, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Pharmacy, Physician, X-Ray

Allowable PCPs:
- Family Practitioners
- General Practitioners
- Indian Health Service (IHS) Providers
- Internists
- Obstetricians/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
COLORADO
Primary Care Physician Program

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

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

Lock-In Provision:
  12 month lock-in

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

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

ePCCM - Fee-for-Service

Included Services:
  Case Management

Allowable PCPs:
  -Not Applicable

Service Delivery

Enrollment

Populations Voluntarily Enrolled:
  -Blind/Disabled Adults and Related Populations
  -Blind/Disabled Children and Related Populations
  -Medicare Dual Eligibles

Populations Mandatorily Enrolled:
  None

Subpopulations Excluded from Otherwise Included Populations:
  -Medicare Dual Eligibles

Lock-In Provision:
  No lock-in

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

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
COLORADO
Primary Care Physician Program

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

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

Agencies with which Medicaid Coordinates the Operation of the Program:
- Developmental Disabilities Agency
- Public Health Agency
- Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ePCCM
Primary Care Physician Program

ADDITIONAL INFORMATION

This program provides beneficiaries the option of a fee-for-service physician who acts as a gatekeeper and refers for specialty care. In addition to the gatekeeper "Primary Care Case Management Program" called the "Primary Care Physician Program", Colorado offers an enhanced Primary Care Case Management (ePCCM) program with two levels of enhanced services. All three versions share the common elements: Reimbursement for medical services is fee-for-service, Enrollment is voluntary (a "passive" or default enrollment mechanism is available), There is a 12 month lock-in period (until the Enrollees next birthday), and Most medical services provided by someone other than the chosen Primary Care Provider need a referral.

The two enhanced version of the program have these additional characteristics: Per Member per Month (PMPM) case management payments depending upon the level of "enhancements" provided and the kinds of clients enrolled, and Ability to earn bonus incentive payments attributable to a reduction in utilization or costs after recovery of PMPM expenditures.
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
Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932(a) - State Plan Option to Use Managed Care
Implementation Date: April 01, 1994
Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable
Enrollment Broker: Policy Studies, Inc.
Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable
Guaranteed Eligibility: No guaranteed eligibility

SERVICE DELIVERY

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
- Obstetricians/Gynecologists or Gynecologists
- Other Specialists Approved on a Case-by-Case Basis
- Pediatricians
- Psychiatrists
- Psychologists

Enrollment

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## 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

### Medicare Dual Eligibles Included:
None

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

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

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

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

### Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses provider referrals to identify members of these groups

### Agencies with which Medicaid Coordinates the Operation of the Program:
- Developmental Disabilities Agency
- Maternal and Child Health Agency
- Public Health Agency
- Social Services Agencies

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>DC Chartered Health Plan, Incorporated</th>
<th>United Healthcare Community Plan</th>
</tr>
</thead>
</table>

### 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.
DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

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 continuous enrollment requirement for some or all of the measures

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

Use of Collected Data:

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 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

Encounter Data

Collection: 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

Validation - Methods:
- Automated analysis of encounter data submission to help determine data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
- Medical record validation
- Per member per month analysis and comparisons across MCOs
- Specification/source code review, such as a programming language used to create an encounter data file for submission
MCO/HIO conducts data accuracy check(s) on specified data elements:
- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
- Adolescent immunization rate
- Check-ups after delivery
- Dental services
- Depression management/care
- Follow-up after hospitalization for mental illness
- Hearing services for individuals less than 21 years of age
- HIV/AIDS care
- Immunizations for two year olds
- Initiation of prenatal care - timeliness of
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit
- Vision services for individuals less than 21 years of age
- Well-child care visit rates in first 15 months of life
- Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality:
- Number of children with diagnosis of rubella(measles)/1,000 children
- Patient satisfaction with care
- Percentage of low birth weight infants

Access/Availability of Care:
- Average distance to PCP
- Average wait time for an appointment with PCP
- Children's access to primary care practitioners
- Ratio of mental health providers to 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:

Clinical Topics:
DISTRICT OF COLUMBIA
District of Columbia Medicaid Managed Care Program

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

Non-Clinical Topics:
-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
-NCOA (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
-NCOA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation: None

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Name:
-Delmarva Foundation for Medical Care

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

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

Pay for Performance (P4P)

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

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Not Applicable

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

<table>
<thead>
<tr>
<th>Initial Year of Reward:</th>
<th>Evaluation Component:</th>
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</thead>
<tbody>
<tr>
<td>2006</td>
<td>The State HAS NOT conducted an evaluation of the effectiveness of its P4P program</td>
</tr>
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</table>

Member Incentives: Not Applicable
GEORGIA
Georgia Better Health Care

CONTACT INFORMATION

State Medicaid Contact: Juanita Hines
Director, GBHC
(404) 657-0623

State Website Address: http://www.dch.ga.gov

PROGRAM DATA

Program Service Area: Statewide
Operating Authority:
1932(a) - State Plan Option to Use Managed Care
Statutes Utilized: Not Applicable
Enrollment Broker: No
For All Areas Phased-In: No

Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: Not Applicable
Implementation Date: October 01, 1993
Waiver Expiration Date: Not Applicable
Sections of Title XIX Waived: Not Applicable
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

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

Enrollment

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

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Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in Another Managed Care Program
- Medicare Dual Eligibles
- Other Insurance
- Participate in HCBS Waiver
- Poverty Level Pregnant Woman
- Reside in Nursing Facility or ICF/MR
- Retroactive Eligibility
- Special Needs Children (BBA defined)
- Special Needs Children (State defined)
- Title XXI CHIP

Medicare Dual Eligibles Included:
None

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

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

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

Serving People with Complex (Special) Needs

Program Includes People with Complex (Special) Needs:
Yes

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

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

Participating Plans/PCCM and Other Programs

Georgia Better Health Care

Additional Information

None

Quality Activities for PCCM
# GEORGIA
## Georgia Better Health Care

### Quality Oversight Activities:
- Enrollee Hotlines
- Performance Measures (see below for details)

### Use of Collected Data:
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:
None

### Performance Measures

<table>
<thead>
<tr>
<th>Performance Measures - Others:</th>
<th>Performance Measures - Others:</th>
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<tbody>
<tr>
<td>None</td>
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<tr>
<th>Process Quality:</th>
<th>Health Status/Outcomes Quality:</th>
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<tr>
<td>None</td>
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<thead>
<tr>
<th>Access/Availability of Care:</th>
<th>Use of Services/Utilization:</th>
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<tbody>
<tr>
<td>Average distance to primary care case manager</td>
<td>Drug Utilization</td>
</tr>
<tr>
<td>Average wait time for an appointment with primary care case manager</td>
<td>Emergency room visits/1,000 member months</td>
</tr>
<tr>
<td>Ratio of primary care case managers to beneficiaries</td>
<td>Inpatient admissions/1,000 member months</td>
</tr>
<tr>
<td>Number of primary care case manager visits per beneficiary</td>
<td></td>
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<table>
<thead>
<tr>
<th>Provider Characteristics:</th>
<th>Beneficiary Characteristics:</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>Percentage of beneficiaries who are auto-assigned to PCCM</td>
</tr>
</tbody>
</table>


**GEORGIA**  
Georgia Families  

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**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**  

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<thead>
<tr>
<th>Program Service Area:</th>
<th>Initial Waiver Approval Date:</th>
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<td>Statewide</td>
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<th>Operating Authority:</th>
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<td>1932(a) - State Plan Option to Use Managed Care</td>
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<th>Statutes Utilized:</th>
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<tr>
<th>Enrollment Broker:</th>
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<td>Maximus</td>
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<thead>
<tr>
<th>For All Areas Phased-In:</th>
<th>Sections of Title XIX Costs Not Otherwise Matchable Granted:</th>
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</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Guaranteed Eligibility:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No guaranteed eligibility</td>
</tr>
</tbody>
</table>

---  
**SERVICE DELIVERY**  

**MCO (Comprehensive Benefits) - Risk-based Capitation**  

**Service Delivery**  

**Included Services:**  

**Allowable PCPs:**  
- Family Practitioners  
- Federally Qualified Health Centers (FQHCs)  
- General Practitioners  
- Interns  
- Nurse Practitioners  
- Obstetricians/Gynecologists or Gynecologists  
- Other Specialists Approved on a Case-by-Case Basis  
- Pediatricians  
- Physician Assistants  
- Public Health Department  
- Rural Health Clinics (RHCs)  

**Enrollment**  

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### GEORGIA

#### Georgia Families

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
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<tbody>
<tr>
<td>None</td>
<td>- Low-income Medicaid</td>
</tr>
<tr>
<td></td>
<td>- Poverty-Level Pregnant Women</td>
</tr>
<tr>
<td></td>
<td>- Refugees</td>
</tr>
<tr>
<td></td>
<td>- Right from State Medicaid</td>
</tr>
<tr>
<td></td>
<td>- Section 1931 Adults and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Section 1931 Children and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Women with Breast or Cervical Cancer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Aged, Blind, and Disabled</td>
</tr>
<tr>
<td>- Foster Care Children</td>
</tr>
<tr>
<td>- Long Term Care (includes Hospice)</td>
</tr>
<tr>
<td>- Medicare Dual Eligibles</td>
</tr>
<tr>
<td>- Participate in HCBS Waiver</td>
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<tr>
<td>- Reside in Nursing Facility or ICF/MR</td>
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<tr>
<td>- Special Needs Children (BBA defined)</td>
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<tr>
<td>- SSI and Members of Federally Recognized Indian Tribes</td>
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<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Included:</th>
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</thead>
<tbody>
<tr>
<td>None</td>
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**Part D Benefit**

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<tr>
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<thead>
<tr>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
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</table>

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Public Health Agency
- Social Services Agencies

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Amerigroup Community Care</th>
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</thead>
<tbody>
<tr>
<td>WellCare</td>
</tr>
<tr>
<td>Peach State Health Plan</td>
</tr>
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### ADDITIONAL INFORMATION

None
# QUALITY ACTIVITIES FOR MCO/HIO

<table>
<thead>
<tr>
<th>State Quality Assessment and Improvement Activities:</th>
<th>Use of Collected Data:</th>
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</thead>
<tbody>
<tr>
<td>- Accreditation for Participation</td>
<td>- Contract Standard Compliance</td>
</tr>
<tr>
<td>- Consumer Self-Report Data (see below for details)</td>
<td>- Data Mining</td>
</tr>
<tr>
<td>- Encounter Data (see below for details)</td>
<td>- Enhanced/Revise State managed care Medicaid Quality Strategy</td>
</tr>
<tr>
<td>- Focused Studies</td>
<td>- Fraud and Abuse</td>
</tr>
<tr>
<td>- MCO Standards (see below for details)</td>
<td>- Monitor Quality Improvement</td>
</tr>
<tr>
<td>- Network Data</td>
<td>- Plan Reimbursement</td>
</tr>
<tr>
<td>- Non-Duplication Based on Accreditation</td>
<td>- Program Evaluation</td>
</tr>
<tr>
<td>- On-Site Reviews</td>
<td>- Program Modification, Expansion, or Renewal</td>
</tr>
<tr>
<td>- Performance Improvement Projects (see below for details)</td>
<td>- Regulatory Compliance/Federal Reporting</td>
</tr>
<tr>
<td>- Performance Measures (see below for details)</td>
<td>- Track Health Service provision</td>
</tr>
<tr>
<td>- Provider Data</td>
<td></td>
</tr>
</tbody>
</table>

**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

**Use of Collected Data:**

- 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

**Encounter Data 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.

**Collection: Submission Specifications:**

- Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)

**Validation - Methods:**

- A monthly reconciliation of submitted encounters
- Periodic audit of encounter transaction to source document

**MCO/HIO conducts data accuracy check(s) on specified data elements:**

- Date of Service
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Age-appropriate diagnosis/procedure
- A unique TCN
- All required CMS1500 and UB04 codes
- CMO Paid Amount

**State conducts general data completeness assessments:**

- Yes
GEORGIA
Georgia Families

- Date of Birth
- Diagnosis Primary and Secondary
- Facility Code
- NPI Number
- Patient Name
- Place of Service
- Tax Identification Number
- Treating Provider
- Units of Service

Performance Measures

Process Quality:
- Adolescent well-care visit rate
- Appropriate treatment for Children with Upper Respiratory Infection (URI)
- Asthma care - medication use
- Breast Cancer screening rate
- Cervical cancer screening rate
- Comprehensive Diabetes Management
- Dental services
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation of prenatal care - timeliness of
- Lead screening rate
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of low birth weight infants

Access/Availability of Care:
- Adult's access to preventive/ambulatory health services
- Average distance to PCP
- Average wait time for an appointment with PCP
- Children's access to primary care practitioners
- Percent of PCPs with open or closed patient assignment panels
- Ratio of PCPs to beneficiaries

Use of Services/Utilization:
- Emergency room visits/1,000 member months
- Inpatient admissions/1,000 member months
- Re-admission rates of MH/SUD

Health Plan Stability/Financial/Cost of Care:
- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Total revenue

Health Plan/Provider Characteristics:
- None

Beneficiary Characteristics:
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries who are auto-assigned to MCO

Performance Measures - Others:
- None

Performance Improvement Projects

Project Requirements:
- MCOs are required to conduct a project(s) of their own choosing
- All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
- Adult Access
- Blood Lead Screening
- Dental
- Emergency Room Service Utilization
- Immunization
- Obesity
- Well Child Care/EPSDT
Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
- NCQA (National Committee for Quality Assurance) Standards
- URAC Standards

Accreditation Required for Participation:
- AAAHC (Accreditation Association for Ambulatory Health Care)
- JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
- NCQA (National Committee for Quality Assurance)

Non-Duplication Based on Accreditation:
- NCQA (National Committee for Quality Assurance)

EQRO Name:
- Health Services Advisory Group (HSAG)

EQRO Organization:
- Private accreditation organization
- QIO-like entity
- Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
- Review of health plan compliance with State and Federal Medicaid Managed Care Regulations
- Validation of performance improvement projects
- Validation of performance measures

EQRO Optional Activities:
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Population Categories Included:
Covers all MCO members

Rewards Model:
Payment incentives/differentials to reward MCOs

Clinical Conditions:
Not Applicable

Measurement of Improved Performance:
Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)

Initial Year of Reward:
2009

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but plans to conduct an evaluation in the future

Member Incentives:
Not Applicable
ILLINOIS
Illinois Health Connect Primary Care Case Management

CONTACT INFORMATION

State Medicaid Contact: Michelle Maher
Illinois Department of Healthcare and Family Services
(217) 524-7478

State Website Address: http://www.hfs.illinois.gov/

PROGRAM DATA

Program Service Area: Statewide

Operating Authority: 1932(a) - State Plan Option to Use Managed Care

Statutes Utilized: Not Applicable

Enrollment Broker: Automated Health Systems

For All Areas Phased-In: No

Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: Not Applicable

Implementation Date: July 01, 2006

Waiver Expiration Date: Not Applicable

Sections of Title XIX Waived: Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services: Assisted/Augmentative Communication Devices, Audiology, Blood and Blood Components, Case Management, Chiropractic, Clinic, Dental, Diagnosis and treatment of medical conditions of the eye, Disease Management, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Psychiatric Care, Inpatient Substance Use Disorders, Laboratory, Non-Durable Medical Equipment and Supplies, Nurse Midwives, Occupational Therapy, Orthotic/Prosthetic Devices, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Psychiatric Care, Skilled Nursing Facility, Speech Therapy, Transplants, Transportation, Vision, X-Ray

Allowable PCPs: -Certified Local Health Departments -Family Practitioners -Federally Qualified Health Centers (FQHCs) -General Practitioners -Internists -Obstetricians/Gynecologists or Gynecologists -Other Specialists Approved on a Case-by-Case Basis -Pediatricians -Rural Health Clinics (RHCs) -School-Based/Linked Clinics

Enrollment

401
ILLINOIS
Illinois Health Connect Primary Care Case Management

Populations Voluntarily Enrolled:
- American Indian/Alaska Native

Subpopulations Excluded from Otherwise Included Populations:
- All Kids Rebate and Family Care Rebate Program
- Blind Disabled Children and Related Populations
- Emergency Medical Only
- Individuals enrolled for treatment in the health benefit for persons with Breast or Cervical Cancer Program
- Individuals enrolled in programs with limited benefits
- Individuals in Presumptive Eligible Programs
- Medicare Dual Eligibles
- Non-citizens only receiving emergency services
- Other Insurance (High Level)
- PACE Participants
- Refugees
- Reside in Nursing Facility or ICF/MR
- Some people who receive Home and Community Based services
- Special Needs Children (BBA defined)
- Spenddown Eligibles
- Transitional Assistance, Age 19 and Older

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses claims data to identify members of these groups
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- All local agencies under administrative oversight of State agencies
- Employment Agencies
- Housing Agencies
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
ILLINOIS
Illinois Health Connect Primary Care Case Management

- Social Services Agencies
- Substance Abuse Agency
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Illinois Health Connect

ADDITIONAL INFORMATION
Enrollment in Illinois Health Connect is mandatory 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

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
<table>
<thead>
<tr>
<th>Illinois Health Connect Primary Care Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Pneumonia vaccination</td>
</tr>
<tr>
<td>- Prenatal and Postpartum Care</td>
</tr>
<tr>
<td>- Prenatal and Postpartum Screening for Depression</td>
</tr>
<tr>
<td>- Retinal Exam</td>
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<tr>
<td>- Statin Therapy</td>
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<tr>
<td>- Vision Services for 3, 4, 5, and 6 year olds</td>
</tr>
<tr>
<td>- Well-child care visit rates in 3, 4, 5, and 6 years of life</td>
</tr>
<tr>
<td>- Well-child care visit rates in first 15 months of life</td>
</tr>
</tbody>
</table>

**Access/Availability of Care:**
- Adult access to preventive/ambulatory health services
- Average distance to primary care case manager
- Children's access to primary care practitioners
- Enrollee Helpline to locate providers for services
- Percent of PCPs with open or closed patient assignment panels
- Ratio of primary care case managers to beneficiaries

**Use of Services/Utilization:**
- Emergency room visits/1,000 beneficiaries
- Hospitalizations for ambulatory sensitive conditions/1,000 beneficiaries
- Increase in Well Child Visits/3,4,5 and 6 yrs
- Increase in Well Child Visits/first 15 months

**Provider Characteristics:**
- Gender
- Languages spoken (other than English)
- Office hours
- Panel Availability
- Specialties

**Beneficiary Characteristics:**
- Disenrollment rate
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries who are auto-assigned to PCCM

**Performance Measures - Others:**
None
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

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, 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
-Obstetricians/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
ILLINOIS
Integrated Care Program

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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups
- Uses Medicaid claims data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Employment Agencies
- Housing Agencies
- Mental Health Agency
- Other Local Agencies under administrative oversight of State Agencies
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aetna Better Health
IlliniCare Health Plan, Inc.
ILLINOIS
Integrated Care Program

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/requirements MCOs to modify some or all NCQA specifications in ways other than continuous enrollment

Encounter Data

Collection: Requirements:
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for data validation
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
- 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.

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

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
## ILLINOIS
### Integrated Care Program

**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

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### Performance Measures

#### Process Quality:
- Ace Inhibitor/ARB Therapy
- Adult BMI assessment
- Ambulatory 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
- 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

#### Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care

#### 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
ILLINOIS
Integrated Care Program

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 Organization

**EQRO Mandatory Activities:**
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

**EQRO Optional Activities:**
- 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.)
### ILLINOIS Integrated Care Program

<table>
<thead>
<tr>
<th><strong>Initial Year of Reward:</strong></th>
<th>2012</th>
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</thead>
</table>

| **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: Sarah Jagger
Office of Medicaid Policy & Planning
(317) 234-5545

State Website Address: http://www.in.gov/fssa/2408.htm

PROGRAM DATA

Program Service Area: Statewide
Operating Authority: 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 or Gynecologists
- Other Specialists Approved on a Case-by-Case Basis
- Pediatricians

Enrollment

Populations Voluntarily Enrolled: 411

Populations Mandatorily Enrolled:
INDIANA
Care Select

- Aged and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in Another Managed Care Program
- Enrolled with Spend Down
- HCBS Waiver Participants
- Hospice
- Medicare Dual Eligibles
- Reside in Nursing Facility or ICF/MR

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Claims Data
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Eligibility Agency
- Health Plan
- Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Advantage Health Solutions-Care Select
MDwise-Care Select

ADDITIONAL INFORMATION

None
## QUALITY ACTIVITIES FOR PCCM

### Quality Oversight Activities:
- Consumer Self-Report Data  (see below for details)
- Enrollee Hotlines
- Focused Studies
- Network Data
- On-Site Reviews
- Performance Improvement Projects  (see below for details)
- Performance Measures  (see below for details)
- Provider Data

### Use of Collected Data:
- Beneficiary Provider Selection
- Contract Standard Compliance
- Data Mining
- Enhanced/Revise State managed care Medicaid Quality Strategy
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting

### Consumer Self-Report Data:
- State-developed Survey

### Performance Measures

#### Process Quality:
- Adolescent well care visits, ages 12-21, one or more visits
- Annual dental visit for ages 21-64
- Annual dental visits for ages 3-20
- Annual medical attention for Nephropathy for those with diabetes
- Annual monitoring for members on ACE inhibitors or ARB
- Breast Cancer Screening for ages 52-69
- Comprehensive diabetes care, LDL-C screening
- ER bounce back measure
- Follow-Up after mental health hospitalization, 7 days
- Inpatient bounce back measure
- Well child visits in the 3rd through 6th years of life, one or more visits

#### Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care

#### Access/Availability of Care:
- Adult access to preventive/ambulatory health services

#### Provider Characteristics:
- Languages spoken (other than English)
- Provider turnover

#### 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

#### 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

#### Non-Clinical Topics:
- Adults access to preventive/ambulatory health services
- Children’s access to primary care practitioners
- Well child visits, ages 7 through 11, one or more visits
- Well child visits in the 3rd through 6th years of life, one or more visits
INDIANA
Hoosier Healthwise (1932)

CONTACT INFORMATION

State Medicaid Contact: Sarah Jagger
Office of Medicaid Policy & Planning
(317) 234-5545

State Website Address: http://www.in.gov/fssa/2408.htm

PROGRAM DATA

Program Service Area: Statewide
Operating Authority: 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
- Obstetricians/Gynecologists or Gynecologists
- Pediatricians

Enrollment

Populations Voluntarily Enrolled: None
Populations Mandatorily Enrolled:
- Presumptively Eligible Pregnant Women
INDIANA
Hoosier Healthwise (1932)

-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

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses Health Needs Assessment

Agencies with which Medicaid Coordinates the Operation of the Program:
- Eligibility Agency
- Enrollment Broker
- Health Plans
- PBM
- State Actuary

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem-Hoosier Healthwise
MDwise-Hoosier Healthwise
Managed Health Services (MHS)-Hoosier Healthwise

ADDITIONAL INFORMATION

Hoosier Healthwise is authorized by both an 1115(a) Demonstration and a 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
INDIANA
Hoosier Healthwise (1932)

State Quality Assessment and Improvement
Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- 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

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.

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

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

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

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
- Controlling high blood pressure
- Depression management/care
- Diabetes Management
- Follow-up after hospitalization for mental illness
- Follow-Up for Children Prescribed ADHD Medication
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation and engagement of SUD treatment
- Initiation of Prenatal Care
- Lead screening rate
- Use of Imaging Studies for Low Back Pain
- Utilization for Ambulatory, Inpatient, and Mental Health Treatment
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

**Health Status/Outcomes Quality:**
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care

**Access/Availability of Care:**
- Adult's access to preventive/ambulatory health services
- Average distance to PCP
- Average wait time for an appointment with PCP
- Children's access to primary care practitioners
- Percent of PCPs with open or closed patient assignment panels
- Ratio of PCPs to beneficiaries

**Use of Services/Utilization:**
- Average number of visits to MH/SUD providers per beneficiary
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
- Re-admission rates of MH/SUD

**Health Plan Stability/Financial/Cost of Care:**
- Administrative Cost Ratio
- Claims Payable per Member
- Cost per Member
- Days cash on hand
- Days in Claims Receivable
- Days in unpaid claims/claims outstanding
- Equity per member
- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- Net worth
- Ratio Assets to Liabilities
- Revenue per Member
- State minimum reserve requirements
- Total revenue

**Health Plan/Provider Characteristics:**
- Grievance and Appeal Timeliness
- Languages Spoken (other than English)
- Provider Complaints
- Provider turnover
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 prenatal care
- Generic dispensing rate
- Medication utilization 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

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

Clinical Conditions:
Annual dental visits ages 21-64 (state)
Annual dental visits ages 3-20 (state)
Appropriate use of asthma medications ages 5-56 (HEDIS)
Breast cancer screening (mammogram) for women ages 52-69 (HEDIS)
Comprehensive diabetes care - LDL-C screening
ER bounce back-percentage of ER visits that result in a second ER visit within 30 days (state)
Follow-up after hospitalization to mental health illness within 7 days
Inpatient bounce back-percentage of inpatient stays that result in a second stay within 30 days (state)
Well-Child Visits (3-6 years) - one or more visits
Well-Child Visits for children 7-11 years old (state)

Initial Year of Reward:
2008

Rewards Model:
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

Member Incentives:
Not Applicable
## IOWA
### Iowa Medicaid Managed Health Care

### CONTACT INFORMATION

| State Medicaid Contact: | Dennis Janssen  
Department of Human Services  
(515) 256-4643 |
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>State Website Address:</td>
<td><a href="http://www.dhs.state.ia.us">http://www.dhs.state.ia.us</a></td>
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### PROGRAM DATA

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<tr>
<th>Program Service Area:</th>
<th>County</th>
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<tr>
<td>Operating Authority:</td>
<td>1932(a) - State Plan Option to Use Managed Care</td>
</tr>
<tr>
<td>Statutes Utilized:</td>
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<tr>
<td>Enrollment Broker:</td>
<td>Maximus</td>
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<td>For All Areas Phased-In:</td>
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<td>Initial Waiver Approval Date:</td>
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<td>Implementation Date:</td>
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<td>Waiver Expiration Date:</td>
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<td>Sections of Title XIX Waived:</td>
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<tr>
<td>Sections of Title XIX Costs Not Otherwise Matchable Granted:</td>
<td>Not Applicable</td>
</tr>
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### 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
IOWA
Iowa Medicaid Managed Health Care

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 commercial insurance paid under the Health Insurance Payment Program
- Reside in Nursing Facility or ICF/MR
- Special Needs Children (BBA defined)

Lock-in Provision:
6 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medipass

ADDITIONAL INFORMATION

Selected Medicaid member categories are required to select (or accept) a primary care provider (PCP) who will provide services or make a referral for services not offered at the PCP practice location.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines
- Performance Measures (see below for details)

Use of Collected Data:
- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Provider Profiling

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Child Medicaid AFDC Questionnaire

Performance Measures
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<th><strong>Process Quality:</strong></th>
<th><strong>Health Status/Outcomes Quality:</strong></th>
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<tr>
<td>None</td>
<td>Patient satisfaction with care</td>
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<th><strong>Access/Availability of Care:</strong></th>
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<tr>
<td>Adult access to preventive/ambulatory health services</td>
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<tr>
<td>Average distance to primary care case manager</td>
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<tr>
<td>Average wait time for an appointment with primary care case manager</td>
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<tr>
<td>Children's access to primary care practitioners</td>
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<th><strong>Provider Characteristics:</strong></th>
<th><strong>Beneficiary Characteristics:</strong></th>
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<tr>
<td>None</td>
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<table>
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<tr>
<th><strong>Performance Measures - Others:</strong></th>
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</thead>
<tbody>
<tr>
<td>None</td>
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</table>
KANSAS
HealthConnect Kansas

CONTACT INFORMATION

State Medicaid Contact: Tracy Conklin
Division of Health Care Finance
(785) 296-7788

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
- Pediatrics
- Physician Assistants
- Rural Health Centers (RHCs)

Enrollment

424
KANSAS
HealthConnect Kansas

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

MCE has Medicare Contract: Not Applicable

Part D Benefit

Provides Part D Benefits: Not Applicable

Scope of Part D Coverage: Not Applicable

Part D - Enhanced Alternative Coverage: Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs: Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses information from Title V agency to identify members
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
KANSAS
HealthConnect Kansas

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
HealthConnect Kansas

ADDITIONAL INFORMATION
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)
- Provider Data

Use of Collected Data:
- Beneficiary Provider Selection
- Contract Standard Compliance
- Data Mining
- Fraud and Abuse
- Health Services Research
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Adult Medicaid SSI Questionnaire
  - Child Medicaid AFDC Questionnaire
  - Child Medicaid SSI Questionnaire
  - Child with Special Needs Questionnaire

Performance Measures

Process Quality:
- Adolescent immunization rate
- Adolescent well-care visits rates
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds
- Lead screening rate
- Vision services for individuals less than 21 years of age
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
- Average distance to primary care case manager
- Average wait time for an appointment with primary care case manager
- Ratio of primary care case managers to beneficiaries

Use of Services/Utilization:
- Drug Utilization

Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

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KANSAS
HealthWave 19

CONTACT INFORMATION

State Medicaid Contact: Tracy Conklin
Division of Health Care Finance
(785) 296-7788

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: 427
Populations Mandatorily Enrolled:
Subpopulations Excluded from Otherwise Included Populations:
- Aliens eligible for Medicaid for emergency conditions only
- Blind/Disabled Adults
- Blind/Disabled Children
- Clients participating in Refugee Resettlement program
- Clients participating in the subsidized adoption program
- Clients residing in State Institutions
- Clients under the custody of Juvenile Justice Authority
- Clients who are residing out of state
- Clients whose eligibility is only retro-active
- Enrolled in Another Managed Care Program
- Medicare Dual Eligibles
- Other Insurance
- Participate in HCBS Waiver
- Reside in Nursing Facility or ICF/MR
- Reside in State Hospitals
- Retroactive Eligibility
- Spenddown
- Title XXI CHIP

Lock-in Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
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Scope of Part D Coverage:
Not Applicable

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Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

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Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses information from the Title V agency to identify members
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Children's Mercy's Family Health Partners

UniCare Health Plan of Kansas, Inc.
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)
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- CAHPS
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- Contract Standard Compliance
- Data Mining
- Fraud and Abuse
- Health Services Research
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- Program Evaluation
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- 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 use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

COLLECTION: REQUIREMENTS:
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Requirements for data validation
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission

COLLECTION: STANDARDIZED FORMS:
- ANSI ASC X12 837 - transaction set format for transmitting health care claims data
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form

MCO/HIO conducts data accuracy check(s) on specified data elements:
- Date of Service
- Provider ID
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes

COLLECTION: 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

VALIDATION - METHODS:
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Medical record validation

STATE CONDUCTS GENERAL DATA COMPLETENESS ASSESSMENTS:
Yes
KANSAS
HealthWave 19

Performance Measures

Process Quality:
- Adolescent immunization rate
- Adolescent well-care visit rates
- Asthma care - medication use
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Vision services for individuals less than 21 years of age
- Well-child care visit rates in first 15 months of life
- Well-child care visits rates in 3, 4, 5, and 6 years of life

Health Status/Outcomes Quality:
- Asthma treatment outcomes
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
- Average distance to PCP
- Average wait time for an appointment with PCP
- Children's access to primary care practitioners
- Panel size
- Percent of PCPs with open or closed patient assignment panels
- Ratio of PCPs to beneficiaries

Use of Services/Utilization:
- Drug Utilization
- Emergency room visits/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care:
- Days cash on hand
- Days in unpaid claims/claims outstanding
- Medical loss ratio
- Net income
- Net worth
- Total revenue

Health Plan/ Provider Characteristics:
- Board Certification
- Languages Spoken (other than English)

Beneficiary Characteristics:
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries who are auto-assigned to MCOs

Performance Improvement Projects

Project Requirements:
- MCOs are required to conduct a project(s) of their own choosing
- All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
- Diabetes management
- Pre-natal care

Non-Clinical Topics:
- Telephonic Improvement of Customer Care

Standards/Accreditation

MCO Standards:
- State-Developed/Specified Standards

Accreditation Required for Participation:
- None

Non-Duplication Based on Accreditation:
- None

EQRO Name:
- Kansas Foundation for Medical Care
### EQRO Organization:
- Quality Improvement Organization (QIO)

### EQRO Mandatory Activities:
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

### EQRO Optional Activities:
- Administration or validation of consumer or provider surveys
- Assessment of MCO information systems
- Calculation of performance measures
- Focused Studies
- Technical assistance to MCOs to assist them in conducting quality activities

### Pay for Performance (P4P)

#### Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

#### Program Payers:
Not Applicable

#### Population Categories Included:
Not Applicable

#### Rewards Model:
Not Applicable

#### Clinical Conditions:
Not Applicable

#### Measurement of Improved Performance:
Not Applicable

#### Initial Year of Reward:
Not Applicable

#### Evaluation Component:
Not Applicable

#### Member Incentives:
Not Applicable
KENTUCKY
Kentucky Patient Access and Care (KENPAC) Program

CONTACT INFORMATION

State Medicaid Contact: Lee Barnard
Division of Medical Management
(502) 564-9444

State Website Address: http://www.chfs.ky.gov/dms

PROGRAM DATA

Program Service Area: Statewide
Operating Authority: 1932(a) - State Plan Option to Use Managed Care
Statutes Utilized: Not Applicable
Enrollment Broker: No
For All Areas Phased-In: No
Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: Not Applicable
Implementation Date: April 01, 2000
Waiver Expiration Date: Not Applicable
Sections of Title XIX Waived: Not Applicable
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
- Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Internists
- Nurse Practitioners
- Obstetricians/Gynecologists
- Other Specialists Approved on a Case-by-Case Basis
- Pediatricians
- Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled: None

Populations Mandatorily Enrolled:
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
- Title XXI CHIP
KENTUCKY
Kentucky Patient Access and Care (KENPAC) Program

Subpopulations Excluded from Otherwise Included Populations:
- American Indian/Alaskan Native
- Enrolled in Another Managed Care Program
- Medicare Dual Eligibles
- Participate in HCBS Waiver
- Reside in Nursing Facility or ICF/MR
- Special Needs Children (BBA defined)
- Special Needs Children (State defined)
- Spenddown

Lock-in Provision:
No lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Kentucky Patient Access and Care (KenPAC)

ADDITIONAL INFORMATION

For the following Included services - EPDST, Mental Health, and Maternity Care including prenatal care delivery and post partum beneficiary may go to any participating providers for these services without a referral.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
- Enrollee Hotlines
- Ombudsman

Use of Collected Data:
- Beneficiary Provider Selection
- Contract Standard Compliance
Kentucky Patient Access and Care (KENPAC) Program

- Provider Data
  - Health Services Research
  - Monitor Quality Improvement
  - Program Evaluation
  - Program Modification, Expansion, or Renewal
  - Provider Profiling
  - Regulatory Compliance/Federal Reporting
  - Track Health Service provision

Consumer Self-Report Data:
None
CONTACT INFORMATION

State Medicaid Contact: Veronica Dent
Department of Health and Hospitals
(225) 342-0327

State Website Address: http://www.dhh.louisiana.gov

PROGRAM DATA

Program Service Area: Statewide
Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932(a) - State Plan Option to Use Managed Care
Implementation Date: April 01, 2006
Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable
Enrollment Broker: Automated Health Systems (AHS)
Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

Guaranteed Eligibility:
Children under 19 have 12 months guaranteed eligibility
months guaranteed eligibility

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

Allowable PCPs:
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Internists
- Nurse Practitioners
- Obstetricians/Gynecologists or Gynecologists
- Pediatricians
- Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled: None

Populations Mandatorily Enrolled:
- Blind/Disabled Adults and Related Populations
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
LOUISIANA
CommunityCARE Program

Subpopulations Excluded from Otherwise Included Populations:
- American Indian/Alaskan Native
- CHAMP pregnant women
- Eligibility Less Than 3 Months
- Enrollees in the PACE Program
- Foster children, or children receiving adoption assistance
- Medically high-risk on a case-by-case basis
- Medicare Dual Eligibles
- Office of Youth Development recipients
- Presumptive Eligible (PE) recipients
- Recipients in SURS lock-in (except "pharmacy-only" lock in)
- Recipients in the Family Planning Waiver Program
- Recipients in the Hospice Program
- Recipients in the LaChip Affordable Plan
- Recipients under the age of 19 in the NOW and Children's Choice Waiver Programs
- Recipients under the age of 19 in the Supports Waiver and Supports SSI Programs
- Recipients who are 65 and older
- Recipients who have other primary insurance that includes physician benefits
- Reside in Nursing Facility or ICF/MR
- Residents of Psychiatric facilities
- Retroactive Eligibility
- SSI recipients under the age of 19

Lock-In Provision:
- 12 month lock-in

Serious Illness Child Protection Act (SICPA) Excluded:
- None

Medicare Dual Eligibles Included:
- None

Medicare Dual Eligibles Excluded:
- Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
- No

Scope of Part D Coverage:
- Not Applicable

Provides Part D Benefits:
- Not Applicable

Part D - Enhanced Alternative Coverage:
- Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
- Yes

Agencies with which Medicaid Coordinates the Operation of the Program:
- Behavioral Health Agency
- Department of Children and Family Services
- Education Agency
- Public Health Agency

Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

CommunityCARE
## ADDITIONAL INFORMATION

None

## QUALITY ACTIVITIES FOR PCCM

### Quality Oversight Activities:
- Enrollee Hotlines
- Performance Measures (see below for details)

### Use of Collected Data:
- Fraud and Abuse
- Program Improvements

### Consumer Self-Report Data:
None

### Performance Measures

#### Process Quality:
- Adolescent well-care visits rates
- Adult well care visits
- Breast Cancer screening rate
- Cervical cancer screening rate
- Childhood Immunization Status
- Cholesterol Management for People with cardiovascular conditions
- Cholesterol screening and management
- Lead screening rate
- Use of Appropriate Medications for People with Asthma
- Well child visits 7-11 years of life
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

#### Health Status/Outcomes Quality:
None

#### Access/Availability of Care:
- Adolescent access to primary care practitioners
- Adult access to preventive/ambulatory health services
- Annual dental visits
- Children's access to primary care practitioners

#### Use of Services/Utilization:
None

#### Provider Characteristics:
None

#### Beneficiary Characteristics:
None

#### Performance Measures - Others:
None
MAINE
MaineCare Primary Care Case Management

CONTACT INFORMATION

State Medicaid Contact: Loretta Dutill
MaineCare Services
(207) 624-6929

State Website Address: http://www.maine.gov/

PROGRAM DATA

Program Service Area: Statewide
Operating Authority: 1932(a) - State Plan Option to Use Managed Care
Statutes Utilized: Not Applicable
Enrollment Broker: Public Consulting Group, Inc.
For All Areas Phased-In: No
Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: Not Applicable
Implementation Date: May 01, 1999
Waiver Expiration Date: Not Applicable
Sections of Title XIX Waived: Not Applicable
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Ambulatory Surgical Center, Certain Family Planning,
Chiropractic, Clinic, Durable Medical Equipment, EPSDT,
Family Planning, Hearing, Home Health, Immunization,
Inpatient Hospital, Laboratory, Medical Supplies,
Occupational Therapy, Outpatient Hospital, Physical Therapy,
Physician, Podiatric, Speech/Language Pathology, Vision, X-Ray

Allowable PCPs:
-Ambulatory Care Clinic or Hospital Based Outpatient Clinic
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Practitioners
-Obstetricians/Gynecologists
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Alaska Natives and Native Americans

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
MaineCare Primary Care Case Management

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

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Developmental Disabilities Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

MaineCare Primary Care Case Management
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 physician's office. Clinic services may include FQHCs and RHCs.

Special Needs Children (State defined) are children who have or are at increased risk for a chronic, physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

**QUALITY ACTIVITIES FOR PCCM**

**Quality Oversight Activities:**
- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines
- Ombudsman
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

**Use of Collected Data:**
- Beneficiary Provider Selection
- Contract Standard Compliance
- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

**Consumer Self-Report Data:**
- Asthma Dx For Pediatrics
- HIV/AIDS Survey
- Pregnancy Status
- SCHIP Survey
- Smoking Status
- State-developed Survey

**Performance Measures**

**Process Quality:**
- Ace Inhibitor/ARB Therapy
- Adolescent immunization rate
- Adolescent well-care visits rates
- Appropriate testing for children with Pharyngitis
- Appropriate treatment for children with Upper Respiratory Infection (URI)
- Asthma care - medication use
- Breast Cancer screening rate
- Cervical cancer screening rate
- Chlamydia screening in women
- Cholesterol screening and management
- Colorectal Cancer Screening
- Dental services
- Diabetes management/care
- HIV/AIDS care
- Immunizations for two year olds
- Influenza vaccination rate
- Initiation of prenatal care - timeliness of
- Lead screening rate
- Percentage of beneficiaries with at least one dental visit
- Smoking prevention and cessation
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

**Health Status/Outcomes Quality:**
- Patient satisfaction with care

**Access/Availability of Care:**
- Adult access to preventive/ambulatory health services

**Use of Services/Utilization:**
- Drug Utilization
MAINE
MaineCare Primary Care Case Management

- 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

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: David Godfrey
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
-Foster Care Children
Minnesota Prepaid Medical Assistance Program-1932(a)

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 with private coverage through a MCO not participating in Medicaid
- Recipients with terminal or communicable diseases at time of enrollment
- Refugee Assistance Program recipients

Medicare Dual Eligibles Included:
- QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
- QMB
- SLMB, QI, and QDWI

Lock-in Provision:
- 12 month lock-in

MCE has Medicare Contract:
- Yes

Scope of Part D Coverage:
- Not Applicable

Part D - Enhanced Alternative Coverage:
- Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- None - managed care entity provides standard prescription drug coverage

Program Includes People with Complex (Special) Needs:
- Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

| Blue Plus | Health Partners |
| Itasca Medical Care | Medica |
| Metropolitan Health Plan | PrimeWest Health System |
| South Country Health Alliance | UCARE |
MINNESOTA
Minnesota Prepaid Medical Assistance Program-1932(a)

ADDITIONAL INFORMATION

PCP provider types are designated by MCO, not the State. County staff perform enrollment function.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement

Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- Non-Duplication Based on Accreditation
- Ombudsman
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data:
- Assess program results
- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track access and utilization

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

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 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

Encounter Data

Collection: Requirements:
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
- ANSI ASC X12 837 - transaction set format for transmitting health care claims data
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
- None

MCO/HIO conducts data accuracy check(s) on specified data elements:
- None

State conducts general data completeness assessments:
- No

Performance Measures

Process Quality:
- Adolescent well-care visit rate
- Adult Preventive Visits
- Antidepressant medication management

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Appropriate treatment for Children with Upper Respiratory Infection (URI)
- Asthma care - medication use
- Beta-blocker treatment after heart attack
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Chlamydia screening in women
- Colorectal Cancer Screening
- Dental services
- Diabetes Screening
- Immunizations for two year olds
- Mental Health Discharges
- Osteoporosis Care After Fracture
- Percentage of beneficiaries with at least one dental visit
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

Access/Availability of Care:
- Adult's access to preventive/ambulatory health services
- Children's access to primary care practitioners

Use of Services/Utilization:
- Chemical Dependency Initiation or Treatment
- Mental Health Discharges
- Postpartum Visits
- Primary Care Visits 3 to 6-Year-Olds
- Well Care Visits, Adolescents
- Well Child Visits - First 15 Months

Health Plan Stability/ Financial/Cost of Care:
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)
- 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
MINNESOTA
Minnesota Prepaid Medical Assistance Program-1932(a)

<table>
<thead>
<tr>
<th>MCO Standards:</th>
<th>Accreditation Required for Participation:</th>
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<tbody>
<tr>
<td>-NCQA (National Committee for Quality Assurance) Standards</td>
<td>None</td>
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<tr>
<th>Non-Duplication Based on Accreditation:</th>
<th>EQRO Name:</th>
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<tbody>
<tr>
<td>-NCQA (National Committee for Quality Assurance)</td>
<td>-MetaStar (QIO)</td>
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<td></td>
<td>-Michigan Performance Review Organization</td>
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<th>EQRO Organization:</th>
<th>EQRO Mandatory Activities:</th>
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<td>-Quality Improvement Organization (QIO)</td>
<td>-Review of MCO compliance with structural and operational standards established by the State</td>
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<td>-Validation of performance improvement projects</td>
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<td>-Validation of performance measures</td>
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<tr>
<th>EQRO Optional Activities:</th>
<th>Pay for Performance (P4P)</th>
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<tbody>
<tr>
<td>-Administration or validation of consumer or provider surveys</td>
<td>Implementation of P4P:</td>
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<tr>
<td></td>
<td>The State has implemented a Pay-for-Performance program with MCO</td>
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<tr>
<th>Population Categories Included:</th>
<th>Program Payers:</th>
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<tr>
<td>A subset of MCO members, defined by disease and medical condition</td>
<td>MCOs</td>
</tr>
<tr>
<td></td>
<td>Medicaid has collaborated with a public sector entity to support the P4P program</td>
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<table>
<thead>
<tr>
<th>Clinical Conditions:</th>
<th>Rewards Model:</th>
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<tbody>
<tr>
<td>Cardiac Care</td>
<td>Payment incentives/differentials to reward MCOs</td>
</tr>
<tr>
<td>Diabetes</td>
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<table>
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<tr>
<th>Initial Year of Reward:</th>
<th>Measurement of Improved Performance:</th>
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<tbody>
<tr>
<td>1999</td>
<td>Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)</td>
</tr>
<tr>
<td></td>
<td>Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)</td>
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<table>
<thead>
<tr>
<th>Member Incentives:</th>
<th>Evaluation Component:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>The State HAS NOT conducted an evaluation of the effectiveness of its P4P program</td>
</tr>
</tbody>
</table>
## CONTACT INFORMATION

| State Medicaid Contact: | Phyllis Williams  
Division of Medicaid  
(601) 359-5244 |
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>State Website Address:</td>
<td><a href="http://www.medicaid.ms.gov">www.medicaid.ms.gov</a></td>
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## PROGRAM DATA

<table>
<thead>
<tr>
<th>Program Service Area:</th>
<th>Initial Waiver Approval Date:</th>
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<table>
<thead>
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<td>1932(a) - State Plan Option to Use Managed Care</td>
<td>January 01, 2011</td>
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<table>
<thead>
<tr>
<th>Enrollment Broker:</th>
<th>Sections of Title XIX Waived:</th>
</tr>
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<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>For All Areas Phased-In:</th>
<th>Sections of Title XIX Costs Not Otherwise Matchable Granted:</th>
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</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
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</table>

<table>
<thead>
<tr>
<th>Guaranteed Eligibility:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No guaranteed eligibility</td>
<td></td>
</tr>
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</table>

## 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
- Obstetricians/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
### MISSISSIPPI
#### MississippiCAN

- 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

#### Medicare Dual Eligibles Included:
None

#### Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

#### Lock-In Provision:
12 month lock-in

#### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
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</table>

<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

#### Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

#### Program Includes People with Complex (Special) Needs:
Yes

#### Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups

#### Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

| Magnolia Health Plan | United HealthCare |

### ADDITIONAL INFORMATION

MississippiCAN is a statewide Medicaid coordinated care program. The program 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.
MISSISSIPPI
MississippiCAN

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:
- Does Not Use the Data Collected

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

Consumer Self-Report Data:
None

Use of Collected Data:
- Does Not Use the Data Collected

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 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
## MISSISSIPPI
**MississippiCAN**

<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Adult's access to preventive/ambulatory health services</td>
</tr>
<tr>
<td>- Average distance to PCP</td>
</tr>
<tr>
<td>- Children's access to primary care practitioners</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Emergency room visits/1,000 beneficiary</td>
</tr>
<tr>
<td>- Inpatient admissions/1,000 beneficiary</td>
</tr>
<tr>
<td>- Number of PCP visits per beneficiary</td>
</tr>
</tbody>
</table>

### Health Plan Stability/ Financial/Cost of Care:
**None**

### Beneficiary Characteristics:
**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**

#### EQRO Name:
**Not Applicable**

#### EQRO Organization:
- No EQRO Organization

#### EQRO Mandatory Activities:
**Not Applicable**

#### 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**
<table>
<thead>
<tr>
<th><strong>Initial Year of Reward:</strong></th>
<th><strong>Evaluation Component:</strong></th>
</tr>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

**Member Incentives:**
Not Applicable
NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

CONTACT INFORMATION

State Medicaid Contact: Heather Leschinsky
Nebraska Medicaid
(402) 471-9337

State Website Address: http://www.dhhs.state.ne.us

PROGRAM DATA

Program Service Area: County

Operating Authority: 1932(a) - State Plan Option to Use Managed Care

Statutes Utilized: Not Applicable

Enrollment Broker: Medicaid Enrollment Center

For All Areas Phased-In: Yes

Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: Not Applicable

Implementation Date: July 01, 1995

Waiver Expiration Date: Not Applicable

Sections of Title XIX Waived: Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians

Enrollment

Populations Voluntarily Enrolled: None

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP
NEBRASKA
Nebraska Health Connection Combined Waiver Program - 1932(a)

Subpopulations Excluded from Otherwise Included Populations:
- American Indian/Alaskan Native
- Clients Participating in Breast and Cervical Cancer Prevention and Treatment Act of 2000 Program
- Clients Participating in the State Disability Program
- Clients Participating in the Subsidized Adoption Program
- Clients Receiving Medicaid Hospice Services
- Clients with Excess Income
- Medicare Dual Eligibles
- Other Insurance
- Participate in HCBS Waiver
- Presumptive Eligibility
- Reside in Nursing Facility or ICF/MR
- Retroactive Eligibility
- Special Needs Children (State defined)
- Transplant Recipients

Lock-In Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Title V Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coventry Nebraska
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
- 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

Use of Collected Data:
- Fraud and Abuse
- Regulatory Compliance/Federal Reporting

Use of HEDIS:
- The State DOES NOT use any of the HEDIS measures
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
- Guidelines for frequency of encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing 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)
- 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
# NEBRASKA
## Nebraska Health Connection Combined Waiver Program - 1932(a)

<table>
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<tr>
<th>Health Plan Stability/ Financial/Cost of Care:</th>
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<tr>
<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
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</tbody>
</table>

## 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) Standards

### Accreditation Required for Participation:
- Department of Insurance Certification
- 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

### 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
Nebraska Medicaid Medical Home Pilot

CONTACT INFORMATION

State Medicaid Contact: Pat Taft
Medicaid and Long-Term Care
402-471-9247

State Website Address: http://dhhs.ne.gov/medicaid/Pages/med_pilot_index.

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: February 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

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
NEBRASKA
Nebraska Medicaid Medical Home Pilot

- Special Needs Children (State defined)
- Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
- Retroactive Eligibility

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Lock-In Provision:
No lock-in

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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:
- Consumer Self-Report Data (see below for details)
- Provider Data

Use of Collected Data:
- Program Evaluation

Consumer Self-Report Data:
- State-developed Survey
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, Psychologist, Radiology, Residential Treatment Center, Respiratory Therapy, Rural Health Clinics, Skilled Nursing Facility, Special Clinics, Speech Therapy, Swing Beds, Transitional Rehabilitative Center, Transportation, 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

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- American Indian</td>
<td>- Child Health Assurance Program (CHAP)</td>
</tr>
<tr>
<td>- Seriously Mentally Ill Adults</td>
<td>- Section 1931 Adults and Related Populations</td>
</tr>
<tr>
<td>- Severely Emotionally Disturbed Children</td>
<td>- Section 1931 Children and Related Populations</td>
</tr>
<tr>
<td>- Special Needs Children (State defined)</td>
<td></td>
</tr>
</tbody>
</table>

**Subpopulations Excluded from Otherwise Included Populations:**

- Medicare Dual Eligibles
- Reside in Nursing Facility or ICF/MR
- Residents in Nursing Facilities beyond 45 Days

**Medicare Dual Eligibles Included:** None

**Medicare Dual Eligibles Excluded:** Medicare Dual Eligibles

**Lock-in Provision:**

- 12 month lock-in

#### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**

- None

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**

Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**

- Asks advocacy groups to identify members of these groups
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**

- Developmental Disabilities Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Transportation Agencies

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

| Amerigroup Community Care | Health Plan of Nevada |

### ADDITIONAL INFORMATION
NEVADA
Mandatory Health Maintenance Program

Temporary Assistance for Needy Families/Child Health Assurance Program is included in the Mandatory Program. Severely Emotionally Disturbed Children, Seriously Mentally Ill Adults, Children with Special Health Care Needs and American Indians are provided voluntary enrollment and/or disenrollment at any time.

Transportation is included but for emergency only.

Special Needs Children (State defined) is any child with a parent that deems them to have a special need.

### QUALITY ACTIVITIES FOR MCO/HIO

#### State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Focused Studies
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- Network Data
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data
- State's Quality Assessment and Performance Improvement Strategy and Work Plan

#### Use of Collected Data:
- Contract Standard Compliance
- Enhanced/Revise State managed care Medicaid Quality Strategy
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting

#### Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Child Medicaid AFDC Questionnaire

#### Use of HEDIS:
- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State modifies/requires MCOs to modify some or all NCQA specifications in ways other than continuous enrollment

### Encounter Data

#### Collection: Requirements:
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for data validation
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission

#### Collection: Standardized Forms:
- 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

#### 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

#### 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
NEVADA
Mandatory Health Maintenance Program

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
- 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

Health Status/Outcomes Quality:
- Blood Lead Screening
- Diabetes
- Improving Immunization Rates

Access/Availability of Care:
- Children's access to primary care practitioners

Use of Services/Utilization:
- Available emergency room visits
- 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
### NEVADA

#### Mandatory Health Maintenance Program

**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 Organization:**
- Quality Improvement Organization (QIO)

**EQRO Name:**
- Health Services Advisory Group

**EQRO Mandatory Activities:**
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

**EQRO Optional Activities:**
- Administration or validation of consumer or provider surveys
- Assessment of MCO information systems
- Calculation of performance measures
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
  - FFS HEDIS Rates
  - Technical assistance to MCOs to assist them in conducting quality activities
  - Validation of client level data, such as claims and encounters
  - Validation of encounter data

#### Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
A subset of MCO members, defined by beneficiary age
A subset of MCO members, defined by disease and medical condition

**Rewards Model:**
Payment incentives/differentials to reward MCOs
NEVADA
Mandatory Health Maintenance Program

<table>
<thead>
<tr>
<th>Clinical Conditions:</th>
<th>Measurement of Improved Performance:</th>
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<tr>
<td>Annual Dental Visits</td>
<td>Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)</td>
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<tr>
<td>Childhood immunizations</td>
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<td>Well-child visits</td>
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<th>Initial Year of Reward:</th>
<th>Evaluation Component:</th>
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</thead>
<tbody>
<tr>
<td>2006</td>
<td>The State has conducted an evaluation of the effectiveness of its P4P program</td>
</tr>
</tbody>
</table>

| 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: 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

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
### NEW JERSEY
**NJ FamilyCare - 1932(a)**

#### Populations Voluntarily Enrolled:
- Medicare Dual Eligibles

#### Subpopulations Excluded from Otherwise Included Populations:
- American Indian/Alaskan Native
- Enrolled in Another Managed Care Program
- Institutionalized in inpatient psychiatric facility
- Medically needy and presumptive eligibility beneficiaries
- Medicare Dual Eligibles
- Participate in HCBS Waiver except for CCW
- Reside in Nursing Facility or ICF/MR

#### Medicare Dual Eligibles Included:
- QMB Plus

#### Medicare Dual Eligibles Excluded:
- SLMB Plus
- Medicaid-only
- SLMB, QI, and QDWI
- QMB

#### Part D Benefit

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<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
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</thead>
<tbody>
<tr>
<td>None</td>
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</tbody>
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### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

#### Program Includes People with Complex (Special) Needs:
Yes

#### Strategies Used to Identify Persons with Complex (Special) Needs:
- Self-Referral
- Surveys medical needs of enrollee to identify members of these groups
- Use of Data Mining
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

#### Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Division of Youth and Family Services Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>AMERIGROUP New Jersey, Inc.</th>
<th>Healthfirst Health Plan of New Jersey, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horizon NJ Health</td>
<td>UnitedHealthCare Community Plan</td>
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</table>
NEW JERSEY
NJ FamilyCare - 1932(a)

ADDITIONAL INFORMATION

Lock-in Period: 12 month lock-in is for AFDC/TANF, Title XXI population, and SSI, Aged, Blind, Disabled, DDD or DYFS populations. Populations Excluded: Those that participate in HCBS Waiver except DDD/CCW non-duals. Pharmacy services are for Blind/Disabled Adults and Children.

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

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

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Adult Medicaid SSI Questionnaire
  - Adult with Special Needs Questionnaire
  - Child Medicaid AFDC Questionnaire
- Disenrollment Survey

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)
### Performance Measures

**Process Quality:**
- Adolescent immunization rate
- Adolescent well-care visit rate
- Appropriate Testing for Children with Pharyngitis
- Appropriate treatment for Children with Upper Respiratory Infection (URI)
- Asthma care - medication use
- BMI Assessment for Children/Adolescents
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Childhood Immunizations
- Chlamydia screening in women
- Comprehensive Diabetes Care
- Follow-up after hospitalization for mental illness
- Followup Care for Children Prescribed ADHD Medication (Initial Phase Only)
- Frequency of Ongoing 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 received 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 beneficiary
- 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

Beneficiary Characteristics:  
- Information of beneficiary ethnicity/race  
- Information on primary languages spoken by beneficiaries  
- Percentage of beneficiaries who are auto-assigned to MCOs

Health Plan/ Provider Characteristics:  
None

Performance Measures - Others:  
- EPSDT Performance  
- Lead Screening

Performance Improvement Projects

Project Requirements:  
- All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:  
- Adolescent Well Care/EPSDT  
- Birth Outcomes  
- Child/Adolescent Dental Screening and Services  
- Lead Screenings  
- Postnatal care  
- Pre-natal care  
- Well Child Care/EPSDT

Non-Clinical Topics:  
- Children’s access to primary care practitioners  
- Encounter Data Improvement  
- Health information technology (e.g. state implementation of immunization and other registries, telemedicine initiatives, etc…)

Standards/Accreditation

MCO Standards:  
- CMS’s Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation:  
- Department of Banking and Insurance

Non-Duplication Based on Accreditation:  
None

EQRO Name:  
- Island Peer Review Organization (IPRO)

EQRO Organization:  
- Quality Improvement Organization (QIO)

EQRO Mandatory Activities:  
- Review of MCO compliance with structural and operational standards established by the State  
- Validation of performance improvement projects  
- Validation of performance measures

EQRO Optional Activities:  
- Calculation of performance measures  
- Conduct studies on access that focus on a particular aspect of clinical or non-clinical services  
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services  
- Medical Record Review  
- Technical Assistance to MCOs to assist them in conducting quality improvement activities
NEW JERSEY
NJ FamilyCare - 1932(a)

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: | Betty West  
Division of Medical Assistance  
(919) 855-4784 |
<table>
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<tr>
<th></th>
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<tr>
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<td><a href="http://www.ncdhhs.gov/dma/">http://www.ncdhhs.gov/dma/</a></td>
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## PROGRAM DATA

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<td>Statutes Utilized:</td>
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<td>Enrollment Broker:</td>
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<td>For All Areas Phased-In:</td>
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Guaranteed Eligibility:  
No guaranteed eligibility

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<th>Initial Waiver Approval Date:</th>
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<td>Waiver Expiration Date:</td>
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<td>Sections of Title XIX Waived:</td>
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<td>Sections of Title XIX Costs Not Otherwise Matchable Granted:</td>
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## SERVICE DELIVERY

**PCCM Provider - Fee-for-Service**

### Service Delivery

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<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
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</table>
| 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 | -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

470
### Populations Voluntarily Enrolled:
- Aged and Related Populations
- American Indian/Alaska Native
- Foster Care Children
- Medicare Dual Eligibles
- Poverty-Level Pregnant Women
- Special Needs Children (BBA defined)

### Populations Mandatorily Enrolled:
- Blind/Disabled Adults and Related Populations
- Qualified Aliens
- Section 1931 Adults and Related Populations
- Title XXI CHIP

### Subpopulations Excluded from Otherwise Included Populations:
- Any Recipient Currently Under a Deductible Eligibility Period that is only Retroactive
- MAF-D Family Planning Waiver Program
- MAF-W Breast and Cervical Cancer Control Program
- Medicare Dual Eligibles
- Refugees
- Reside in Nursing Facility or ICF/MR
- SAA Special Assistance to the Aged

### Subpopulations Excluded from Otherwise Included Populations:
- MAF-F Family Planning Waiver Program
- MAF-W Breast and Cervical Cancer Control Program
- Refugees
- Reside in Nursing Facility or ICF/MR
- SAA Special Assistance to the Aged

### Medicare Dual Eligibles Included:
- Medicaid-only

### Medicare Dual Eligibles Excluded:
- QMB
- SLMB, QI, and QDWI
- QMB Plus
- SLMB Plus

### Lock-In Provision:
No lock-in

### Part D Benefit
- Provides Part D Benefits: Not Applicable
- Part D - Enhanced Alternative Coverage: Not Applicable

### Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS
- Program Includes People with Complex (Special) Needs: Yes

### Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

### Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Community Care of North Carolina Networks
- Division of Mental Health
- Maternal and Child Health Agency
- Office of Rural Health and Community Care
- Public Health Agency
- Social Services Agencies

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Carolina Access
The recipient must choose and enroll with or be assigned to a primary care provider who is paid a monthly case management fee of $1.00 for each enrollee in addition to regular fee for service payments. Hearing services do not include hearing aids for recipients age 21 years and above.

### QUALITY ACTIVITIES FOR PCCM

#### Quality Oversight Activities:
- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines
- Ombudsman
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

#### Use of Collected Data:
- Beneficiary Provider Selection
- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

#### Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Child Medicaid AFDC Questionnaire

#### Performance Measures

<table>
<thead>
<tr>
<th>Process Quality:</th>
<th>Health Status/Outcomes Quality:</th>
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<tr>
<th>Access/Availability of Care:</th>
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<td>Adult access to preventive/ambulatory health services</td>
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<td>Children's access to primary care practitioners</td>
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<th>Beneficiary Characteristics:</th>
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<tr>
<td>Board Certification</td>
<td>Information of beneficiary ethnicity/race</td>
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<td>Languages spoken (other than English)</td>
<td>Information on primary languages spoken by beneficiaries</td>
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<tr>
<td>Afterhours</td>
<td>Information of percentage of beneficiaries who are auto-assigned to PCCM</td>
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<td>Enrollment</td>
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<td>Overrides</td>
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#### Performance Improvement Projects

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<th>Non-Clinical Topics:</th>
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</table>
NORTH CAROLINA
Community Care of North Carolina (ACCESS II/III)

CONTACT INFORMATION

State Medicaid Contact: Betty West
Community Care of NC
(919) 855-4784

State Website Address: http://www.ncdhhs.gov

PROGRAM DATA

Program Service Area: Statewide
Operating Authority: 1932(a) - State Plan Option to Use Managed Care
Statutes Utilized: Not Applicable
Enrollment Broker: No
For All Areas Phased-In: No

Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: Not Applicable
Implementation Date: July 01, 1998
Waiver Expiration Date: Not Applicable
Sections of Title XIX Waived: Not Applicable
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
- Chiropractic, Dental, Dialysis, Disease Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, 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

473
### Community Care of North Carolina (ACCESS II/III)

#### Populations Voluntarily Enrolled:
- American Indian/Alaska Native
- Foster Care Children
- Medicare Dual Eligibles
- Poverty-Level Pregnant Women
- 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
- Eligibility 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

#### Medicaid Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

#### Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

### Part D Benefit

#### MCE has Medicare Contract:
No

#### Provides Part D Benefits:
Not Applicable

#### Scope of Part D Coverage:
Not Applicable

#### Part D - Enhanced Alternative Coverage:
Not Applicable

#### Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

### Serving People with Complex (Special) Needs

#### Program Includes People with Complex (Special) Needs:
Yes

#### Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses health assessment forms and claims data to identify members
- Uses provider referrals to identify members of these groups

#### Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Community Care of North Carolina Networks
- Division of Mental Health
- Maternal and Child Health Agency
- North Carolina Community Care Networks, Inc
- Office of Rural Health and Community Care
- Public Health Agency
- Social Services Agency

### Participating Plans/PCCM and Other Programs

Community Care of North Carolina (Access II/III)
ADDITIONAL INFORMATION

An Administrative Entity is paid an additional PCCM case management fee of at least $3.72 per recipient participating in Access II/III to monitor care and implement disease management initiatives and target preventive studies. ACCESS II/III manages the highest risk Medicaid enrollees to improve coordination and continuity of care. Hearing services do not include hearing aids for recipients age 21 years and older.

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- Network Data
- Ombudsman
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data:
- Beneficiary Provider Selection
- Contract Standard Compliance
- Data Mining
- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Child Medicaid AFDC Questionnaire
- Consumer/beneficiary Focus Groups

Performance Measures

Process Quality:
- Adolescent well-care visits rates
- Asthma care - medication use
- Beta-blocker treatment after heart attack
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Cholesterol screening and management
- Colon Cancer screening rates
- Controlling high blood pressure
- Depression medication management
- Diabetes management/care
- Hearing services for individuals less than 21 years of age
- Heart Failure care
- Influenza vaccination rate
- Percentage of beneficiaries with at least one dental visit
- Primary cesarean section rates among 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
- Diabetes eye exams
- ED & Hospitalization Rates
- HbA1C Testing
- Patient satisfaction with care
- Percentage of low birth weight infants
- Preventable Hospital Readmissions

Access/Availability of Care:
- Adult access to preventive/ambulatory health services
- Average wait time for an appointment with primary care case manager
- Children's access to primary care practitioners

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
NORTH CAROLINA
Community Care of North Carolina (ACCESS II/III)

- Ratio of primary care case managers to beneficiaries
- Inpatient admission for MH/SUD conditions per 100 members/month for Aged, Blind, Disabled population
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiaries
- Inpatient Readmission
- Inpatient Stays
- Number of primary care case manager visits per beneficiary
- Number of specialist visits per beneficiary
- Percentage of beneficiaries under 21 with at least one dental visit

Provider Characteristics:
- Best Practices for Asthma and Diabetes
- Best Practices for Heart Failure/Cardiovascular disease
- Board Certification
- Languages spoken (other than English)

Beneficiary Characteristics:
- Beneficiary need for interpreter
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- Percentage of enrollees with chronic illnesses, asthma, diabetes, CHF and COPD

Performance Measures - Others:
None

Performance Improvement Projects

Clinical Topics:
- Adolescent Well Care/EPSDT
- Asthma management
- Beta Blocker treatment after a heart attack
- Breast cancer screening (Mammography)
- Cardiovascular Disease Management
- Cervical cancer screening (Pap Test)
- Child/Adolescent Hearing and Vision Screening and Services
- Cholesterol screening and management
- Colorectal Cancer Screening
- Coordination of primary and behavioral health care
- Depression management
- Developmental Screening
- Diabetes management
- Emergency Room service utilization
- Hospital Discharge Planning
- Hypertension management
- Low birth weight baby
- Palliative Care
- Pharmacy management
- Post natal care
- Pre-natal care
- Prevention of Influenza
- Smoking prevention and cessation
- Well Child Care/EPSDT

Non-Clinical Topics:
- Adults access to preventive/ambulatory health services
- Availability of language interpretation services
- Children's access to primary care practitioners
- Health Information Technology
- Practice Readiness for Quality Improvement
- Reducing health care disparities
NORTH DAKOTA
North Dakota Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact: Eric Elkins
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

PCCM Provider - Primary Care Case Management Fee

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, Specialty
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 477
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
- Eligibility Period that is only Retroactive
- Enrolled in Another Managed Care Program
- Enrolled in CDC BCCT Program
- Foster Care
- Medically Needy Individuals with Spend-down
- Medicare Dual Eligibles
- Participate in HCBS Waiver
- Refugee Assistance
- Reside in Nursing Facility or ICF/MR
- Special Needs Children (BBA defined)

Lock-In Provision:
6 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Primary Care Case Management

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM

Quality Oversight Activities:
- Consumer Self-Report Data (see below for details)
- Focused Studies
- Provider Data

Use of Collected Data:
- Beneficiary Provider Selection
- Fraud and Abuse
- Health Services Research
Consumer Self-Report Data:
-State-developed Survey
**OHIO**
State Plan Amendment for Ohio's full-risk managed care program

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### CONTACT INFORMATION

| State Medicaid Contact: | John McCarthy  
| | Ohio Department of Job and Family Services  
| | (614) 466-4443 |
| State Website Address: | http://jfs.ohio.gov/OHP/index.stm |

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### 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 |

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### SERVICE DELIVERY

**MCO (Comprehensive Benefits) - Risk-based Capitation**

#### Service Delivery

**Included Services:**  
Care Management, Certified Family Nurse Practitioner, Certified Pediatric Nurse Practitioner, Chiropractic, Dental, Developmental Therapy, Durable Medical Equipment, EPSDT, Family Planning, FQHC, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Podiatry, Prescription Drugs Administered In A Provider Setting, Private Duty Nurse, RHC, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

**Allowable PCPs:**  
- Clinical Nurse Specialists  
- Family Practitioners  
- Federally Qualified Health Centers (FQHCs)  
- General Practitioners  
- Internists  
- Nurse Midwives  
- Nurse Practitioners  
- Obstetricians/Gynecologists or Gynecologists  
- Other Specialists Approved on a Case-by-Case Basis  
- Pediatricians  
- Rural Health Clinics (RHCs)

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**Enrollment**

| Populations Voluntarily Enrolled: | 480 |
| Populations Mandatorily Enrolled: | |

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### OHIO

State Plan Amendment for Ohio's full-risk managed care program

<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
<th>Lock-In Provision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Enrolled in Another Managed Care Program</td>
<td>12 month lock-in</td>
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<tr>
<td>- Enrolled in CDC BCCT Program</td>
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<tr>
<td>- Medically Needy Individuals with Spend-down</td>
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<tr>
<td>- Medicare Dual Eligibles</td>
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<tr>
<td>- Participate in HCBS Waiver</td>
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<tr>
<td>- Reside in Nursing Facility or ICF/MR</td>
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<tr>
<th>Medicare Dual Eligibles Included:</th>
<th>Medicare Dual Eligibles Excluded:</th>
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<tbody>
<tr>
<td>None</td>
<td>Exclude all categories of Medicare Dual Eligibles</td>
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**Part D Benefit**

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
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<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
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<tbody>
<tr>
<td>None</td>
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### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

<table>
<thead>
<tr>
<th>Program Includes People with Complex (Special) Needs:</th>
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<tbody>
<tr>
<td>Yes</td>
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<table>
<thead>
<tr>
<th>Strategies Used to Identify Persons with Complex (Special) Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Care management identification and assessment</td>
</tr>
<tr>
<td>- Surveys medical needs of enrollee to identify members of these groups</td>
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<tr>
<td>- Uses eligibility data to identify members of these groups</td>
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<tr>
<td>- Uses enrollment forms to identify members of these groups</td>
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<tr>
<td>- Uses provider referrals to identify members of these groups</td>
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<tr>
<td>- Uses self referrals to identify members of these groups</td>
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<table>
<thead>
<tr>
<th>Agencies with which Medicaid Coordinates the Operation of the Program:</th>
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<tbody>
<tr>
<td>- Developmental Disabilities Agency</td>
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<tr>
<td>- Education Agency</td>
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<tr>
<td>- Maternal and Child Health Agency</td>
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<tr>
<td>- Mental Health Agency</td>
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<tr>
<td>- National Alliance on Mental Illness</td>
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<tr>
<td>- Ohio Academy of Family Physicians</td>
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<tr>
<td>- Ohio Association of Community Healthcenters</td>
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<tr>
<td>- Ohio Association of County Behavioral Health Authorities</td>
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<tr>
<td>- Ohio Association of Health Plans</td>
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<tr>
<td>- Ohio Chapter of the American Academy of Pediatrics</td>
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<tr>
<td>- Ohio Childrens Hospital Association</td>
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<tr>
<td>- Ohio Council of Behavioral Healthcare Providers</td>
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<tr>
<td>- Ohio County Departments of Job and Family Services</td>
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<tr>
<td>- Ohio Hospital Association</td>
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<tr>
<td>- Ohio Psychological Association</td>
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<tr>
<td>- Ohio State Medical Association</td>
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<tr>
<td>- Public Health Agency</td>
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<tr>
<td>- Social Services Agency</td>
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<tr>
<td>- Substance Abuse Agency</td>
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<tr>
<td>- Transportation Agencies</td>
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</tbody>
</table>

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State Plan Amendment for Ohio's full-risk managed care program

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Amerigroup Ohio</th>
<th>Buckeye Community Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareSource</td>
<td>Molina Healthcare of Ohio</td>
</tr>
<tr>
<td>Paramount Advantage</td>
<td>United Healthcare Community Plan of Ohio</td>
</tr>
<tr>
<td>WellCare of Ohio</td>
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</tr>
</tbody>
</table>

ADDITIONAL INFORMATION

Regarding Program Service Area:
Services are provided in all eighty-eight Ohio counties which are divided into eight regions.

Regarding Included Services:
Between February 1, 2010 and September 30, 2011, pharmacy benefits (specified prescribed drugs and certain medical supplies) for MCP enrollees were carved out of the risk-based managed care program. During this time, MCP enrollees accessed the carved-out pharmacy benefits through the Medicaid fee-for-service delivery system. However, pharmaceuticals administered in certain provider settings continued to be provided by MCPs.

Services provided in a nursing facility are covered by MCPs only when they are provided for short-term stays up to 62 days.

Mental health and substance abuse services are covered through the MCP when a member is unable or unwilling to access such services through the Ohio Department of Mental Health (ODMH) community mental health centers and Ohio Department of Alcohol and Drug Abuse Services (ODADAS) certified Medicaid providers.

Transportation services include ambulance and ambulette services.

Regarding State Quality Assessment and Improvement Activities:
On July 1, 2011, Ohio required contracting MCPs to be NCQA accredited by July 1, 2014.

Regarding Managed Care Entity Name:
Unison Health Plan of Ohio changed their name to United Healthcare Community Plan of Ohio effective April 1, 2011.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
- Care management
- Consumer complaints and grievances
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- Network Data
- Non-compliance penalties
- Non-Duplication Based on Accreditation
- On-Site Reviews
- Pay 4 performance (P4P) program
- Performance Improvement Projects (see below for details)

Use of Collected Data:
- Beneficiary Plan Selection
- Contract Standard Compliance
- Data Mining
- Health Services Research
- Monitor Quality Improvement
- Performance Incentive System Determination
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- State Medicaid Managed Care Quality Strategy
- Track Health Service provision

Use of HEDIS:
- The State uses SOME of the HEDIS measures listed for Medicaid

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Adult Medicaid SSI Questionnaire

Use of HEDIS:
- The State generates from encounter data SOME of the HEDIS
OHIO
State Plan Amendment for Ohio's full-risk managed care program

Child Medicaid AFDC Questionnaire
Child with Special Needs Questionnaire
-State-developed Survey

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 continuous enrollment requirement for some or all of the measures
-State modifies/requirements MCOs to modify some or all NCQA specifications in ways other than continuous enrollment

Encounter Data

Collection: Requirements:
-Actuarial reviews
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Encounter Data Testing
-EQRO accuracy studies
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-ISCAT (EQRO), as needed
-Requirements for data validation
-Requirements for MCO data certification
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Certification Letters for Encounter Data Submissions
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Delivery Payment Submission Specifications
-Encounters to be submitted based upon national standardized forms (e.g., UB-92, NCPDP, NSF)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Payment data submission specifications
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92, electronic media claims 4.0

Validation - Methods:
-Actuarial review
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
-EQRO studies
-ISCAT (EQRO), as needed
-Medical record validation
-Per member per month analysis and comparisons across MCOs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Type of Provider, Specialty Code

State conducts general data completeness assessments:
Yes
Performance Measures

**Process Quality:**
- Adolescent well-care visit rates
- Antidepressant medication management
- Asthma care - medication use
- Beta-blocker treatment after heart attack
- Care management of high-risk members
- Care management of members
- Check-ups after delivery
- Cholesterol screening and management
- Dental services
- Diabetes management/care
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Heart Attack care
- Heart Failure care
- Immunizations for two year olds
- Initiation and engagement of SUD treatment
- Initiation of prenatal care - timeliness of
- Lead screening rate
- Percentage of beneficiaries with at least one dental visit
- Spirometry testing in the assessment and diagnosis of COPD
- Well-child care visit rates in first 15 months of life
- Well-child care visits rates in 3, 4, 5, and 6 years of life

**Health Status/Outcomes Quality:**
- Emergency hospital discharge rates, inpatient hospital discharge rates, and inpatient hospital readmission rates, for chronic disease conditions
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of low birth weight infants

**Access/Availability of Care:**
- Adult’s access to preventive/ambulatory health services
- Children’s access to primary care practitioners
- Provider Panel Requirements for PCP Capacity and Provider Type, by Region and County

**Use of Services/Utilization:**
- Adult preventive care visit rates
- Ancillary services/1,000 member months
- Behavioral health services/1,000 member months
- Care management of high-risk members
- Care management of members
- Child primary care visit rates
- Dental visits/1,000 member months
- Drug Utilization
- Durable medical equipment/supply services/1,000 member months
- Emergency department utilization rates for chronic disease conditions
- Emergency room visits/1,000 member months
- Follow up after hospitalization for mental illness
- Initiation and engagement of AOD treatment
- Inpatient discharges/1,000 member months
- Inpatient hospital discharge rates for chronic disease conditions
- Inpatient hospital readmission rates for chronic disease conditions
- Maternity/deliveries/1,000 member months
- Percentage of beneficiaries with at least one dental visit
- Perinatal care visit rates
- Pharmacy prescriptions/1,000 member months
- Primary care visits/1,000 member months
- Vision visits/1,000 member months
- Well child visit rates

**Health Plan Stability/ Financial/Cost of Care:**
- Actual reserves held by plan
- Administrative Expense Ratio
- Days cash on hand
- Days in unpaid claims/claims outstanding
- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- Net worth
- Overall Expense Ratio

**Health Plan/ Provider Characteristics:**
- Provider Panel by specialty and service area and capacity
OHIO
State Plan Amendment for Ohio's full-risk managed care program

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:
- Timely identification, assessment, and care management for members with special health care needs

Standards/Accreditation

MCO Standards:
- NCQA (National Committee for Quality Assurance) Standards
- State-Developed/Specified Standards
- URAC Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
- NCQA (National Committee for Quality Assurance)
- URAC

EQRO Name:
- Health Services Advisory Group

EQRO Mandatory Activities:
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

EQRO Optional Activities:
- Administration or validation of consumer or provider surveys
- Calculation of performance measures
- Conduct of performance improvement projects
- Technical assistance to MCOs to assist them in conducting quality activities
- Validation of encounter data

Pay for Performance (P4P)

Implementation of P4P:
The State has implemented a Pay-for-Performance program with MCO

Program Payers:
Medicaid is the only payer

Rewards Model:
Payment incentives/differentials to reward MCOs
A subset of MCO members, defined by disease and medical condition
Covers all MCO members

Clinical Conditions:
- Adult preventive care visits
- Asthma
- Cardiac Care
- Care management of high-risk members
- Child preventive care visits
- Dental care
- Diabetes
- Inpatient hospital discharge rate (chronic conditions composite)
- Lead screening
- Mental health
- Perinatal Care
- Well-child visits

Measurement of Improved Performance:
- Assessing achievement in access to care
- Assessing improvement in care management of high-risk members over time
- Assessing improvement in clinical quality (by condition) over time
- Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)
- Assessing patient satisfaction measures
- Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

Initial Year of Reward:
- 2002

Evaluation Component:
The State HAS NOT conducted an evaluation of the effectiveness of its P4P program

Member Incentives:
- Not Applicable

Preferential auto-enrollment to reward MCOs
The state takes back premiums at risk should an MCP fail to meet P4P standards.
SOUTH CAROLINA
Health Maintenance Organization (HMO)

CONTACT INFORMATION

State Medicaid Contact: Jennifer Campbell
                       Managed Care
                       (803) 898-2593

State Website Address: http://www.scdhhs.gov

PROGRAM DATA

Program Service Area: County
Operating Authority: 1932(a) - State Plan Option to Use Managed Care
Statutes Utilized: Not Applicable
Enrollment Broker: Maximus
For All Areas Phased-In: No
Guaranteed Eligibility: No guaranteed eligibility
Initial Waiver Approval Date: Not Applicable
Implementation Date: August 01, 1996
Waiver Expiration Date: Not Applicable
Sections of Title XIX Waived: Not Applicable
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
- Alcohol and Drug Screening, Durable Medical Equipment,
- EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Interactive Psychiatric Interview Exam with other Mechanisms of Communication, Laboratory, Outpatient Hospital, Pharmacy, Physical Exam through the SC Department of Alcohol and other Drug Abuse, Physician, Psychiatric Diagnostic Interview Exam, Skilled Nursing Facility, Transportation, X-Ray

Allowable PCPs:
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Internists
- Nurse Practitioners
- Obstetricians/Gynecologists
- Pediatricians
- Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled: None
Populations Mandatorily Enrolled:
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
SOUTH CAROLINA
Health Maintenance Organization (HMO)

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

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Education Agency
- Family Connections
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Absolute Total Care
First Choice by Select Health of South Carolina, Inc.
BlueChoice Health Plan
United HealthCare of SC

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

488
SOUTH CAROLINA
Health Maintenance Organization (HMO)

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 continuous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for data validation
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms:
- 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.

Collection: 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

Validation - Methods:
- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Medical record validation
- Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
- Date of Service
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure
- Date of Admission Invalid
- Date of Discharge Invalid
- Dollar amount billed not greater than zero

State conducts general data completeness assessments:
Yes
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
- Chlamydia screening in women
- Cholesterol screening and management
- Controlling high blood pressure
- Dental services
- Depression management/care
- Diabetes medication management
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- Heart Attack care
- Heart Failure care
- HIV/AIDS care
- Immunizations for two year olds
- Initiation of prenatal care - timeliness of
- Lead screening rate
- Pregnancy Prevention
- Smoking prevention and cessation
- Vision services for individuals less than 21 years of age
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of low birth weight infants

Access/Availability of Care:
- Average distance to PCP
- Average wait time for an appointment with PCP
- Children's access to primary care practitioners
- Percent of PCPs with open or closed patient assignment panels
- Ratio of PCPs to beneficiaries

Use of Services/Utilization:
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary
- Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
- Actual reserves held by plan
- State minimum reserve requirements

Health Plan/ Provider Characteristics:
- Board Certification
- Languages Spoken (other than English)
- Provider turnover

Beneficiary Characteristics:
- Information on primary languages spoken by beneficiaries
- MCO/PCP-specific disenrollment rate
- Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects
SOUTH CAROLINA
Health Maintenance Organization (HMO)

Project Requirements:
- MCOs are required to conduct a project(s) of their own choosing
- Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
- (Newborn) Failure to thrive
- Adolescent Immunization
- Adolescent Well Care/EPSDT
- Asthma management
- Beta Blocker treatment after a heart attack
- Breast cancer screening (Mammography)
- Cervical cancer screening (Pap Test)
- Child/Adolescent Dental Screening and Services
- Child/Adolescent Hearing and Vision Screening and Services
- Childhood Immunization
- Cholesterol screening and management
- Coronary artery disease prevention
- Depression management
- Diabetes management
- Emergency Room service utilization
- Hypertension management
- Inpatient maternity care and discharge planning
- Lead toxicity
- Low birth-weight baby
- Otitis Media management
- Pharmacy management
- Post-natal Care
- Pregnancy Prevention
- Pre-natal care
- Prescription drug abuse
- Sickle cell anemia management
- Smoking prevention and cessation
- Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
- JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
- NCQA (National Committee for Quality Assurance) Standards
- State-Developed/Specified Standards
- URAC Standards

Accreditation Required for Participation:
- AAAHC (Accreditation Association for Ambulatory Health Care)
- NCQA (National Committee for Quality Assurance)
- URAC

Non-Duplication Based on Accreditation:
None

EQRO Name:
Carolinias Center for Medical Excellence

EQRO Organization:
- Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

EQRO Optional Activities:
- Assessment of MCO information systems
- Calculation of performance measures
- Conduct performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)
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<tr>
<th>Implementation of P4P:</th>
<th>Program Payers:</th>
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<td>The State HAS NOT implemented a Pay-for-Performance program with the MCO</td>
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<th>Population Categories Included:</th>
<th>Rewards Model:</th>
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<th>Clinical Conditions:</th>
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<th>Initial Year of Reward:</th>
<th>Evaluation Component:</th>
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<th>Member Incentives:</th>
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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

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, 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
- Obstetricians/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
SOUTH CAROLINA
Medical Homes Network

- 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

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract: Yes
Provides Part D Benefits: No

Scope of Part D Coverage: Not Applicable
Part D - Enhanced Alternative Coverage: Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs: Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agencies
- Developmental Disabilities Agency
- Educational Agencies
- Family Connections
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency

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
**SOUTH CAROLINA Medical Homes Network**

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:
- 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)

#### Beneficiary Characteristics:
- Information on primary languages spoken by beneficiaries
- Weeks of pregnancy at time of enrollment in PCCM, for women
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: Valerie Osterkamp
Office of Medical Services
(605) 773-3495

State Website Address: http://dss.sd.gov/sdmedx/

PROGRAM DATA

Program Service Area: Statewide
Operating Authority: 1932(a) - State Plan Option to Use Managed Care
Statutes Utilized: Not Applicable
Enrollment Broker: No
For All Areas Phased-In: No
Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: Not Applicable
Implementation Date: September 01, 1993
Waiver Expiration Date: Not Applicable
Sections of Title XIX Waived: Not Applicable
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
- Case Management
- Durable Medical Equipment, EPSDT
- Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Laboratory, Ophthalmology, 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
### SOUTH DAKOTA PRIME

**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)

**Medicare Dual Eligibles Excluded:**
Exclude all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Included:**
None

**Part D Benefit**

- **MCE has Medicare Contract:** Not Applicable
- **Scope of Part D Coverage:** Not Applicable

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
- Provider contacts - Medically fragile protocol
- Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Aging Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

**PRIME**

### ADDITIONAL INFORMATION

None
TEXAS
PCCM

CONTACT INFORMATION

State Medicaid Contact: Joseph Vesowate
Texas Health and Human Services Commission
(512) 491-1379

State Website Address: http://www.hhsc.state.tx.us/medicaid/care_case_pro

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932(a) - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 2005

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable
Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Institutional, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Internists
- Nurse Midwives
- Nurse Practitioners
- Obstetricians/Gynecologists or Gynecologists
- Other Specialists Approved on a Case-by-Case Basis
- Pediatricians
- Physician Assistants
- Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
- Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
- Aged and Related Populations
## Subpopulations Excluded from Otherwise Included Populations:

- Eligibility Less Than 3 Months
- Enrolled in Another Managed Care Program
- Medicare Dual Eligibles
- Participate in HCBS Waiver
- Reside in Nursing Facility or ICF/MR
- Special Needs Children (BBA defined)
- Special Needs Children (State defined)

## Medicare Dual Eligibles Included:

None

## Medicare Dual Eligibles Excluded:

Exclude all categories of Medicare Dual Eligibles

## Lock-In Provision:

Does not apply because State only contracts with one managed care entity

## Part D Benefit

### MCE has Medicare Contract:

No

### Provides Part D Benefits:

Not Applicable

### Scope of Part D Coverage:

Not Applicable

### Part D - Enhanced Alternative Coverage:

Not Applicable

### Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:

None

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**SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS**

<table>
<thead>
<tr>
<th>Program Includes People with Complex (Special) Needs:</th>
<th>Yes</th>
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</thead>
</table>

### Strategies Used to Identify Persons with Complex (Special) Needs:

- DOES NOT identify members of these groups

### Agencies with which Medicaid Coordinates the Operation of the Program:

- DOES NOT coordinate with any other Agency

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**PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS**

PCCM

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**ADDITIONAL INFORMATION**

None

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**QUALITY ACTIVITIES FOR PCCM**

### Quality Oversight Activities:

- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines

### Use of Collected Data:

- Beneficiary Provider Selection
- Contract Standard Compliance
TEXAS
PCCM

-Focused Studies
-Network Data
-Ombudsman
-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
  - Adult Medicaid SSI Questionnaire
  - Child Medicaid AFDC Questionnaire

Performance Measures

Process Quality:
- Adolescent immunization rate
- Adolescent well-care visits rates
- Asthma care - medication use
- Controlling high blood pressure
- Dental services
- Diabetes management/care
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation of prenatal care - timeliness of
- Percentage of beneficiaries with at least one dental visit
- Smoking prevention and cessation
- Vision services for individuals less than 21 years of age
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care:
- Adult access to preventive/ambulatory health services
- Average distance to primary care case manager
- Average wait time for an appointment with primary care case manager
- Children's access to primary care practitioners

Use of Services/Utilization:
- Emergency room visits/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiaries
- Number of OB/GYN visits per adult female beneficiary

Provider Characteristics:
- Board Certification
- Languages spoken (other than English)
- Provider turnover

Beneficiary Characteristics:
- Disenrollment rate
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries who are auto-assigned to PCCM
- Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

Performance Measures - Others:
None

Performance Improvement Projects

Clinical Topics:
- Adolescent Immunization
- Adolescent Well Care/EPSDT
- Asthma management
- Child/Adolescent Dental Screening and Services
- Child/Adolescent Hearing and Vision Screening and Services
- Childhood Immunization
- Diabetes management
- Emergency Room service utilization

Non-Clinical Topics:
- Children's access to primary care practitioners
- Hypertension management
- Newborn screening for heritable diseases
- Pre-natal care
- Well Child Care/EPSDT
WASHINGTON
Chronic Care Management Program (CCMP)

CONTACT INFORMATION

State Medicaid Contact: Barbara Lantz
Health Care Authority
(360) 725-1640

State Website Address: http://www.hca.wa.gov

PROGRAM DATA

Program Service Area: County
Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932(a) - State Plan Option to Use Managed Care
Implementation Date: January 01, 2007
Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable
Enrollment Broker: No
Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

Guaranteed Eligibility:
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
WASHTON
Chronic Care Management Program (CCMP)

Medicare Dual Eligibles Included: None

Medicare Dual Eligibles Excluded: Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract: No

Provides Part D Benefits: Not Applicable

Scope of Part D Coverage: Not Applicable

Part D - Enhanced Alternative Coverage: Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs: Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Housing Agencies
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

City of Seattle Human Services

Cowlitz County Guidance Association

ADDITIONAL INFORMATION

Chronic Care Management program provides disease management services to clients who are categorically needy, aged, blind and disabled and who receive Medicaid and other services through fee-for-service system. The program provides intensive educational services, coordination with other needed services and assistance in accessing care.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Monitoring of PAHP Standards
- On-Site Reviews
- Performance Measures (see below for details)

Use of Collected Data:
- Contract Standard Compliance
- Data Mining
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Track Health Service provision
## WASHINGTON
Chronic Care Management Program (CCMP)

<table>
<thead>
<tr>
<th>Consumer Self-Report Data:</th>
<th>Use of HEDIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- CAHPS</td>
<td>- The State DOES NOT use any of the HEDIS measures</td>
</tr>
<tr>
<td>- Adult Medicaid SSI Questionnaire</td>
<td></td>
</tr>
<tr>
<td>- State-developed Survey</td>
<td></td>
</tr>
</tbody>
</table>

### 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 beneficiaries

#### Health Plan Stability/ Financial/Cost of Care:
None

### Standards/Accreditation

#### PAHP Standards:
- State-Developed/Specified Standards

#### Accreditation Required for Participation:
None

#### Non-Duplication Based on Accreditation:
None
WASHINGTON
Healthy Options

CONTACT INFORMATION

State Medicaid Contact: Michael Paulson
Division of Health Care Services/Health Care Authority
(360) 725-1641

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

Initial Waiver Approval Date: Not Applicable

Implementation Date: July 01, 2002

Waiver Expiration Date: Not Applicable

Sections of Title XIX Waived: Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT,
Family Planning, Home Health, Hospice, Immunization,
Inpatient Hospital, Laboratory, Outpatient Hospital,
Pharmacy, Physician, X-Ray

Allowable PCPs:
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Indian Health Service (IHS) Providers
- Internists
- Nurse Practitioners
- Obstetricians/Gynecologists or Gynecologists
- Pediatricians
- Physician Assistants
- Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Special Needs Children (State defined)

Populations Mandatorily Enrolled:
-Optional Children
### WASHINGTON Healthy Options

**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

**Medicare Dual Eligibles Included:** None

**Medicare Dual Eligibles Excluded:**
- Exclude all categories of Medicare Dual Eligibles

**Lock-in Provision:**
No lock-in

**Part D Benefit**

**MCE has Medicare Contract:**
No

**Scope of Part D Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

**Provides Part D Benefits:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

---

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
- Obtains an electronic listing from Department of Health, a separate agency
- Uses enrollment forms to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Maternal and Child Health Agency
- Public Health Agency
- Social Services Agencies

---

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Asuris Northwest Health</th>
<th>Columbia United Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Plan</td>
<td>Group Health Cooperative</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan</td>
<td>Molina Healthcare</td>
</tr>
<tr>
<td>Regence Blue Shield</td>
<td></td>
</tr>
</tbody>
</table>
**WASHINGTON**  
Healthy Options  

**ADDITIONAL INFORMATION**

Children with special health care needs are those who have 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 MCO/HIO

<table>
<thead>
<tr>
<th><strong>State Quality Assessment and Improvement Activities:</strong></th>
<th><strong>Use of Collected Data:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Consumer Self-Report Data (see below for details)</td>
<td>- Conduct Performance Improvements Projects</td>
</tr>
<tr>
<td>- Encounter Data (see below for details)</td>
<td>- Contract Standard Compliance</td>
</tr>
<tr>
<td>- Enrollee Hotlines</td>
<td>- Monitor Quality Improvement</td>
</tr>
<tr>
<td>- Focused Studies</td>
<td>- Plan Reimbursement</td>
</tr>
<tr>
<td>- MCO Standards (see below for details)</td>
<td>- Program Evaluation</td>
</tr>
<tr>
<td>- Monitoring of MCO Standards</td>
<td>- Regulatory Compliance/Federal Reporting</td>
</tr>
<tr>
<td>- On-Site Reviews</td>
<td>- Track Health Service provision</td>
</tr>
<tr>
<td>- Performance Improvement Projects (see below for details)</td>
<td></td>
</tr>
<tr>
<td>- Performance Measures (see below for details)</td>
<td></td>
</tr>
</tbody>
</table>

**Consumer Self-Report Data:**
- State-developed Survey

**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

**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 continuous enrollment requirement for some or all of the measures

## Encounter Data

**Collection: Requirements:**
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)  
- Requirements for MCOs to collect and maintain encounter data  
- Specifications for the submission of encounter data to the Medicaid agency  
- Standards to ensure complete, accurate, timely encounter data submission

**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

**State conducts general data completeness assessments:**
- Yes
WASHINGTON
Healthy Options

- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality:
- Adolescent well-care visit rate
- Diabetes medication management
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
- HbA1c Control

Access/Availabilty of Care:
- Prenatal/postpartum measures

Use of Services/Utilization:
- Ambulatory Care Utilization
- Inpatient Acute Care Utilization
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- Inpatient Non-acute Care Utilization
- Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan Provider Characteristics:
None

Beneficiary Characteristics:
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
- MCOs are required to conduct a project(s) of their own choosing
- All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics:
- Adolescent Immunization
- Adolescent Well Care/EPSDT
- Asthma management
- Childhood Immunization
- Depression management
- Diabetes management
- Emergency Room service utilization
- Obesity management
- Well Child Care/EPSDT
- Well Infant Care/EPSDT

Non-Clinical Topics:
- Access to Care
- Customer Service
- Reducing health care disparities via health literacy, education campaigns, or other initiatives

Standards/Accreditation

MCO Standards:
- BBA Protocols Supplemented with NCQA Standards

Accreditation Required for Participation:
None
### Pay for Performance (P4P)

<table>
<thead>
<tr>
<th><strong>Implementation of P4P:</strong></th>
<th><strong>Program Payers:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The State has implemented a Pay-for-Performance program with MCO</td>
<td>Medicaid is the only payer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Population Categories Included:</strong></th>
<th><strong>Rewards Model:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A subset of MCO members, defined by beneficiary age</td>
<td>Withholds as an incentive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Clinical Conditions:</strong></th>
<th><strong>Measurement of Improved Performance:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Initial Year of Reward:</strong></th>
<th><strong>Evaluation Component:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>The State HAS NOT conducted an evaluation of the effectiveness of its P4P program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Member Incentives:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
WASHINGTON
Washington Medicaid Integration Partnership (WMIP)

CONTACT INFORMATION

State Medicaid Contact: Michael Paulson
Health Care Authority
(360) 725-1641

State Website Address: http://www.dshs.wa.gov

PROGRAM DATA

Program Service Area: County
Operating Authority: 1932(a) - State Plan Option to Use Managed Care
Statutes Utilized: Not Applicable
Enrollment Broker: No
For All Areas Phased-In: No
Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: Not Applicable
Implementation Date: January 01, 2005
Waiver Expiration Date: Not Applicable
Sections of Title XIX Waived: Not Applicable
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
- Disease Management, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Laboratory, Longterm Care, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Vision, X-Ray

Allowable PCPs:
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Internists
- Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
- Aged and Related Populations
- Blind/Disabled Adults and Related Populations
- Medicare Dual Eligibles

Populations Mandatorily Enrolled: None
WASHINGTON
Washington Medicaid Integration Partnership (WMIP)

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligibles
- Poverty Level Pregnant Woman
- Special Needs Children (BBA defined)
- Special Needs Children (State defined)
- TANF

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Lock-In Provision:
No lock-in

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Benodiazepines
-Nonprescription drugs

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Housing Agencies
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Molina Healthcare (WMIP)

ADDITIONAL INFORMATION

The state contracts with Molina Healthcare of Washington to provide an integrated managed care program that covers a full scope of medical services, long-term care, inpatient, and outpatient mental health and chemical dependency services. The program includes an intensive care management component to assist enrollees with multiple health needs to access needed services.

QUALITY ACTIVITIES FOR MCO/HIO
WASHINGTON
Washington Medicaid Integration Partnership (WMIP)

State Quality Assessment and Improvement
Activities:
- Consumer Self-Report Data  (see below for details)
- Encounter Data  (see below for details)
- Enrollee Hotlines
- Medical Reviews
- Performance Improvement Projects  (see below for details)
- Performance Measures  (see below for details)

Use of Collected Data:
- Contract Standard Compliance
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

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 continuous enrollment requirement for some or all of the measures

Consumer Self-Report Data:
- CAHPS
  Adult Medicaid AFDC Questionnaire with Suplemental Questions

Use of Collected Data:
- 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 continuous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
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- Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
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- 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

Health Status/Outcomes Quality:
- Comprehensive Diabetes Care
WASHINGTON
Washington Medicaid Integration Partnership (WMIP)

-Use of High-Risk Medications in the Elderly

<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
<td>-Average number of visits to MH/SUD providers per beneficiary</td>
</tr>
<tr>
<td></td>
<td>-Emergency room visits/1,000 beneficiary</td>
</tr>
<tr>
<td></td>
<td>-Inpatient admission for MH/SUD conditions/1,000 beneficiaries</td>
</tr>
<tr>
<td></td>
<td>-Inpatient admissions/1,000 beneficiary</td>
</tr>
<tr>
<td></td>
<td>-Number of PCP visits per beneficiary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Plan Stability/ Financial/Cost of Care:</th>
<th>Health Plan/ Provider Characteristics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
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<table>
<thead>
<tr>
<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Information of beneficiary ethnicity/race</td>
<td>-Effectiveness of Care</td>
</tr>
<tr>
<td>-Information on primary languages spoken by beneficiaries</td>
<td>-Experience of Care</td>
</tr>
<tr>
<td>-MCO/PCP-specific disenrollment rate</td>
<td></td>
</tr>
</tbody>
</table>

**Performance Improvement Projects**

**Project Requirements:**
-Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

**Non-Clinical Topics:**
-Improve the rate of completion of Documented Care Plans.
-Increasing successful initial contacts between WMIP members and Care Coordination Team

**Clinical Topics:**
-Increasing depression assessments
-Increasing Influenza vaccine participation

**Standards/Accreditation**

<table>
<thead>
<tr>
<th>MCO Standards:</th>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Duplication Based on Accreditation:</th>
<th>EQRO Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Acumentra formerly known as OMPRO</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>EQRO Organization:</th>
<th>EQRO Mandatory Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Quality Improvement Organization (QIO)</td>
<td>-Validation of performance measures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EQRO Optional Activities:</th>
<th>Pay for Performance (P4P):</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Validation of encounter data</td>
<td>Implementation of P4P:</td>
</tr>
<tr>
<td></td>
<td>The State HAS NOT implemented a Pay-for-Performance program with the MCO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Payers:</th>
<th>Population Categories Included:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Rewards Model:</th>
<th>Clinical Conditions:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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</tbody>
</table>

<p>| Measurement of Improved Performance: | 514 |</p>
<table>
<thead>
<tr>
<th>Initial Year of Reward:</th>
<th>Evaluation Component:</th>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

**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
Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932(a) - State Plan Option to Use Managed Care
Implementation Date: February 01, 2008
Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable
Enrollment Broker: Automated Health Systems
Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable

Guaranteed Eligibility: 12 months guaranteed eligibility for children

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Dental, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Indian Health Service (IHS) Providers
- Internists
- Obstetricians/Gynecologists
- Pediatricians
- Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled: - Medicare Dual Eligibles

Populations Mandatorily Enrolled: - Poverty-Level Pregnant Women
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
## Wisconsin BadgerCare Plus

**Subpopulations Excluded from Otherwise Included Populations:**
- American Indian/Alaskan Native
- Enrolled in Another Managed Care Program
- Foster Care Children
- Medicare Dual Eligibles
- Migrant workers
- Participate in HCBS Waiver
- Reside in Nursing Facility or ICF/MR
- Residents residing in FFS counties
- Special Needs Children (BBA defined)

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Lock-In Provision:**
9 month lock-in

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
- Outreach and Access
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses enrollment forms to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Maternal and Child Health Agency (County departments)
- Mental Health Agency (County departments)
- Public Health Agency (County departments)
- Social Services Agency (County departments)
- Substance Abuse Agency (County departments)

### Participating Plans/PCCM and Other Programs

<table>
<thead>
<tr>
<th>Children's Community Health Plan - Medicaid HMO</th>
<th>CommunityConnect Health Plan - Medicaid HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CompCare -- Medicaid HMO</td>
<td>Dean Health Plan -- Medicaid HMO</td>
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<td>Group Health Cooperative Of Eau Claire -- Medicaid HMO</td>
<td>Group Health Cooperative Of South Central WI -- Medicaid HMO</td>
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<td>Gundersen Lutheran Health Plan - Medicaid HMO</td>
<td>Health Tradition Health Plan -- Medicaid HMO</td>
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<td>Independent Care (iCare) - Medicaid HMO</td>
<td>Managed Health Services -- Medicaid HMO</td>
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<td>MercyCare Insurance Company -- Medicaid HMO</td>
<td>Molina Health Plan -- Medicaid HMO</td>
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<td>Network Health Plan -- Medicaid HMO</td>
<td>Physicians Plus Health Plan - Medicaid HMO</td>
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<td>Security Health Plan -- Medicaid HMO</td>
<td>UnitedHealthcare Community Plan of WI - Medicaid HMO</td>
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<td>Unity Health Insurance -- Medicaid HMO</td>
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</tbody>
</table>

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WISCONSIN
BadgerCare Plus

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)
- 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

Use of Collected Data:
- Beneficiary Plan Selection
- Contract Standard Compliance
- Data Mining
- Enhanced/Revise State managed care Medicaid Quality Strategy
- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data:
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

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.

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

Validation - Methods:
- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Medical record validation
- Per member per month analysis and comparisons across MCOs
MCO/HIO conducts data accuracy check(s) on specified data elements:
- Date of Service
- Date of Payment
- Provider ID
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure
- Admission source
- Admission type
- Days supply
- Modifier codes
- Patient status code
- Place of service codes
- Quantity

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
- Adolescent well-care visit rate
- Breast Cancer screening rate
- Cervical cancer screening rate
- Children with at least one comprehensive EPSDT well-child visit in the look-back period at age 3-5 years, 6-14 years, and 15-20 years
- Children with at least one non-EPSDT well-child visit in the look-back period at ages birth-1 year, 1-2 years, 3-5 years, 6-14 years and 15-20 years
- Comprehensive EPSDT well-child visits for children age birth to two years for those receiving 5, 6 and 7 or more visits
- Dental services
- Diabetes management
- Follow-up after hospitalization for mental illness
- 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 of all ages
- 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
- Breast malignancies detected
- Cervix/uterus malignancies detected
- HPV infections detected
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of low birth weight infants

Access/Availability of Care:
- Adult's access to preventive/ambulatory health services
- Average distance to PCP
- Children's access to primary care practitioners
- Provider network data on geographic distribution
- Ratio of dental providers to beneficiaries
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

Use of Services/Utilization:
- Drug Utilization
- Percent of beneficiaries with at least one PCP visit
- Percent of beneficiaries with at least one specialist visit
- Percentage of beneficiaries with at least one dental visit

Health Plan Stability/Financial/Cost of Care:
- OCI certification
- Review of medical loss ratios

Health Plan/Provider Characteristics:
- Board Certification
- Languages Spoken (other than English)

Beneficiary Characteristics:
None

Performance Measures - Others:
- Accreditation
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)
- Breast cancer treatment
- Cervical cancer screening (Pap Test)
- Cervical cancer treatment
- 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
- Newborn screening for heritable diseases
- Post-natal Care
- Pre-natal care
- Prescription drug abuse
- Smoking prevention and cessation
- Substance Use Disorders treatment after detoxification service
- Treatment of myocardial infarction
- Well Child Care/EPSDT

Non-Clinical Topics:
- Health living individual incentive program

Standards/Accreditation

MCO Standards:
- State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
- AAAHC (Accreditation Association for Ambulatory Health Care)
- NCQA (National Committee for Quality Assurance)
- URAC

EQRO Name:
- MetaStar, Inc.

EQRO Organization:
- Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

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 Tobacco Registries

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

Clinical Conditions:
AMM- Depression
Asthma
Blood Lead Testing
Breast Cancer Screening
Childhood immunizations
Dental
Diabetes
Perinatal Care
Tobacco Cessation
Well-child visits

Initial Year of Reward:
1996

Member Incentives:
Not Applicable

Rewards Model:
Payment incentives/differentials to reward MCOs
Public reporting to reward MCOs
Withholds as an incentive

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.)

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
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
Initial Waiver Approval Date: Not Applicable
Operating Authority: 1932(a) - State Plan Option to Use Managed Care
Implementation Date: April 01, 2005
Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable
Enrollment Broker: Automated Health Systems
Sections of Title XIX Waived: Not Applicable
For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable Granted: Not Applicable
Guaranteed Eligibility: No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Coordination With Non-Medicaid Services (Social & Vocational), Recreational & Wellness Prog, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pediatricians, Personal Care, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Indian Health Service (IHS) Providers
- Internists
- Obstetricians/Gynecologists
- Other Specialists Approved on a Case-by-Case Basis
- Pediatricians
- Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:
- American Indians
- Blind/Disabled Adults and Related Populations
- Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None
Subpopulations Excluded from Otherwise Included Populations:
- Beneficiaries Who After Enrollment Are Placed In A Nursing Home For Longer Than 90 Days
- Children Under Age 19
- Enrolled in Another Managed Care Program
- In Family Care
- Medicare Dual Eligibles
- Participate in HCBS Waiver
- Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Asks advocacy groups to identify members of these groups
- Comprehensive Assessment Required At Time of Enrollment
- Only SSI-Disabled Adult Recipients May Enroll
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
- Local Public Health Agency
- Mental Health Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Compcare -- SSI
Independent Care Health Plan -- SSI
Molina Health Plan -- SSI
United Healthcare Community Plan of WI -- SSI

Group Health of Eau Claire -- SSI
Managed Health Services -- SSI
Network Health Plan -- SSI

ADDITIONAL INFORMATION
SSI Managed Care Program is for SSI and SSI-related Medicaid recipients, age 19 or older not living in an institution and not participating in a home and community based waiver. Dually eligible persons and Medicaid Purchase Plan recipients may enroll on a voluntary basis. Targeted Case Management, Community Support Program Services, and Crisis Intervention Services are covered under fee-for-service for enrollees in this program.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement
Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- Ombudsman
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data:
- Contract Standard Compliance
- 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

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 continuous enrollment

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid SSI Questionnaire
  - Adult with Special Needs Questionnaire

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

Collection: Requirements:
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to ensure 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

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

Encounter Data

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

State conducts general data completeness assessments:
Yes
WISCONSIN
Medicaid SSI Managed Care Program

- 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

Performance Measures

Process Quality:
- Breast Cancer screening rate
- Cervical cancer screening rate
- Dental services
- Diabetes management/care
- Follow-up after hospitalization for mental illness and substance abuse at 7 and 30 days
- Initiation and engagement of SUD treatment

Health Status/Outcomes Quality:
- Patient satisfaction with care

Access/Availability of Care:
None

Use of Services/Utilization:
- Emergency room visits/1,000 beneficiary
- Number of hospital admissions per member per year
- Number of hospital days per member per year
- Percentage of beneficiaries with at least one dental visit
- Percentage of people living at home, CBRF/group home, nursing home

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
- MCO/PCP-specific disenrollment rate

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
- MCOs are required to conduct a project(s) of their own choosing
- Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
- 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
- Enrollee satisfaction with the HMO customer service
- Grievances, appeals and complaints
WISCONSIN
Medicaid SSI Managed Care Program

-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

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

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:  
Member incentives in the MCO P4P program
Payment incentives/differentials to reward MCOs
Public reporting to reward MCOs
Withholds as an incentive

Clinical Conditions:  
Breast cancer screening
Diabetes
Follow-up after MH Hospitalization
Substance abuse

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:  
HMOs pay a max of $25 pmpm for disease prev. activities.
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
Initial Waiver Approval Date: Not Applicable

Operating Authority: 1915(a) - Voluntary
Implementation Date: April 01, 1995

Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable

Enrollment Broker: No
Sections of Title XIX Waived: None

For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable Granted: None

Guaranteed Eligibility: No guaranteed eligibility

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
CALIFORNIA
AIDS Healthcare Foundation

-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Eligibility Period Less Than 3 Months
-Medicare Dual Eligibles
-Member approved for a Major Organ Transplant
-Poverty Level Pregnant Woman

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
-Agents when used for anorexia, weight loss, weight gain
-Agents when used for symptomatic relief of cough and colds
-Barbituates
-Benzodiazepines
-Nonprescription drugs
-Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
-Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

Strategies Used to Identify Persons with Complex (Special) Needs:
-Plan is responsible to identify this group

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

Non-Clinical Topics:
None

Clinical Topics:
- Advance Care Directives
- CD4 and Viral Load Testing

Standards/Accreditation

MCO Standards:
- State-Developed/Specified Standards

Non-Duplication Based on Accreditation:
None

EQRO Name:
- Health Services Advisory Group

EQRO Organization:
- Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

EQRO Optional Activities:
- Calculation of performance measures
- Technical assistance to MCOs to assist them in conducting quality activities

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable
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<table>
<thead>
<tr>
<th>Member Incentives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
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: Initial Waiver Approval Date:
City Not Applicable
County

Operating Authority: Implementation Date:
1915(a) - Voluntary January 01, 1996

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
No None

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
Granted:
No None

Guaranteed Eligibility:
None

SERVICE DELIVERY

Emotional and Mental Health Support PIHP - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:
Crisis, Emotional Support, Inpatient Mental Health, Mental -N/A
Health Rehabilitation, Mental Health Support, Outpatient
Mental Health, Pharmacy

Contractor Types:
None

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Children and Related Populations

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligibles

Lock-in Provision:
No lock-in
-Populations residing outside plans service area defined by contract
-Reside in Nursing Facility or ICF/MR

Medicare Dual Eligibles Included: None
Medicare Dual Eligibles Excluded: Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract: No
Provides Part D Benefits: Not Applicable

Scope of Part D Coverage: Not Applicable
Part D - Enhanced Alternative Coverage: Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs: Yes

Strategies Used to Identify Persons with Complex (Special) Needs: -Plan is responsible to identify this group

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
San Francisco City & CO/Family Mosaic

ADDITIONAL INFORMATION
San Francisco City and County/Family Mosaic only provides emotional and mental support to severely emotionally disturbed children.
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
Initial Waiver Approval Date: Not Applicable

Operating Authority: 1915(a) - Voluntary
Implementation Date: January 01, 1972

Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable

Enrollment Broker:
Health Care Options/Maximus

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

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:
CALIFORNIA Prepaid Health Plan Program

- 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)

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan-LA
Care 1st Health Plan-Dental-LA
Health Net of CA-Dental-LA
Safeguard Dental-LA

American Health Guard-Dental Plan-LA
Community Dental Services-LA
Liberty Dental Plan of CA-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
CALIFORNIA
Prepaid Health Plan Program

- 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:
None

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: Initial Waiver Approval Date:
Zip Code Not Applicable

Operating Authority: Implementation Date:
1915(a) - Voluntary January 01, 2008

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
No None

For All Areas Phased-In:
No Sections of Title XIX Costs Not Otherwise Matchable

Guaranteed Eligibility:
No guaranteed eligibility

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
- Obstetricians/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: 537

Populations Mandatorily Enrolled:
CALIFORNIA
Senior Care Action Network

- Aged and Related Populations
- Blind/Disabled Adults and Related Populations
- Medicare Dual Eligibles

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)

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- Agents when used for anorexia, weight loss, weight gain
- Agents when used for symptomatic relief of cough and colds
- Barbiturates
- Benzodiazepines
- Nonprescription drugs
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Senior Care Action Network (SCAN)

ADDITIONAL INFORMATION

SCAN Health Plan was formerly a Social HMO operating under an 1115(a)-Demonstration waiver program authority which expired December 31, 2007. Effective January 1, 2008, SCAN Health Plan is now a Medicare Advantage Special Needs Plan that contracts with the Department of Health Care Services to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los Angeles, San Bernardino, and Riverside counties. SCAN is a managed care organization operating under Section 1915(a) of the Social Security Act. SCAN provides all services in the Medi-Cal State Plan; 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)
- 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

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

State conducts general data completeness assessments:
Yes
Performance Measures

Process Quality:
- Beta-blocker treatment after heart attack
- Breast Cancer screening rate

Access/Availability of Care:
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

Beneficiary Characteristics:
None

Health Status/Outcomes Quality:
None

Use of Services/Utilization:
None

Performance Improvement Projects

Project Requirements:
- MCOs are required to conduct a project(s) of their own choosing

Performance Measures - Others:
None

Clinical Topics:
- Care for Older Adults
- Prevention of Stroke and Transient Ischemic Attack

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
- State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
- Health Services Advisory Group

EQRO Organization:
- Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

EQRO Optional Activities:
- Calculation of performance measures
- Technical assistance to MCOs to assist them in conducting quality activities
<table>
<thead>
<tr>
<th><strong>Implementation of P4P:</strong></th>
<th><strong>Program Payers:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The State HAS NOT implemented a Pay-for-Performance program with the MCO</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th><strong>Population Categories Included:</strong></th>
<th><strong>Rewards Model:</strong></th>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<tr>
<th><strong>Clinical Conditions:</strong></th>
<th><strong>Measurement of Improved Performance:</strong></th>
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<td>Not Applicable</td>
<td>Not Applicable</td>
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<tr>
<th><strong>Initial Year of Reward:</strong></th>
<th><strong>Evaluation Component:</strong></th>
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<tbody>
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<td>Not Applicable</td>
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<th><strong>Member Incentives:</strong></th>
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<tr>
<td>Not Applicable</td>
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</table>
COLORADO
Managed Care Program

CONTACT INFORMATION

State Medicaid Contact: Valerie Baker-Easley
Department of Health Care Policy and Financing
(303) 866-3684

State Website Address: http://www.colorado.gov/hcpf

PROGRAM DATA

Program Service Area: Statewide

Operating Authority:
1915(a) - Voluntary

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS, INC.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 1983

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable
Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Family Planning,
Hearing, Home Health, Immunization, Inpatient Hospital,
Laboratory, Occupational Therapy, Outpatient Hospital,
Pharmacy, Physical Therapy, Physician, Speech Therapy,
Telemedicine, Vision, X-Ray

Allowable PCPs:
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Gerontologists
- Internists
- Obstetricians/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

542
COLORADO
Managed Care Program

- Medicare Dual Eligibles
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
- American Indian/Alaskan Native
- Enrolled in Another Managed Care Program
- Medicare Dual Eligibles

Lock-in Provision:
12 month lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
COLORADO
Managed Care Program

Medical-only PIHP (risk or non-risk, non-comprehensive) - Non-risk Capitation

Service Delivery

Included Services:
- Case Management, Disease Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Speech Therapy, Telemedicine, Transportation, Vision, X-Ray

Allowable PCPs:
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Gerontologist
- Internists
- Obstetricians/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

Medicare Dual Eligibles Included:
- QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
- SLMB, QI, and QDWI
- QMB

Lock-In Provision:
- 12 month lock-in

Part D Benefit

MCE has Medicare Contract:  
- No

Provides Part D Benefits:  
- Not Applicable

Scope of Part D Coverage:  
- Not Applicable

Part D - Enhanced Alternative Coverage:  
- Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:  
- Yes

Strategies Used to Identify Persons with Complex (Special) Needs:  

Agencies with which Medicaid Coordinates the Operation of the Program:
COLORADO
Managed Care Program

- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups
- Developmental Disabilities Agency
- Mental Health Agency
- Social Services Agencies

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 varies by county. 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

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 continuous enrollment

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid SSI Questionnaire
  - Child Medicaid SSI Questionnaire

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
COLORADO
Managed Care Program

<table>
<thead>
<tr>
<th>Collection: Standardized Forms:</th>
<th>Validation - Methods:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANSI ASC X12 837 - transaction set format for transmitting health care claims data</td>
<td>-Medical record validation</td>
</tr>
<tr>
<td>NCPDP - National Council for Prescription Drug Programs pharmacy claim form</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MCO/HIO conducts data accuracy check(s) on specified data elements:</th>
<th>State conducts general data completeness assessments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Processing, Date of Payment, Provider ID, Type of Service, Medicaid Eligibility, Plan Enrollment, Diagnosis Codes, Revenue Codes, Gender-appropriate diagnosis/procedure</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Performance Measures

<table>
<thead>
<tr>
<th>Process Quality:</th>
<th>Health Status/Outcomes Quality:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent well-care visit rate, Annual Monitoring for Patients on Persistent Medications, Childhood Immunization Status, 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</td>
<td>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</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult's access to preventive/ambulatory health services, Children's access to primary care practitioners, Prenatal and Postpartum Care</td>
<td>Antibiotic Utilization, Frequency of Selected Procedures, Inpatient Utilization - General Hospital/Acute Care Ambulatory Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Plan Stability/ Financial/Cost of Care:</th>
<th>Health Plan/ Provider Characteristics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
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</table>

<table>
<thead>
<tr>
<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Performance Improvement Projects

<table>
<thead>
<tr>
<th>Project Requirements:</th>
<th>Clinical Topics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Managed Care is performing a focus study</td>
</tr>
</tbody>
</table>
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 Organization:
- QIO-like entity

EQRO Name:
- Health Services Advisory Group, Inc.

EQRO Mandatory Activities:
- Site Reviews
- Validation of performance improvement projects
- Validation of performance measures

EQRO Optional Activities:
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

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)
- Provider Data

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
COLORADO
Managed Care Program

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
- Chlamydia 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

Beneficiary Characteristics:
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 Behavioral 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
<table>
<thead>
<tr>
<th><strong>Non-Duplication Based on Accreditation:</strong></th>
<th><strong>EQRO Name:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- Health Services Advisory Group, Inc.</td>
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<table>
<thead>
<tr>
<th><strong>EQRO Organization:</strong></th>
<th><strong>EQRO Mandatory Activities:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- QIO-like entity</td>
<td>- Site Reviews</td>
</tr>
<tr>
<td></td>
<td>- Validation of performance improvement projects</td>
</tr>
<tr>
<td></td>
<td>- Validation of performance measures</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>EQRO Optional Activities</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services</td>
</tr>
</tbody>
</table>
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
Initial Waiver Approval Date: Not Applicable

Operating Authority: 1915(a) - Voluntary
Implementation Date: February 01, 1996

Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable

Enrollment Broker: No
Sections of Title XIX Waived: None

For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable Granted: None

Guaranteed Eligibility: None

SERVICE DELIVERY

Medical-only 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
### DISTRICT OF COLUMBIA
Children and Adolescent Supplemental Security Income Program

<table>
<thead>
<tr>
<th>Medicare Dual Eligibles Included:</th>
<th>Medicare Dual Eligibles Excluded:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Exclude all categories of Medicare Dual Eligibles</td>
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#### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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</table>

<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
</tr>
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<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

<table>
<thead>
<tr>
<th>Program Includes People with Complex (Special) Needs:</th>
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<tbody>
<tr>
<td>Yes</td>
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<table>
<thead>
<tr>
<th>Strategies Used to Identify Persons with Complex (Special) Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Reviews complaints and grievances to identify members of these groups</td>
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</table>

<table>
<thead>
<tr>
<th>Agencies with which Medicaid Coordinates the Operation of the Program:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Maternal and Child Health Agency</td>
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</table>

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Health Services For Children with Special Needs</th>
</tr>
</thead>
</table>

### ADDITIONAL INFORMATION

This is no longer a demonstration program but a cost-base reimbursement program and there is no risk involved for providers. Program provides Emergency Transportation only and Skilled Nursing Facility for first 30 days.

### QUALITY ACTIVITIES FOR PIHP

#### State Quality Assessment and Improvement

<table>
<thead>
<tr>
<th>Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Encounter Data (see below for details)</td>
</tr>
<tr>
<td>-Enrollee Hotlines</td>
</tr>
<tr>
<td>-Focused Studies</td>
</tr>
<tr>
<td>-Monitoring of PIHP Standards</td>
</tr>
<tr>
<td>-On-Site Reviews</td>
</tr>
<tr>
<td>-Performance Measures (see below for details)</td>
</tr>
<tr>
<td>-PIHP Standards (see below for details)</td>
</tr>
<tr>
<td>-Provider Data</td>
</tr>
</tbody>
</table>

#### 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
DISTRICT OF COLUMBIA
Children and Adolescent Supplemental Security Income Program

of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continuous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements:
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to ensure 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 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

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of low birth weight infants
### District of Columbia

**Children and Adolescent Supplemental Security Income Program**

<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Initiation of prenatal care - timeliness of</td>
<td>- Average number of visits to MH/SUD providers per beneficiary</td>
</tr>
<tr>
<td>- Lead screening rate</td>
<td>- Drug Utilization</td>
</tr>
<tr>
<td>- Percentage of beneficiaries with at least one dental visit</td>
<td>- Emergency room visits/1,000 beneficiary</td>
</tr>
<tr>
<td>- Vision services for individuals less than 21 years of age</td>
<td>- Inpatient admission for MH/SUD conditions/1,000 beneficiaries</td>
</tr>
<tr>
<td>- Well-child care visit rates in first 15 months of life</td>
<td>- Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility</td>
</tr>
<tr>
<td>- Well-child care visits rates in 3, 4, 5, and 6 years of life</td>
<td>- Percentage of beneficiaries with at least one dental visit</td>
</tr>
<tr>
<td>- Ratio of dental providers to beneficiaries</td>
<td>- Re-admission rates of MH/SUD</td>
</tr>
<tr>
<td>- Ratio of mental health providers to number of beneficiaries</td>
<td></td>
</tr>
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<table>
<thead>
<tr>
<th>Health Plan Stability/ Financial/Cost of Care:</th>
<th>Health Plan/ Provider Characteristics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Net income</td>
<td>- Board Certification</td>
</tr>
<tr>
<td>- Net worth</td>
<td>- Languages Spoken (other than English)</td>
</tr>
<tr>
<td>- Total revenue</td>
<td>- Provider turnover</td>
</tr>
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<table>
<thead>
<tr>
<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
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</table>

**Standards/Accreditation**

<table>
<thead>
<tr>
<th>PIHP Standards:</th>
<th>Accreditation Required for Participation:</th>
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<tbody>
<tr>
<td>- JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards</td>
<td>None</td>
</tr>
<tr>
<td>- NCQA (National Committee for Quality Assurance) Standards</td>
<td></td>
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<tr>
<td>- State-Developed/Specified Standards</td>
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<table>
<thead>
<tr>
<th>Non-Duplication Based on Accreditation:</th>
<th>EQRO Name:</th>
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<tr>
<td>None</td>
<td>- Delmarva Foundation for Medical Care</td>
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<thead>
<tr>
<th>EQRO Organization:</th>
<th>EQRO Mandatory Activities:</th>
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</thead>
<tbody>
<tr>
<td>- Quality Improvement Organization (QIO)</td>
<td>- Review of PIHP compliance with structural and operational standards established by the State</td>
</tr>
<tr>
<td></td>
<td>- Validation of performance improvement projects</td>
</tr>
<tr>
<td></td>
<td>- Validation of performance measures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EQRO Optional Activities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Administration or validation of consumer or provider surveys</td>
<td></td>
</tr>
<tr>
<td>- Calculation of performance measures</td>
<td></td>
</tr>
<tr>
<td>- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services</td>
<td></td>
</tr>
<tr>
<td>- Technical assistance to PIHPs to assist them in conducting quality activities</td>
<td></td>
</tr>
<tr>
<td>- Validation of client level data, such as claims and encounters</td>
<td></td>
</tr>
</tbody>
</table>
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
Initial Waiver Approval Date: Not Applicable
Operating Authority: 1915(a) - Voluntary
Implementation Date: November 01, 1974
Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable
Enrollment Broker: Illinois Client Enrollment Broker
Sections of Title XIX Waived: None
For All Areas Phased-In: Yes
Sections of Title XIX Costs Not Otherwise Matchable
Granted: None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - 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
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**ILLINOIS**  
**Voluntary Managed Care**

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- American Indian/Alaska Native</td>
<td></td>
</tr>
<tr>
<td>- Poverty-Level Pregnant Women</td>
<td></td>
</tr>
<tr>
<td>- Section 1931 Adults and Related Populations</td>
<td></td>
</tr>
<tr>
<td>- Section 1931 Children and Related Populations</td>
<td></td>
</tr>
<tr>
<td>- Title XXI CHIP</td>
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<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
<th>Lock-in Provision:</th>
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</thead>
<tbody>
<tr>
<td>- All Kids Premium Levels 2 through 8</td>
<td></td>
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<tr>
<td>- All Kids Rebate and Family Care Rebate</td>
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</tr>
<tr>
<td>- Blind Disabled Children and Related Population</td>
<td></td>
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<tr>
<td>- Enrolled in CDC BCCT Program</td>
<td></td>
</tr>
<tr>
<td>- Individuals enrolled in presumptive eligible programs</td>
<td></td>
</tr>
<tr>
<td>- Individuals enrolled in programs with limited benefits</td>
<td></td>
</tr>
<tr>
<td>- Medicare Dual Eligibles</td>
<td></td>
</tr>
<tr>
<td>- Non-citizens only receiving emergency services</td>
<td></td>
</tr>
<tr>
<td>- Other Insurance - High Level</td>
<td></td>
</tr>
<tr>
<td>- Pace Participants</td>
<td></td>
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<tr>
<td>- Participate in HCBS Waiver</td>
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<tr>
<td>- Refugees</td>
<td></td>
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<tr>
<td>- Reside in Nursing Facility or ICF/MR</td>
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<tr>
<td>- Special Needs Children (BBA defined)</td>
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<td>- Spenddown Eligibles</td>
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<td>- Transitional Assistance, Age 19 and Older</td>
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<td>- Veterans Care Program</td>
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<tr>
<th>Medicare Dual Eligibles Included:</th>
<th>Medicare Dual Eligibles Excluded:</th>
</tr>
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<tbody>
<tr>
<td>None</td>
<td>Exclude all categories of Medicare Dual Eligibles</td>
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<table>
<thead>
<tr>
<th>Part D Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCE has Medicare Contract:</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
<tr>
<td>Provides Part D Benefits:</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
<tr>
<td>Scope of Part D Coverage:</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
<tr>
<td>Part D - Enhanced Alternative Coverage:</td>
</tr>
<tr>
<td>Not Applicable</td>
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</table>

| Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: | None |

## PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Family Health Network</th>
<th>Harmony Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meridian Health Plan</td>
<td></td>
</tr>
</tbody>
</table>

## 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)

**Use of Collected Data:**
- Contract Standard Compliance
- Data Mining - HEDIS calculations

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ILLINOIS
Voluntary Managed Care

- 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

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
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation - Methods:
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
- Medical record validation
- Per member per month analysis and comparisons across MCOs
- Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/HIO conducts data accuracy check(s) on specified data elements:
- Date of Service
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
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
- 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

## 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

## 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:
- Asthma management
- EPSDT/Content of care for under age three
- Follow-up After Hospitalization for Mental Illness/PCP
- Communication
- Prenatal Depression Screening and referral

### Non-Clinical Topics:
- None
ILLINOIS
Voluntary Managed Care

Standards/Accreditation

MCO Standards:
- CMS Quality Improvement Systems - for performance improvement
- NCQA for HEDIS
- State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Organization:
- External Quality Review Organization

EQRO Name:
- Health Services Advisory Group

EQRO Mandatory Activities:
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

EQRO Optional Activities:
- 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 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: David Godfrey
Minnesota Department of Human Services
(651) 431-2319

State Website Address: http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date: County Not Applicable
Operating Authority: Implementation Date: 1915(a) - Voluntary January 01, 2008
Statutes Utilized: Waiver Expiration Date: Not Applicable Not Applicable
Enrollment Broker: Sections of Title XIX Waived: No
For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
Guaranteed Eligibility: Granted: None
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery
Included Services: Allowable PCPs:
Case Management, Child & Teen Check-Up, Chiropractic, -Not Applicable; Contractors Not Required to Identify PCPs
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

Enrollment

Populations Voluntarily Enrolled: Populations Mandatorily Enrolled:
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations None
MINNESOTA
Special Needs Basic Care

- 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

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Lock-In Provision:
No lock-in

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- Agents when used for symptomatic relief of cough and colds
- Barbiturates
- Benzodiazepines
- Nonprescription drugs
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Mental Health Agency
- Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Medica
Metropolitan Health Plan
PrimeWest Health System
South Country Health Alliance
UCARE

ADDITIONAL INFORMATION

None
MINNESOTA
Special Needs Basic Care

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- Non-Duplication Based on Accreditation
- Ombudsman
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data:
- Assess program results
- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track access and utilization

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

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Adult Medicaid SSI Questionnaire
  - Adult with Special Needs Questionnaire
  - Disenrollment Survey

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

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

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
- Chlamydia screening in women
- Colorectal cancer screening

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care
MINNESOTA
Special Needs Basic Care

- Dental services
- Diabetes screening
- Mental health discharges
- Osteoporosis care after fracture

Access/Availability of Care:
- Adult's access to preventive/ambulatory health services

Use of Services/Utilization:
- CD initiating and treatment
- Mental health discharges
- Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care:
None

Health Plan/ Provider Characteristics:
None

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
- MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
- Aspirin therapy
- Asthma management
- Asthma-reduction of emergency department visits
- Breast cancer screening (Mammography)
- Calcium/Vitamin D
- Cholesterol screening and management
- Colon cancer screening
- Depression management
- Diabetes management
- Diabetic statin use, 40 to 75 year olds
- Human papillomavirus
- Hypertension management
- Mental health/chemical dependency dual diagnoses
- Obesity
- Pneumococcal vaccine

Non-Clinical Topics:
- Adults access to preventive/ambulatory health services

Standards/Accreditation

MCO Standards:
- NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
- NCQA (National Committee for Quality Assurance)

EQRO Name:
- MetaStar (QIO)
- Michigan Performance Review Organization

EQRO Organization:
- Quality Improvement Organization (QIO)

EQRO Mandatory Activities:
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

EQRO Optional Activities:
- Administration or validation of consumer or provider surveys
### Pay for Performance (P4P)

<table>
<thead>
<tr>
<th><strong>Implementation of P4P:</strong></th>
<th>Program Payers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The State HAS NOT implemented a Pay-for-Performance program with the MCO</td>
<td>Not Applicable</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Population Categories Included:</strong></th>
<th>Rewards Model:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Clinical Conditions:</strong></th>
<th>Measurement of Improved Performance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Initial Year of Reward:</strong></th>
<th>Evaluation Component:</th>
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</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Member Incentives:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
NEW YORK
Managed Long Term Care Program

CONTACT INFORMATION

State Medicaid Contact: Linda Gowdy
Division of Long Term Care
(518) 474-6965

State Website Address: http://www.nyhealth.gov

PROGRAM DATA

Program Service Area: County
Initial Waiver Approval Date: Not Applicable
Operating Authority: 1915(a) - Voluntary
Implementation Date: January 01, 1998
Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable
Enrollment Broker: No
Sections of Title XIX Waived: None
For All Areas Phased-In: Yes
Sections of Title XIX Costs Not Otherwise Matchable Granted: None

Guaranteed Eligibility: 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 Services, Nutrition, Occupational Therapy, Personal Care, Personal Emergency Response System, Physical Therapy, Podiatry, Private Duty Nursing, Respiratory Therapy, Skilled Nursing Facility, Social and Environmental Supports, Speech Pathology, Transportation, Vision

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None
NEW YORK
Managed Long Term Care Program

<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
<th>Lock-In Provision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Enrolled in Another Managed Care Program</td>
<td>1 month lock-in</td>
</tr>
<tr>
<td>-Medicare Dual Eligibles</td>
<td></td>
</tr>
<tr>
<td>-Participate in HCBS Waiver</td>
<td></td>
</tr>
</tbody>
</table>

Medicare Dual Eligibles Included: QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded: SLMB, QI, and QDWI, QMB

Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

Scope of Part D Coverage: Not Applicable

Part D - Enhanced Alternative Coverage: Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs: Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

<table>
<thead>
<tr>
<th>Amerigroup Community Connections</th>
<th>CCM Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>ElderPlan/Managed Long Term Care</td>
<td>Elderserve</td>
</tr>
<tr>
<td>Fidelis Care at Home</td>
<td>Guildnet</td>
</tr>
<tr>
<td>Health Advantage/Elant Choice</td>
<td>HHHH Choices</td>
</tr>
<tr>
<td>Independent Care Systems</td>
<td>Senior Health Partners</td>
</tr>
<tr>
<td>Senior Network Health</td>
<td>Total Aging in Place</td>
</tr>
<tr>
<td>VNS Choice</td>
<td>WellCare Advocate</td>
</tr>
</tbody>
</table>

ADDITIONAL INFORMATION

To be eligible for this program, a person must be age 18+ and eligible for nursing home placement but able to live in the community upon enrollment. Beneficiaries may receive services at home or in a Nursing Home in the plan network.

QUALITY ACTIVITIES FOR PIHP
NEW YORK
Managed Long Term Care Program

State Quality Assessment and Improvement
Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- Monitoring of PIHP Standards
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data:
- Contract Standard Compliance
- Plan Reimbursement
- Program Evaluation
- Regulatory Compliance/Federal Reporting

Use of HEDIS:
- The State DOES NOT use any of the HEDIS measures
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Consumer Self-Report Data:
- Consumer satisfaction survey

Use of Collected Data:
- Contract Standard Compliance
- Plan Reimbursement
- Program Evaluation
- Regulatory Compliance/Federal Reporting

Use of HEDIS:
- The State DOES NOT use any of the HEDIS measures
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data
Collection: Requirements:
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Specifications for the submission of encounter data to the Medicaid agency

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
### NEW YORK
#### Managed Long Term Care Program

<table>
<thead>
<tr>
<th><strong>Access/Availability of Care:</strong></th>
<th><strong>Use of Services/Utilization:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Provider networks and updates are collected quarterly and reviewed for accuracy</td>
<td>- Drug Utilization</td>
</tr>
<tr>
<td></td>
<td>- Number of home health visits per beneficiary</td>
</tr>
<tr>
<td></td>
<td>- Percentage of beneficiaries with at least one dental visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Health Plan Stability/ Financial/Cost of Care:</strong></th>
<th><strong>Health Plan/ Provider Characteristics:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)</td>
<td>- Languages Spoken (other than English)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Beneficiary Characteristics:</strong></th>
<th><strong>Performance Measures - Others:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Upon enrollment and semi-annual assessment</td>
<td>None</td>
</tr>
</tbody>
</table>

### Performance Improvement Projects

<table>
<thead>
<tr>
<th><strong>Project Requirements:</strong></th>
<th><strong>Clinical Topics:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- PIHPs are required to conduct a project(s) of their own choosing</td>
<td>- Diabetes management</td>
</tr>
<tr>
<td></td>
<td>- Improve dental utilization</td>
</tr>
<tr>
<td></td>
<td>- Reduction of Hosp/ER for CHF</td>
</tr>
<tr>
<td></td>
<td>- Standardized pain assessment tool</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Non-Clinical Topics:</strong></th>
<th><strong>Standards/Accreditation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Advanced Directives</td>
<td><strong>PIHP Standards:</strong></td>
</tr>
<tr>
<td></td>
<td>- State-Developed/Specified Standards</td>
</tr>
<tr>
<td>- DME tracking</td>
<td><strong>Accreditation Required for Participation:</strong></td>
</tr>
<tr>
<td>- Effective use of PERS</td>
<td>None</td>
</tr>
<tr>
<td>- Improving SASM scoring</td>
<td><strong>Non-Duplication Based on Accreditation:</strong></td>
</tr>
<tr>
<td></td>
<td>None</td>
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<table>
<thead>
<tr>
<th><strong>EQRO Organization:</strong></th>
<th><strong>EQRO Name:</strong></th>
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<tbody>
<tr>
<td>- Quality Improvement Organization (QIO)</td>
<td>IPRO - Island Peer Review Organization</td>
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<table>
<thead>
<tr>
<th><strong>EQRO Mandatory Activities:</strong></th>
<th><strong>EQRO Optional Activities:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Validation of performance improvement projects</td>
<td>- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services</td>
</tr>
<tr>
<td></td>
<td>- Technical assistance to PIHPs to assist them in conducting quality activities</td>
</tr>
</tbody>
</table>
NEW YORK
Medicaid Advantage Plus (MAP)

CONTACT INFORMATION

State Medicaid Contact: Linda Gowdy
Division of Long Term Care
(518) 474-6965

State Website Address: http://www.nyhealth.gov

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
Not Applicable

Operating Authority:
1915(a) - Voluntary

Implementation Date:
October 01, 2007

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

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
NEW YORK
Medicaid Advantage Plus (MAP)

Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in Another Managed Care Program
- Medicare Dual Eligibles
- Participate in HCBS Waiver

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Lock-In Provision:
1 month lock-in

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriGroup Advantage Plus/Medicaid Advantage Plus
GuildNet/Medicaid Advantage Plus
NYS Catholic Health Plan/Fidelis/Medicaid Advantage Plus
VNS Choice Plus/Medicaid Advantage Plus
Elder Plan/Medicaid Advantage Plus
HIP Health Plan/Medicaid Advantage Plus
Senior Whole Health/Medicaid Advantage Plus
WellCare Advantage Plus/Medicaid Advantage Plus

ADDITIONAL INFORMATION

To be eligible for this program, a person must be age 18+ and eligible for nursing home placement but able to live in the community upon enrollment. Beneficiaries may receive services at home or in a Nursing Home in the plan network.

Non-Prescription Drugs covered as a wrap benefit: ANALGESIC AND ANTIPYRETIC, ANTACID, ANTI-DIARRHEAL ANTIHISTAMINE, ANTI-VERTIGO, ARTIFICIAL TEARS AND OCCULAR/ORAL LUBRICANTS, CHRONIC RENAL DISEASE, COUGH AND COLD, DERMATOLOGICAL, FAMILY PLANNING, FECAL SOFTENER AND LAXATIVE, HEMATINIC, INSULIN, INSULIN BIOSYNTHETIC HUMAN, PEDICULOCIDE, SMOKING CESSATION AGENTS, VITAMIN/MINERAL, and UNCLASSIFIED.

QUALITY ACTIVITIES FOR PIHP
# NEW YORK
**Medicaid Advantage Plus (MAP)**

## 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 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)
NEW YORK  
Medicaid Advantage Plus (MAP)

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<th>Use of Services/Utilization:</th>
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<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
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<tbody>
<tr>
<td>-Upon enrollment and semi-annual assessment.</td>
<td>None</td>
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</table>

**Performance Improvement Projects**

<table>
<thead>
<tr>
<th>Project Requirements:</th>
<th>Clinical Topics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-PIHPs are required to conduct a project(s) of their own choosing</td>
<td>-Diabetes management</td>
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<tr>
<td></td>
<td>-Improve Dental Utilization</td>
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<td>-Pain Management</td>
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<tr>
<th>Non-Clinical Topics:</th>
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<tr>
<td>-Advance Directives</td>
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**Standards/Accreditation**

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<th>PIHP Standards:</th>
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<tr>
<td>-State-Developed/Specified Standards</td>
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<tr>
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<td>-IPRO - Island Peer Review Organization</td>
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<tr>
<th>EQRO Organization:</th>
<th>EQRO Mandatory Activities:</th>
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<tbody>
<tr>
<td>-Quality Improvement Organization (QIO)</td>
<td>-Validation of performance improvement projects</td>
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</table>

<table>
<thead>
<tr>
<th>EQRO Optional Activities</th>
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<tbody>
<tr>
<td>-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services</td>
<td></td>
</tr>
<tr>
<td>-Technical assistance to PIHPs to assist them in conducting quality activities</td>
<td></td>
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</tbody>
</table>
## 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 |
<table>
<thead>
<tr>
<th></th>
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<tr>
<td>State Website Address:</td>
<td><a href="http://www.state.pa.us">http://www.state.pa.us</a></td>
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### PROGRAM DATA

| Program Service Area: | County  
Zip Code |
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<td>Operating Authority:</td>
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<td>Statutes Utilized:</td>
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<td>Enrollment Broker:</td>
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<td>For All Areas Phased-In:</td>
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<tr>
<td>Guaranteed Eligibility:</td>
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| Initial Waiver Approval Date: | Not Applicable |
| Implementation Date:          | October 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

Medical-only PIHP (risk or non-risk, non-comprehensive) - Risk-based Capitation

#### Service Delivery

**Included Services:**
- Adult Day Care, Case Management, Chiropractic, Dental, Durable Medical Equipment, Hearing, Hospice, Immunization, In-home Supportive Care, Institutional, Occupational Therapy, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision

**Allowable PCPs:**
- Family Practitioners  
- General Practitioners  
- Internists  
- Nurse Practitioners  
- Physician Assistants

#### Enrollment

**Populations Voluntarily Enrolled:**
- Aged and Related Populations  
- Blind/Disabled Adults and Related Populations  
- Medicare Dual Eligibles

**Populations Mandatorily Enrolled:**
- None
### PENNSYLVANIA
**Living Independence for the Elderly (LIFE) Program (PIHP)**

**Subpopulations Excluded from Otherwise Included Populations:**
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- Reside in Nursing Facility or ICF/MR

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**Medicare Dual Eligibles Excluded:**
None

**Lock-In Provision:**
No lock-in

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

---

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
- DOES NOT identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- DOES NOT coordinate with any other Agency

---

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

- Albright LIFE
- Viecare 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...
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 Mandatory Activities:**
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

**EQRO Optional Activities**
-Technical assistance to PIHPs to assist them in conducting quality activities
PENNSYLVANIA
Voluntary HMO Contracts

CONTACT INFORMATION

State Medicaid Contact: Joan Morgan
Pennsylvania Department of Welfare
(717) 772-6300

State Website Address: http://www.state.pa.us

PROGRAM DATA

Program Service Area: County
Operating Authority: 1915(a) - Voluntary
Statutes Utilized: 1915(b)(4), Selective Contracting
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

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PENNSYLVANIA
Voluntary HMO Contracts

- Blind/Disabled Children and Related Populations
- Medicare Dual Eligibles
- Pregnant Women
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
- Special Needs Children (State defined)
- State Only Categorically Needy
- State Only Medically Needy

Subpopulations Excluded from Otherwise Included Populations:

- Enrolled in Another Managed Care Program
- Enrolled in Health Insurance Premium Payment (HIPP) with HMO Coverage
- Enrolled in Long Term Care Capitated Program (LTCCP)
- Incarceration
- Medicare Dual Eligibles
- Monthly Spend Downs
- Reside in Nursing Facility or ICF/MR
- Residence in a State Facility
- State Blind Pension Recipients

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only (under age 21)

Medicare Dual Eligibles Excluded:
QMB (age 21 and over)
SLMB, QI, and QDWI (age 21 and over)

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Serving People with Complex (Special) Needs

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Asks advocacy groups to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Education Agency
- Housing Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency
- Transportation Agency

Participating Plans/PCCM and Other Programs

AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan - 576
PENNSYLVANIA
Voluntary HMO Contracts

VOL
Gateway Health Plan, Inc. - VOL
United Healthcare of PA, Inc. - VOL
UPMC Health Plan, Inc./UPMC for You - VOL

ADDITIONAL INFORMATION

Included Services: Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, and Outpatient Substance Use Disorders are provided on a Fee-For-Service basis or through Behavioral Health MCOs where implemented.

Special Needs Children: (state defined) Broadly defined non-categorical to include all children. Skilled Nursing Facility is provided for the first 30 days. Transportation services only includes emergency ambulance services.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data:
- Beneficiary Plan Selection
- Contract Standard Compliance
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation
- Track Health Service provision

Consumer Self-Report Data:
- CAHPS
  - 4.0H Adult
  - 4.0H Children
- Plan-developed survey

Use of HEDIS:
- The State uses ALL of the HEDIS measures listed for Medicaid
- State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:
- Adolescent immunization rate
- Asthma care - medication use
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Cholesterol screening and management
- Dental services
- Diabetes medication management
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- HIV/AIDS care
- Immunizations for two year olds
- Initiation of prenatal care - timeliness of
- Lead screening rate
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Percentage of beneficiaries with at least one dental visit
- Pregnancy Prevention
- Smoking prevention and cessation
- Vision services for individuals less than 21 years of age
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality:
- Patient satisfaction with care
## Access/Availability of Care:
- Adult's access to preventive/ambulatory health services
- Children's access to primary care practitioners
- Ratio of PCPs to beneficiaries

## Use of Services/Utilization:
- All use of services in HEDIS measures
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admissions/1,000 beneficiary
- Number of home health visits per beneficiary
- Number of OB/GYN visits per adult female beneficiary
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Percentage of beneficiaries with at least one dental visit

## Health Plan Stability/ Financial/Cost of Care:
- Actual reserves held by plan
- Days cash on hand
- Days in unpaid claims/claims outstanding
- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- Net worth
- State minimum reserve requirements
- Total revenue

## Health Plan/ Provider Characteristics:
- Board Certification
- Languages Spoken (other than English)
- Provider turnover

## Performance Measures - Others:
None

## Performance Improvement Projects

### Project Requirements:
- All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

### Clinical Topics:
- Adolescent Pregnancy
- Asthma management
- Child/Adolescent Dental Screening and Services
- Childhood Immunization
- Diabetes management
- Hypertension management
- Smoking prevention and cessation

### Non-Clinical Topics:
- Adults Access to Dental Care
- Children's Access to Dental Care

## Standards/Accreditation

### MCO Standards:
- CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
- JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
- NAIC (National Association of Insurance Commissioners) Standards
- State-Developed/Specified Standards

### Accreditation Required for Participation:
None

### Non-Duplication Based on Accreditation:
None

### EQRO Name:
- Island Peer Review Organization (IPRO)
# PENNSYLVANIA

## Voluntary HMO Contracts

**EQRO Organization:**
- Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

**EQRO Optional Activities:**
- Conduct performance improvement projects
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

## Pay for Performance (P4P)

**Implementation of P4P:**
The State has implemented a Pay-for-Performance program with MCO

**Program Payers:**
Medicaid is the only payer

**Population Categories Included:**
Covers all MCO members

**Rewards Model:**
Payment incentives/differentials to reward MCOs

**Clinical Conditions:**
Not Applicable

**Measurement of Improved Performance:**
Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)

**Initial Year of Reward:**
2006

**Evaluation Component:**
The State has conducted an evaluation of the effectiveness of its P4P program

**Member Incentives:**
Not Applicable

---

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PUERTO RICO
Medicare Platino

CONTACT INFORMATION

State Medicaid Contact: Miguel Negron-Rivera
PR Department of Health - Medicaid Office
(787) 250-0453

State Website Address: http://www.asespr.org

PROGRAM DATA

Program Service Area: Region
Initial Waiver Approval Date: Not Applicable
Operating Authority: 1915(a) - Voluntary
Implementation Date: January 01, 2006
Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable
Enrollment Broker: No
Sections of Title XIX Waived: None
For All Areas Phased-In: Yes
Sections of Title XIX Costs Not Otherwise Matchable Granted: None
Guaranteed Eligibility: No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - 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
-Obstetricians/Gynecologists or Gynecologists
-Pediatricians

Enrollment

Populations Voluntarily Enrolled: -Medicare Dual Eligibles
Populations Mandatorily Enrolled: None
Subpopulations Excluded from Otherwise Included Populations: Lock-In Provision:
PUERTO RICO
Medicare Platino

-All populations who are not dual eligibles

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid
Managed Care Contracts:
- Barbiturates
- Benzodiazepines
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

American Health Medicare
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
Puerto Rico
Medicare Platino

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 continuous enrollment requirement for some or all of the measures

**Encounter Data**

**Collection: Requirements:**
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency

**Collections: Submission Specifications:**
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Deadlines for regular/ongoing encounter data submission(s)
- Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
None

**Validation - Methods:**
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Medical record validation

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
- Date of Service
- Date of Payment
- Type of Service
- Diagnosis Codes
- Procedure Codes
- Gender-appropriate diagnosis/procedure

**State conducts general data completeness assessments:**
No

**Performance Measures**

**Process Quality:**
- Annual monitoring of patients on persistent medications
- Antidepressant medication management
- Beta-blocker treatment after heart attack
- Breast Cancer screening rate
- Cholesterol 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 abandonment
- Call answer timeliness

**Use of Services/Utilization:**
- Ambulatory care
- Antibiotic utilization
- Drug Utilization
- Initiation and engagement of alcohol and other drug dependence treatment

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

Bioenergy Characteristics:
None

Health Plan/ Provider Characteristics:
- Board Certification
- Enrollment by Product Line
- Enrollment by State
- Language Diversity of Membership
- Race / Ethnicity Diversity of Membership

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 Blood 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 the Potentially Inappropriate 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

EQRO Optional Activities:
- Calculation of performance measures

Pay for Performance (P4P)
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<th>Implementation of P4P:</th>
<th>Program Payers:</th>
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<tbody>
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<td>The State HAS NOT implemented a Pay-for-Performance program with the MCO</td>
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<th>Clinical Conditions:</th>
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<th>Member Incentives:</th>
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<tr>
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</table>
PUERTO RICO
Mi Salud

CONTACT INFORMATION

State Medicaid Contact: Miguel Negron-Rivera
PR Department of Health - Medicaid Office
(787) 250-0453

State Website Address: http://www.asespr.org

PROGRAM DATA

Program Service Area: Region
Operating Authority: 1915(a) - Voluntary
Statutes Utilized: Not Applicable
Enrollment Broker: No
For All Areas Phased-In: Yes
Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: Not Applicable
Implementation Date: February 01, 1994
Waiver Expiration Date: Not Applicable
Sections of Title XIX Waived: None
Sections of Title XIX Costs Not Otherwise Matchable Granted: None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Dental, Disease Management, EPSDT,
Family Planning, Immunization, Inpatient Hospital,
Laboratory, Maternity, Outpatient Hospital, Pharmacy,
Physical Exam, Physician, Preventive, Surgery,
Transportation, Vision, X-Ray

Allowable PCPs:
- Family Practitioners
- Federally Qualified Health Centers (FQHCs)
- General Practitioners
- Internists
- Obstetricians/Gynecologists
- Pediatricians

Enrollment

Populations Voluntarily Enrolled:
- Aged and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Foster Care Children
- Individual/Families up to 200% of Puerto Rico poverty level
- Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None
PUERTO RICO
Mi Salud

Subpopulations Excluded from Otherwise Included Populations:
- No populations are excluded

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
- Case Management, 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

Subpopulations Excluded from Otherwise Included Populations:
- No populations are excluded

Medicare Dual Eligibles Included:
- Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
- None

Lock-In Provision:
- No lock-in

Part D Benefit

MCE has Medicare Contract:
- No

Provides Part D Benefits:
- Not Applicable

Scope of Part D Coverage:
- Not Applicable

Part D - Enhanced Alternative Coverage:
- Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- None

Program Includes People with Complex (Special) Needs:
- Yes

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
- Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Public Health Agency
PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

APS Healthcare
MCS Health Management Options, Inc.

Humana Health Plans of Puerto Rico, Inc.

ADDITIONAL INFORMATION

Puerto Rico's Health Care Program is not a voluntary program. It is a mandatory managed care program which requires no waiver authority because Puerto Rico is statutory exempt from Freedom of Choice requirements. PRHIA main duty is to obtain health insurance coverage for the medically indigent. Vision and hearing services are only included under physician services and other ancillary services. Mental Health and Abuse program is separated and handled by MBHOs. There are no QMBs dual eligibles in Puerto Rico.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
- Encounter Data (see below for details)
- Monitoring of MCO Standards
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data:
- Contract Standard Compliance

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

Consumer Self-Report Data:
None

Use of HEDIS:

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

Validation - Methods:
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Medical record validation

MCO/HIO conducts data accuracy check(s) on specified data elements:
- Date of Service
- Date of Payment
- Type of Service
- Diagnosis Codes
- Procedure Codes
- Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments:
No
Performance Measures

**Process Quality:**
- Ambulatory Care
- Appropriate treatment for Children with Upper Respiratory Infection (URI)
- Asthma care - medication use
- Beta-blocker treatment after heart attack
- Breast Cancer screening rate
- Call Abandonment
- Cervical cancer screening rate
- Check-ups after delivery
- Chlamydia 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

**Health Status/Outcomes Quality:**
- Patient satisfaction with care

**Access/Availability of Care:**
- Adolescent Well-Care Visits
- Adult's access to preventive/ambulatory health services
- Children's access to primary care practitioners

**Use of Services/Utilization:**
- Inpatient Utilization - General Hospital / Acute Care
- Inpatient Utilization - Non-Acute Care
- Relative Resource Use for People with Asthma
- Relative Resource Use for People with Cardiovascular Conditions
- Relative Resource Use for People with Diabetes

**Health Plan Stability/ Financial/Cost of Care:**
None

**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
**PUERTO RICO**

**Mi Salud**

<table>
<thead>
<tr>
<th>EQRO Organization:</th>
<th>EQRO Mandatory Activities:</th>
</tr>
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<tbody>
<tr>
<td>- Quality Improvement Organization (QIO)</td>
<td>- Review of MCO compliance with structural and operational standards established by the State</td>
</tr>
<tr>
<td></td>
<td>- Validation of performance improvement projects</td>
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<td>- Validation of performance measures</td>
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<table>
<thead>
<tr>
<th>EQRO Optional Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Assessment of education and prevention programs</td>
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</table>

### Pay for Performance (P4P)

<table>
<thead>
<tr>
<th>Implementation of P4P:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The State HAS NOT implemented a Pay-for-Performance program with the MCO</td>
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<table>
<thead>
<tr>
<th>Program Payers:</th>
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<table>
<thead>
<tr>
<th>Population Categories Included:</th>
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<tr>
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<table>
<thead>
<tr>
<th>Rewards Model:</th>
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</thead>
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<tr>
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</table>

<table>
<thead>
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<th>Clinical Conditions:</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurement of Improved Performance:</th>
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</tbody>
</table>

<table>
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<th>Initial Year of Reward:</th>
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<th>Evaluation Component:</th>
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<table>
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<th>Member Incentives:</th>
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### QUALITY ACTIVITIES FOR PIHP

<table>
<thead>
<tr>
<th>State Quality Assessment and Improvement Activities:</th>
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</thead>
<tbody>
<tr>
<td>- Monitoring of PIHP Standards</td>
</tr>
<tr>
<td>- Performance Improvement Projects (see below for details)</td>
</tr>
<tr>
<td>- Performance Measures (see below for details)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Use of Collected Data:</th>
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<tbody>
<tr>
<td>- Contract Standard Compliance</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Use of HEDIS:</th>
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<tbody>
<tr>
<td>- The State uses SOME of the HEDIS measures listed for Medicaid</td>
</tr>
<tr>
<td>- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid</td>
</tr>
<tr>
<td>- State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects</td>
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</tbody>
</table>

### Performance Measures

<table>
<thead>
<tr>
<th>Process Quality:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Antidepressant medication management</td>
</tr>
<tr>
<td>- Follow-up after hospitalization for mental illness</td>
</tr>
<tr>
<td>- Follow-up Care for Children Prescribed ADHD Medication</td>
</tr>
<tr>
<td>- Identification of Alcohol and Other Drug Services</td>
</tr>
<tr>
<td>- Initiation and engagement of SUD treatment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Status/Outcomes Quality:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Adult's access to preventive/ambulatory health services</td>
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<td>- Children's access to primary care practitioners</td>
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<thead>
<tr>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Mental Health Utilization</td>
</tr>
</tbody>
</table>
### Performance Improvement Projects

**Project Requirements:**  
- PIHPs are required to conduct a project(s) of their own choosing

**Non-Clinical Topics:**  
Not Applicable - PIHPs are not required to conduct common project(s)

**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

### Standards/Accreditation

**PIHP Standards:**  
- State-Developed/Specified Standards

**Non-Duplication Based on Accreditation:**  
None

**HQO Organization:**  
- Quality Improvement Organization (QIO)

**Accreditation Required for Participation:**  
None

**EQRO Name:**  
- Island Peer Review Organization

**EQRO Mandatory Activities:**  
- Review of PIHP compliance with structural and operational standards established by the State  
- Validation of performance improvement projects  
- Validation of performance measures

**EQRO Optional Activities:**  
- Assessment of education and prevention programs  
- Technical assistance to PIHPs to assist them in conducting quality activities
TEXAS
STAR Health

CONTACT INFORMATION

State Medicaid Contact: Joe Vesowate
Texas Health and Human Services Commission
(512) 491-1379

State Website Address: http://www.hhs.state.tx.us/medicaid/StarHealth.shtml

PROGRAM DATA

Program Service Area: Statewide
Initial Waiver Approval Date: Not Applicable

Operating Authority: 1915(a) - Voluntary
Implementation Date: April 01, 2008

Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable

Enrollment Broker: Maximus
Sections of Title XIX Waived: None

For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable Granted: None

Guaranteed Eligibility: No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - 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
- Obstetricians/Gynecologists or Gynecologists
- Other Specialists Approved on a Case-by-Case Basis
- Pediatricians
- Physician Assistants
- Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled: - Children and young adults in DFPS conservatorship

Populations Mandatorily Enrolled: None
Emancipated minors or members age 18-22 who voluntarily agree to continue in foster placement
Young adults age 21 through the month of their 23rd birthday who are participating in the Former Foster Care Program
Young adults who have exited care and are participating in the foster care youth transitional program

Subpopulations Excluded from Otherwise Included Populations:

- Medicare Dual Eligibles
- Placed with TYC or TJPC
- Reside in a state school or other 24 hour facility
- Reside in Nursing Facility or ICF/MR

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Department of Aging and Disability Services (DADS)
- Department of Family and Protective Services (DFPS)
- Department of State Health Services (DSHS)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Superior HealthPlan (STAR Health)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)

Use of Collected Data:
- Contract Standard Compliance
- Encounter Data (see below for details)
- Focused Studies
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

**Consumer Self-Report Data:**
- CAHPS
  - Child Medicaid Questionnaire
- State-developed Survey

**Use of HEDIS:**
- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

**Encounter Data**

**Collection: Requirements:**
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for data validation
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission

**Collections: Submission Specifications:**
- 837 transaction format
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

**Collection: Standardized Forms:**
- 837 transaction format
- ANSI ASC X12 837 - transaction set format for transmitting health care claims data
- Behavioral health layout
- NCPDP - National Council for Prescription Drug Programs pharmacy claim form
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities, etc.

**Validation - Methods:**
- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)
- Medical record validation
- Per member per month analysis and comparisons across MCO
- State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills

**MCO/HIO conducts data accuracy check(s) on specified data elements:**
- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure
- Preparing HEDIS and risk adjustment software

**State conducts general data completeness assessments:**
- Yes
Performance Measures

Process Quality:
- Access to behavioral health treatment
- Access to Dental care
- Access to emergent care
- Access to routine care
- Access to specialist care
- Access to urgent care
- Adolescent immunization rate
- Adolescent well-care visit rate
- Asthma care - medication use
- Cervical cancer screening rate
- Check-ups after delivery
- Chlamydia screening in women
- Depression management/care
- Diabetes care and control
- Diabetes medication management
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds
- Initiation of prenatal care - timeliness of
- Percentage of beneficiaries with at least one dental visit
- Pregnancy Prevention
- Vision services for individuals less than 21 years of age
- Well-child care visit rates in 3, 4, 5, and 6 years of life
- Well-child care visit rates in first 15 months of life
- Well-child care visits rates in adolescents

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of low birth weight infants

Access/Availability of Care:
- Average distance to PCP
- Average wait time for an appointment with PCP
- Ratio of mental health providers to number of beneficiaries
- Ratio of PCPs to beneficiaries

Use of Services/Utilization:
- Drug Utilization
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Number of days in ICF or SNF per beneficiary over 64 years
- Number of PCP visits per beneficiary
- Number of specialist visits per beneficiary
- Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
- Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care:
- None

Health Plan/ Provider Characteristics:
- Languages Spoken (other than English)

Beneficiary Characteristics:
- Beneficiary need for interpreter
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries
- MCO/PCP-specific disenrollment rate
- Percentage of beneficiaries who are auto-assigned to MCO
- Provider Turnover
- Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period

Performance Measures - Others:
- Health Status/Outcomes Process

Performance Improvement Projects

Project Requirements:
- MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
- Diabetes care and management
- Influenza Immunizations
Multiple, but not all, MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
Institute for Child Health Policy

EQRO Organization:
Institute for Child Health Policy, University of Florida

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to 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: Initial Waiver Approval Date:
Statewide Not Applicable

Operating Authority: Implementation Date:
1915(a) - Voluntary March 01, 2001

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
No None

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
No Granted:

Guaranteed Eligibility:
No guaranteed eligibility

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, 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

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:
None

597
UTAH
Healthy Outcomes Medical Excellence (HOME)

-Medicare Dual Eligibles
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-Eligible only for TB-related Services
-Medicare Dual Eligibles
-Reside in Nursing Facility or ICF/MR

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Lock-in Provision:
No lock-in

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit
MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Education Agency
-Housing Agencies
-Social Services Agencies

Strategies Used to Identify Persons with Complex (Special) Needs:
-All clients enrolled with HOME are people with special needs.

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Healthy Outcomes Medical Excellence (HOME)

ADDITIONAL INFORMATION

Enrollees with special health care needs are enrollees 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

598
UTAH
Healthy Outcomes Medical Excellence (HOME)

State Quality Assessment and Improvement Activities:
- MCO Standards (see below for details)
- Performance Improvement Projects (see below for details)

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

Performance Improvement Projects

Project Requirements:
- MCOs are required to conduct a project(s) of their own choosing

Clinical Topics:
- Well Child Care/EPSDT

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
- State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
- HQE

EQRO Organization:
- QIO-like entity

EQRO Mandatory Activities:
- Validation of performance improvement projects

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
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

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Contractor Types:
-County Operated Entity (Public)

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaska Native
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Section 1931 Children and Related Populations
-Title XXI CHIP

Populations Mandatorily Enrolled:
None
## WISCONSIN

Children Come First (CCF)

<table>
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<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
<th>Lock-In Provision:</th>
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</thead>
<tbody>
<tr>
<td>- Enrolled in Another Managed Care Program</td>
<td>Does not apply because State only contracts with one managed care entity</td>
</tr>
<tr>
<td>- Medicare Dual Eligibles</td>
<td></td>
</tr>
<tr>
<td>- Participate in HCBS Waiver</td>
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<thead>
<tr>
<th>Medicare Dual Eligibles Included:</th>
<th>Medicare Dual Eligibles Excluded:</th>
</tr>
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<tbody>
<tr>
<td>None</td>
<td>Exclude all categories of Medicare Dual Eligibles</td>
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### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<table>
<thead>
<tr>
<th>Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:</th>
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## SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

<table>
<thead>
<tr>
<th>Program Includes People with Complex (Special) Needs:</th>
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<tbody>
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</tbody>
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<table>
<thead>
<tr>
<th>Strategies Used to Identify Persons with Complex (Special) Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- DOES NOT identify members of these groups</td>
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</table>

<table>
<thead>
<tr>
<th>Agencies with which Medicaid Coordinates the Operation of the Program:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Community Partnerships</td>
</tr>
<tr>
<td>- Dane County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)</td>
</tr>
<tr>
<td>- Mental Health Agency</td>
</tr>
<tr>
<td>- Other Public And Private Agencies Are On The Statewide Children Come First Advisory Committee.</td>
</tr>
<tr>
<td>- Social Services Agency</td>
</tr>
</tbody>
</table>

## 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

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601
### 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 service delivery
- Follow-up after hospitalization for mental illness
- Identification and process=service/care coordinators (case managers)
- Membership and process=child and family reams (plan of care teams)
- Percentage of beneficiaries who are satisfied with their ability to obtain care
- Process and content=plans of care
- Process and content=service authorization plans

#### Health Status/Outcomes Quality:
- Cost-effectiveness comparison of this managed care program to non-managed care program
- Criminal offenses and juvenile justice contracts of enrollees, pretest and post-test
- Functional impairment of enrollees, pre-test, post-test
- Patient satisfaction with care
- Restrictiveness of living arrangements for enrollees, pre-test, and post-test
- School attendance and performance of enrollees, pre-test, and post-test

#### Access/Availability of Care:
- Internal and external quality assurance audits of access and of monitoring plans of care

#### Use of Services/Utilization:
- Internal and external quality assurance audits of monitoring plans of care and tracking actual service utilization

#### Health Plan Stability/Financial/Cost of Care:
None

#### Health Plan/Provider Characteristics:
- Internal quality assurance review of sub-contracted providers

#### Beneficiary Characteristics:
- Information of beneficiary ethnicity/race
- Other demographic, clinical, and service system characteristics of enrollees
- PIHP/PCP-specific disenrollment rate

### Performance Improvement Projects

#### Project Requirements:
- PIHPs are required to conduct a project(s) of their own choosing

#### 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 measures |
| EQRO Optional Activities | |
| | - Administration or validation of consumer or provider surveys |
| | - Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services |
| | - 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: Initial Waiver Approval Date:
County Not Applicable

Operating Authority: Implementation Date:
1915(a) - Voluntary March 01, 1997

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
No None

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
Yes Granted:

Guaranteed Eligibility:
None

SERVICE DELIVERY

MH/SUD PIHP - Risk-based Capitation

Service Delivery

Included Services:
Community Support Program (CSP), Crisis, Emergency, IMD,
Inpatient Mental Health, Inpatient Substance Use Disorders,
Medical Day Treatment, Mental Health Outpatient, Mental
Health Rehabilitation, Mental Health Residential, Mental
Health Support, Outpatient Substance Use Disorders,
Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Contractor Types:
-County Operated Entity (Public)

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
WISCONSIN
Wraparound Milwaukee

Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in Another Managed Care Program
- Medicare Dual Eligibles
- Participate in HCBS Waiver

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Part D Benefit

MCE has Medicare Contract:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Mental Health Agency
- Milwaukee County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
- Other Public And Private Agencies Are On The Statewide Children Come First Advisory Committee
- Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Milwaukee County Human Services Department -- Wraparound Milwaukee

ADDITIONAL INFORMATION

Program goal is to keep children with severe emotional disturbances out of institutions and to serve these children and their families in the community. The state reallocates previous funding for institutional placement into community based care. It uses a "wraparound," integrated services approach with multi-agency and multi-disciplinary collaboration. Key components include intensive case management, crisis intervention, and a flexible array of services and supports (including some not traditionally covered under Medicaid) based on highly individualized plans of care. This mental health and substance abuse carve-out program does not designate a primary care provider for physical health care. All enrollees must have a special needs to be eligible for enrollment.

QUALITY ACTIVITIES FOR PIHP
**WISCONSIN**  
**Wraparound Milwaukee**

### State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Focused Studies
- Monitoring of PIHP Standards
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)
- PIHP Standards (see below for details)

### Consumer Self-Report Data:
- Annual family satisfaction survey through Families United Inc. (advocacy agency)
- State-developed Survey

### Use of Collected Data:
- Contract Standard Compliance
- Monitor Quality Improvement
- Program Evaluation
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

### 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 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

### 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

### Non-Clinical Topics:
- Transitional Plan

## Standards/Accreditation

### PIHP Standards:
- State-Developed/Specified Standards

### Accreditation Required for Participation:
None
WISCONSIN
Wraparound Milwaukee

Non-Duplication Based on Accreditation: None

EQRO Organization: -Quality Improvement Organization (QIO)

EQRO Name: -MetaStar

EQRO Mandatory Activities:
-Review of PIHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to PIHPs to assist them in conducting quality activities
FLORIDA
Florida Comprehensive Adult Day Health Care Program

CONTACT INFORMATION

State Medicaid Contact: GP Mendie
Florida Agency for Health Care Administration
(850) 412-4252

State Website Address: http://ahca.myflorida.com

PROGRAM DATA

Program Service Area: County

Operating Authority: 1915(b)/1915(c)

Statutes Utilized: 1915(b)(4), Selective Contracting

Enrollment Broker: No

For All Areas Phased-In: No

Guaranteed Eligibility: No guaranteed eligibility

Initial Waiver Approval Date: March 24, 2003

Implementation Date: April 01, 2004

Waiver Expiration Date: March 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

Adult Day Health Care - Fee-for-Service

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Medical Direction, Nutrition, Personal Care, Rehabilitation Therapy, Social, Transportation

Allowable PCPs:
-Adult Day Health Care Centers

Enrollment

Populations Voluntarily Enrolled:
-Aged 60 or older

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in
FLORIDA
Florida Comprehensive Adult Day Health Care Program

- Other Insurance
- Poverty Level Pregnant Woman
- Reside in Nursing Facility or ICF/MR
- Special Needs Children (BBA defined)
- Special Needs Children (State defined)

Medicare Dual Eligibles Included: None

Medicare Dual Eligibles Excluded: Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract: No

Provides Part D Benefits: Not Applicable

Scope of Part D Coverage: Not Applicable

Part D - Enhanced Alternative Coverage: Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs: Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Public Health Agency
- Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Sunrise Community, Inc.

ADDITIONAL INFORMATION

The Adult Day Health Care facilities are not managed care entities, as defined by the State statutes. They are licensed pursuant to chapter 400 Part 5 of the Florida Statutes. The b/c program will be terminated on March 31, 2012.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact: GP Mendie
Medical Health Care Program Analyst
Agency for Healthcare Administration
(850) 412-4252

State Operating Agency Contact: Laura Noyes
**FLORIDA**  
Florida Comprehensive Adult Day Health Care Program

Analyst  
Florida Department of Elder Affairs  
(850) 414-2335

### PROGRAM DATA

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<th>Program Service Area:</th>
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<td>1902(a)(1) Statewidness</td>
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### Service Delivery

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<th>Target Group:</th>
<th>Level of Care:</th>
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<td>Aged 60 or older</td>
<td>Nursing Home</td>
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### ADDITIONAL INFORMATION

The 1915(b) waiver allows Florida to selectively contract vendors for selected counties to provide the 1915(c) services.
KANSAS
Mental Health and Substance Abuse Services

CONTACT INFORMATION

State Medicaid Contact: Elizabeth Phelps
Department of Social and Rehabilitation Services
(785) 296-4552

State Website Address: http://www.srskansas.org

PROGRAM DATA

Program Service Area: Statewide

Operating Authority: 1915(b)/1915(c)

Statutes Utilized:
1915(b)(1), 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: June 30, 2013

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice
-1902(a)(4) Proper and Efficient Administration of the State Plan

Sections of Title XIX Costs Not Otherwise Matchable Granted: None

SERVICE DELIVERY

Substance Use Disorders (SUD) PIHP - Risk-based Capitation

Service Delivery

Included Services:
Detoxification, Inpatient Substance Use Disorders, Outpatient Substance Use Disorders, Residential Substance Use Disorders Treatment Programs, Substance Use Disorders Support

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
KANSAS
Mental Health and Substance Abuse Services

- American Indian/Alaska Native
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Breast/Cervical Cancer
- Foster Care Children
- Medically Impovered
- Medicare Dual Eligibles
- Medicare Dual Eligibles
- Medical Impovered
- Presumptive XIX
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
- Special Needs Children (State defined)
- Working Disable

Subpopulations Excluded from Otherwise Included Populations:
- No State Payment Adult Care Home Resident
- Nursing Facility Head Injury
- Nursing Facility Mental Health
- Nurse Facility Swing Bed
- PACE
- Resides in Nursing Facility or ICF/MR
- State Hospital Developmentally Disabled
- State Hospital Mental Health

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable
KANSAS
Mental Health and Substance Abuse Services

Mental Health (MH) PAHP - Non-risk Capitation

Service Delivery

Included Services:
Case Conferencing, Crisis, Evidence-based Mental Health Practices, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Peer Support for Mental Health, Personal Care, SED Waiver, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Contractor Types:
-Behavioral Health MCO (Private)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
- Adoption Support
- Aged and Related Populations
- American Indian/Alaska Native
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Breast/Cervical Cancer
- Foster Care Children
- Medically Improved
- Medicare Dual Eligibles
- Poverty-Level Pregnant Women
- Presumptive XIX
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
- Special Needs Children (State defined)
- Working Disables

Subpopulations Excluded from Otherwise Included Populations:
- No State Payment Audit Care Home Resident
- Nursing Facility Head Injury
- Nursing Facility Mental Health
- Nursing Facility Swing Bed
- PACE
- Reside in Nursing Facility or ICF/MR
- State Hospital Developmentally Disabled
- State Hospital Mental Health

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None
KANSAS
Mental Health and Substance Abuse Services

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Adult Corrections Systems
- Aging Agency
- Developmental Disabilities Agency
- Education Agency
- Employment Agencies
- Housing Agencies
- Juvenile Justice Agencies
- Maternal and Child Health Agency
- Mental Health Agency
- Physical Health MCOs and Providers
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Kansas Health Solutions
ValueOptions-Kansas

ADDITIONAL INFORMATION
The Value Options (Substance Use Disorders PIHP) is connected to the 1915(b) portion and the Kansas Health Solutions (Mental Health PAHP) is connected to the 1915(c) portion of the 1915(b)/(c) Mental Health and Substance Abuse Services program. Both plans include the same number of eligible members.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION
State Medicaid Agency Contact:
Rita Haver Kamp
Contract Manager
KS Department of Health and Environment
(785) 296-4813

State Operating Agency Contact:
Sandy Hashman
Assistant Director
KS Department of Social and Rehabilitation Services
(785) 296-7926

PROGRAM DATA
Program Service Area: Statewide
Initial Waiver Effective Date: July 01, 2007
KANSAS
Mental Health and Substance Abuse Services

Statutes Waived:
1902(a)(10)(B) Comparability of Services

Waiver Expiration Date:
September 30, 2015

Service Delivery

Target Group: Seriously Emotional Disturbance
Level of Care: Hospital

ADDITIONAL INFORMATION

The administration and oversight of both the 1915(b) and 1915(c) program is conducted by the same program unit; the service array and provider/member services activities are conducted by the same PAHP contractor. The 1915(c) program infrastructure was transferred, with very little modification visible to beneficiaries and providers to the PAHP program contractors.

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement
Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Monitoring of PIHP Standards
- Network Data
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)
- PIHP Standards (see below for details)
- Provider Data

Use of Collected Data:
- Contract Standard Compliance
- Data Mining
- Enhanced/Revise State managed care Medicaid Quality Strategy
- Fraud and Abuse
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting

Consumer Self-Report Data:
- Member Satisfaction Survey
- State-developed Survey

Use of HEDIS:
- The State DOES NOT use any of the HEDIS measures
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

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

Collection: Standardized Forms:
- ANSI ASC X12 837 - transaction set format for transmitting health care claims data

Collections: Submission Specifications:
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. 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

Validation - Methods:
- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
KANSAS
Mental Health and Substance Abuse Services

PIHP conducts data accuracy check(s) on specified data elements:
- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Age-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
None

Health Status/Outcomes Quality:
None

Access/Availability of Care:
- Access to Services
- Adult’s access to preventive/ambulatory health services
- Network capacity to serve members
- Ratio of addictions professionals to number of beneficiaries

Use of Services/Utilization:
- Over and Under Utilization of intensive services
- Over and Under Utilization of lower levels of care

Health Plan Stability/Financial/Cost of Care:
None

Health Plan/Provider Characteristics:
- Annual assessment of provider network
- Geoaccess

Beneficiary Characteristics:
None

Performance Measures - Others:
None

Performance Improvement Projects

Project Requirements:
- Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
- HEDIS Based Initiation and Engagement

Non-Clinical Topics:
- Accuracy of encounter data

Standards/Accreditation

PIHP Standards:
- NAIC (National Association of Insurance Commissioners) Standards
- NCQA (National Committee for Quality Assurance) Standards
- State-Developed/Specified Standards
- URAC Standards

Accreditation Required for Participation:
None
## KANSAS
### Mental Health and Substance Abuse Services

<table>
<thead>
<tr>
<th>Non-Duplication Based on Accreditation:</th>
<th>EQRO Name:</th>
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<tbody>
<tr>
<td>None</td>
<td>- Kansas Foundation for Medical Care</td>
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<table>
<thead>
<tr>
<th>EQRO Organization:</th>
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<td>- Kansas Foundation for Medical Care</td>
<td>- Review of PIHP compliance with structural and operational standards established by the State</td>
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<tr>
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<td>- Validation of performance improvement projects</td>
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<td></td>
<td>- Validation of Performance Measures</td>
</tr>
<tr>
<td></td>
<td>- Validation of state/contractor data systems</td>
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</table>

<table>
<thead>
<tr>
<th>EQRO Optional Activities</th>
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</thead>
<tbody>
<tr>
<td>- Validation of encounter data</td>
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</tbody>
</table>

## 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
- Geographic 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
- Utilization 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.
PAHP conducts data accuracy check(s) on specified data elements:
- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Age-appropriate diagnosis/procedure

State conducts general data completeness assessments:
Yes

Performance Measures

Process Quality:
- Decreased utilization of institutional care
- Rates of competitive employment for adults
- Rates of school attendance for youth
- Rates of youth residing in permanent family home

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of beneficiaries satisfied with their ability to obtain care

Access/Availability of Care:
- Adult's access to preventive/ambulatory health services
- Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization:
- Average number of visits to MH/SUD providers per beneficiary
- Service penetration rates
- Service utilization post-inpatient care

Health Plan Stability/ Financial/Cost of Care:
- Business continuity plan
- Corporate Compliance Plan, including Fraud and Abuse
- Days in unpaid claims/claims outstanding
- Expenditures by medical category of service (ER, pharmacy, lab, x-ray, dental, vision, etc.)
- IBNR claims report (lag report)
- Key Personnel Changes
- Net income
- Net worth
- Subcontractor terms and conditions
- TPL/COB information

Health Plan/ Provider Characteristics:
- Board Certification
- Languages Spoken (other than English)
- Provider turnover

Beneficiary Characteristics:
- Beneficiary need for interpreter
- Information on primary languages spoken by beneficiaries
- Percentage of beneficiaries who are auto-assigned to PAHPs

Performance Measures - Others:
None

Standards/Accreditation
KANSAS
Mental Health and Substance Abuse Services

PAHP Standards:
- CMS’s Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
- State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None
MARYLAND
Living at Home Case Management Waiver

CONTACT INFORMATION

State Medicaid Contact: Marlana Hutchinson
DHMH Long Term Care and Waiver Services
(410) 767-4003

State Website Address: http://www.dhmh.state.md.gov/

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
Statewide November 01, 2009

Operating Authority: Implementation Date:
1915(b)/1915(c) November 01, 2009

Statutes Utilized: Waiver Expiration Date:
1915(b)(4), Selective Contracting September 30, 2013

Enrollment Broker: Sections of Title XIX Waived:
No -1902(a)(23) Freedom of Choice

For All Areas Phased-In:
No Sections of Title XIX Costs Not Otherwise Matchable
Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

Selective Contract - Fee-for-Service

Service Delivery

Included Services: Allowable PCPs:
Case Management -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
MARYLAND
Living at Home Case Management Waiver

Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope of Part D Coverage:</th>
<th>Part D - Enhanced Alternative Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

The Coordinating Center

ADDITIONAL INFORMATION

The Department of Health and Mental Hygiene, Office of Health Services has full administrative authority over the Living at Home Waiver program, located within the Living at Home Waiver Division. Historically, the Living at Home Waiver program was responsible for procuring, maintaining, and monitoring contracts for two administrative services available for waiver participants. Fiscal intermediary and case management contractors are selected through a competitive bid process and are available statewide. On October 31, 2009, the contract for case management services ended; the program moved from the administrative case management model to providing administrative, transitional, and ongoing case management as billable services to eligible applicants and participants effective November 1, 2009.

Reimbursement for case management waiver services in the amendment to the 1915(c) Living at Home Waiver (MD 0353) will be based on a rate defined in COMAR. Maryland used a competitive solicitation process to select its case management provider that will be providing case management as an administrative and waiver service.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:
Marlana Hutchinson
Division Chief
DHMH Long Term Care and Waiver Services
(410) 767-4003

State Operating Agency Contact:

621
MARYLAND
Living at Home Case Management Waiver

PROGRAM DATA

Program Service Area: Statewide
Initial Waiver Effective Date: July 01, 2009
Statutes Waived: 1902(a)(10)(B) Comparability of Services
Waiver Expiration Date: June 30, 2014

Service Delivery

Target Group: Disabled
Level of Care: Nursing Home

ADDITIONAL INFORMATION

Case management is a covered service under the 1915(c) waiver. However, in order to restrict freedom of choice under the 1915(c) waiver, a 1915(b) waiver has to be in place for a selective provider or provider
# 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: | Initial Waiver Approval Date:  
| | Statewide  
| | June 26, 1998  
| Operating Authority: | Implementation Date:  
| | 1915(b)/1915(c)  
| | October 01, 1998  
| Statutes Utilized: | Waiver Expiration Date:  
| | 1915(b)(1), Freedom of Choice  
| | 1915(b)(3), Sharing of Cost Savings  
| | 1915(b)(4), Selective Contracting  
| | September 30, 2013  
| Enrollment Broker: | Sections of Title XIX Waived:  
| | No  
| | -1902(a)(10)(B) Amount, Duration and Scope  
| | -1902(a)(23) Freedom of Choice  
| For All Areas Phased-In: | Sections of Title XIX Costs Not Otherwise Matchable Granted:  
| | No  
| | None  
| Guaranteed Eligibility: |  
| | None  

### SERVICE DELIVERY

#### Mental Health (MH) PIHP - Risk-based Capitation

**Service Delivery**

**Included Services:**

**Allowable PCPs:**
- Addictionologists  
- Clinical Social Workers  
- Other Specialists Approved on a Case-by-Case Basis  
- Psychiatrists  
- Psychologists
MICHIGAN
Specialty Prepaid Inpatient Health Plans

**Contractor Types:**
- County Community Mental Health Services

**Enrollment**

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Medicare Dual Eligibles</td>
<td>- Aged and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Blind/Disabled Adults and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Blind/Disabled Children and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Foster Care Children</td>
</tr>
<tr>
<td></td>
<td>- Section 1931 Adults and Related Populations</td>
</tr>
<tr>
<td></td>
<td>- Section 1931 Children and Related Populations</td>
</tr>
</tbody>
</table>

**Subpopulations Excluded from Otherwise Included Populations:**
- Children Enrolled in Childrens Waiver (Section 1915(c))
- Residing in ICF/MR

**Medicare Dual Eligibles Included:**
Include all categories of Medicare Dual Eligibles

**MCE has Medicare Contract:**
Yes

**Scope of Part D Coverage:**
Not Applicable

**Lock-in Provision:**
No lock-in

**Medicare Dual Eligibles Excluded:**
None

**Part D Benefit**

- **MCE has Medicare Contract:**
  Yes

- **Provides Part D Benefits:**
  No

- **Scope of Part D Coverage:**
  Not Applicable

- **Part D - Enhanced Alternative Coverage:**
  Not Applicable

- **Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
  - Agents when used for anorexia, weight loss, weight gain

---

**SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS**

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
- Identified through other health care agencies
- Outreach
- Referred through other health care practitioners/agencies
- Self-referral

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Aging Agency
- Department of Corrections
- Education Agency
- Housing Agencies
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Rehabilitation Services
- Social Services Agencies
- Specialty Employment Agency (Supported Employment)
- Substance Abuse Agency

---

**PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS**

Access Alliance of Michigan
CMH Affiliation of Mid-Michigan
MICHIGAN
Specialty Prepaid Inpatient Health Plans

CMH for Central Michigan
Detroit-Wayne County CMH Agency
Lakeshore Behavioral Health Alliance
Macomb County CMH Services
North Care
Northwest CMH Affiliation
Saginaw County CMH Authority
Thumb Alliance PIHP

CMH Partnership of Southeast Michigan
Genesee County CMH Services
LifeWays
Network 180
Northern Affiliation
Oakland County CMH Authority
Southwest Affiliation
Venture Behavioral Health

ADDITIONAL INFORMATION

Southwest Michigan Urban & Rural Consortium had a name change since the last submission and is now Southwest Affiliation.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact: Elizabeth Knisely
  Director
  MDCH, Bureau of Community Mental Health Services
  (517) 335-8401

State Operating Agency Contact: Debra Ziegler
  HSW Specialist
  Bureau of Community Health Services
  Michigan Department of Community Health
  (517) 373-5322

PROGRAM DATA

Program Service Area: Initial Waiver Effective Date:
  Statewide
  December 12, 2002

Statutes Waived: Waiver Expiration Date:
  1902(a)(10)(B) Comparability of Services
  September 30, 2015

Service Delivery

Target Group: Level of Care:
  Developmental Disabled
  ICFMR

ADDITIONAL INFORMATION

Under the Michigan Managed Specialty Support and Services Program, PIHPs administer state plans, 1915(b)(3) and 1915(c) waiver services. This managed mental health services program provides support and services to person with serious mental illness, developmental disability and substance use disorders, and children with serious emotional disturbance. Persons served through the 1915(b) waiver use a combination of state plan and 1915 (b)(3) services. Persons enrolled in the C waiver, called the Habilitation
MICHIGAN
Specialty Prepaid Inpatient Health Plans
Supports Waiver (HSW) use a combination of C waiver services, state plan and 1915 (b)(3) service

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
- 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)

Consumer Self-Report Data:
- MHSIP Consumer Survey

Use of Collected Data:
- Actuarial analysis
- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Use of HEDIS:
- The State DOES NOT use any of the HEDIS measures
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements:
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for data validation
- Requirements for 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

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

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

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

Validation - Methods:
- Automated analysis of encounter data submission to help determine data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments:
Yes
# Performance Measures

**Process Quality:**
- 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

**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

**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

**EQRO Optional Activities**
- ER and Hospitalization Use Study
# MINNESOTA

## Minnesota Senior Care/Minnesota Senior Care Plus

### CONTACT INFORMATION

| State Medicaid Contact: | David Godfrey  
|                       | Minnesota Department of Human Services  
|                       | (651) 431-2319 |
| State Website Address: | http://www.dhs.state.mn.us |

### PROGRAM DATA

| Program Service Area: | Initial Waiver Approval Date: |
|                       | March 21, 2005 |
| Operating Authority:  | Implementation Date: |
| 1915(b)/1915(c)       | June 01, 2005 |
| Statutes Utilized:    | Waiver Expiration Date: |
| Enrollment Broker:    | Sections of Title XIX Waived: |
| No                   | -1902(a)(10)(B) Amount, Duration and Scope |
|                      | -1902(a)(23) Freedom of Choice |
| For All Areas Phased-In: | Sections of Title XIX Costs Not Otherwise Matchable Granted: |
| No                   | None |
| Guaranteed Eligibility: | |
| No guaranteed eligibility |

### SERVICE DELIVERY

#### MCO (Comprehensive Benefits) - Risk-based Capitation

### Service Delivery

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>-Not Applicable. Contractors Not Required to Identify PCPs</td>
</tr>
</tbody>
</table>

### Enrollment

628
Minnesota Senior Care/Minnesota Senior Care Plus

Populations Voluntarily Enrolled: None

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)

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Populations Mandatorily Enrolled:
- Aged and Related Populations
- Blind/Disabled Adults and Related Populations
- Medicare Dual Eligibles
- Populations Aged 65+

Lock-In Provision: No lock-in

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract: No

Scope of Part D Coverage: Not Applicable

Provides Part D Benefits: Not Applicable

Part D - Enhanced Alternative Coverage: Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: None

Serving People with Complex (Special) Needs

Program Includes People with Complex (Special) Needs: Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agencies

Participating Plans/PCCM and Other Programs

Blue Plus: Health Partners
Itasca Medical Care: Medica
Metropolitan Health Plan: PrimeWest Health System
South Country Health Alliance: UCARE

Additional Information
MINNESOTA
Minnesota Senior Care/Minnesota Senior Care Plus

None

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:
Ann Berg
Deputy Medicaid Director
Minnesota Department of Human Services
(651) 431-2183

State Operating Agency Contact:
David Godfrey
Medicaid Director
Minnesota Department of Human Services
(651) 431-2319

PROGRAM DATA

Program Service Area:
County

Initial Waiver Effective Date:
April 01, 2005

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

Waiver Expiration Date:
June 30, 2013

Service Delivery

Target Group:
Aged

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

1915(c) services must be part of the MCOs provider network. The 1915(c) Elderly Waiver services are included in MCO contracts in some counties. In the remaining counties, person eligible for EW services receive them through their county or tribe

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement

Activities:
-Annual HCBS quality assurance plan
-Care plan audits
-Care system reviews
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-HCBS self-assessment QA survey
-MCO Standards (see below for details)

Use of Collected Data:
-Assess program results
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision
MINNESOTA
Minnesota Senior Care/Minnesota Senior Care Plus

-Monitoring of MCO Standards
-Non-Duplication Based on Accreditation
-Ombudsman
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data:
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
  Disenrollment Survey

Use of HEDIS:
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-04, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation - Methods:
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills or cost-ratios)

State conducts general data completeness assessments:
No

MCO/HIO conducts data accuracy check(s) on specified data elements:
-Date of Payment

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
-Chlamydia screening in women
-Colorectal Cancer Screening
-COPD-spirometry testing
-Dental services
-Diabetes screening
-Number of Mental Health Inpatient Discharges
-Osteoporosis care after fracture
-Percentage of beneficiaries with at least one dental visit

Health Status/Outcomes Quality:
-Patient satisfaction with care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
# MINNESOTA

**Minnesota Senior Care/Minnesota Senior Care Plus**

<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Adult's access to preventive/ambulatory health services</td>
<td>- CD initiating and treatment</td>
</tr>
<tr>
<td>- Average distance to PCP</td>
<td>- Mental health discharges</td>
</tr>
<tr>
<td></td>
<td>- Percentage of beneficiaries with at least one dental visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Plan Stability/ Financial/Cost of Care:</th>
<th>Health Plan/ Provider Characteristics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

## 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
- Michigan Performance Reivew Organization

**EQRO Organization:**
- Quality Improvement Organization (QIO)

**EQRO Mandatory Activities:**
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

**EQRO Optional Activities:**
- 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
<table>
<thead>
<tr>
<th><strong>Population Categories Included:</strong></th>
<th><strong>Rewards Model:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A subset of MCO members, defined by disease and medical condition</td>
<td>Payment incentives/differentials to reward MCOs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Clinical Conditions:</strong></th>
<th><strong>Measurement of Improved Performance:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>Assessing improvements in, or reaching established standards in, administrative processes (e.g., timeliness of MCO response to grievances, improving customer service, etc.)</td>
</tr>
<tr>
<td></td>
<td>Using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th><strong>Initial Year of Reward:</strong></th>
<th><strong>Evaluation Component:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>The State HAS NOT conducted an evaluation of the effectiveness of its P4P program</td>
</tr>
</tbody>
</table>

| **Member Incentives:** | |
|------------------------|
| Not Applicable         |
NEW MEXICO
Coordination of Long-Term Services

CONTACT INFORMATION

State Medicaid Contact: Paula McGee
NM HSD/Medical Assistance Division
(505) 827-6234

State Website Address: http://www.hsd.state.nm.us/mad/CCoLTSDetail.html

PROGRAM DATA

Program Service Area: Statewide

Operating Authority: 1915(b)/1915(c)

Statutes Utilized: 1915(b)(1), Freedom of Choice
1915(b)(4), Selective Contracting

Initial Waiver Approval Date: August 01, 2008
Implementation Date: August 01, 2008
Waiver Expiration Date: July 31, 2012

Sections of Title XIX Waived:
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted: None

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, 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 Practitioners Certified
-Obstetricians/Gynecologists or Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled: 634

Populations Mandatorily Enrolled:
NEW MEXICO
Coordination of Long-Term Services

Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in another Managed Care Program
- Medicare Dual Eligible without full Medicaid Benefits
- Participate in HCBS Waiver for DD and Medically Fragile
- Reside in ICF/MR

Medicare Dual Eligibles Included:
Medicaid Only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB
QMB Plus
SLMB Plus

Part D Benefit

MCE has Medicare Contract: Yes
Scope of Part D Coverage: Basic Alternative Coverage

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- Barbituates
- Benzodiazepines
- Nonprescription drugs
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs: Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Asks advocacy groups to identify members of these groups
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Department of Health
- Indian Health Services
- Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMERIGROUP Community Care of New Mexico, Inc.
NEW MEXICO
Coordination of Long-Term Services

Evercare of New Mexico

ADDITIONAL INFORMATION

Individuals with Special Health Care Needs (ISHCN) are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition and who require health and related services of a type or amount beyond that required by other individuals. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO/SE can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact: Paula McGee
Healthcare Operations Manager
HSD Medicaid
(505) 827-6234

State Operating Agency Contact:

PROGRAM DATA

Program Service Area: Initial Waiver Effective Date:
Statewide August 01, 2008

Statutes Waived: Waiver Expiration Date:
1902(a)(10)(B) Comparability of Services July 25, 2012
1902(a)(23) Freedom of Choice

Service Delivery

Target Group: Level of Care:
Aged Nursing Home
Disabled
Aged and Disabled

ADDITIONAL INFORMATION

Coordination of Long-Term Services is a managed care program designed to provide and coordinate services to specific Medicaid recipients. Services include doctor visits, hospital services, home and community-based services and long term care services. The intent of the program is to improve the quality of life for enrollees by offering long-term services to meet the individuals needs, allowing the individual to decide whether to received services in their home, community, or in a nursing or assisted living facility. 1915(b) allows New Mexico to implement the Coordinated Long-Term Services program under a managed care model. 1915(c) Home and Community-Based Waiver allows New Mexico to have long-term care services delivered in community settings, an alternative to providing
NEW MEXICO
Coordination of Long-Term Services

comprehensive long-term services in institutional setting

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO Standards (see below for details)
- Monitoring of MCO Standards
- Network Data
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data:
- Contract Standard Compliance
- Data Mining
- Enhanced/Revise State managed care Medicaid Quality Strategy
- Fraud and Abuse
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Adult with Special Needs Questionnaire
  - Child Medicaid AFDC Questionnaire
  - Child with Special Needs Questionnaire

Use of HEDIS:
- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
- State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

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

Encounter Data

Collections: Submission Specifications:
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. 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

State conducts general data completeness assessments:
- Yes
## NEW MEXICO
### Coordination of Long-Term Services

- Date of Payment
- Provider ID
- Type of Service
- Medicaid Eligibility
- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes

## Performance Measures

### Process Quality:
- Asthma care - medication use
- Diabetes medication management
- Influenza vaccination
- Influenza vaccination rate
- Pneumonia care
- Pneumonia vaccination

### Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care

### Access/Availability of Care:
- Adult's access to preventive/ambulatory health services
- 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

### Beneficiary Characteristics:
- Beneficiary need for interpreter
- Information of beneficiary ethnicity/race
- Information on primary languages spoken by beneficiaries

### 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)
- Cholesterol screening and management
- 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
- 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:
None
NEW MEXICO
Coordination of Long-Term Services

Non-Duplication Based on Accreditation:
None

EQRO Organization:
-Quality Improvement Organization (QIO)

EQRO Name:
-HealthInsight dba New Mexico Medical Review Organization

EQRO Mandatory Activities:
-Review of MCO compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities:
-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

Not Applicable
NORTH CAROLINA
Mental Health Developmental Disabilities & Substance Abuse Services

CONTACT INFORMATION

State Medicaid Contact: Judy Walton
Division of Medical Assistance
(919) 855-4265

State Website Address: http://www.ncdhhs.gov/dma

PROGRAM DATA

Program Service Area: County

Operating Authority: 1915(b)/1915(c)

Statutes Utilized:
1915(b)(3), 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, Detoxification, Financial Management, Habilitation, Home Modifications, ICF/MR, IMD, 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, Respite, Specialized Consultation, Supported Employment, Vehicle Modifications

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs
NORTH CAROLINA
Mental Health Developmental Disabilities & Substance Abuse Services

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

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Piedmont Behavioral Healthcare

ADDITIONAL INFORMATION
NORTH CAROLINA
Mental Health Developmental Disabilities & Substance Abuse Services

None

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact: Judy Walton
Program Administrator
Division of Medical Assistance
(919) 855-4265

State Operating Agency Contact:

PROGRAM DATA

Program Service Area: Initial Waiver Effective Date:
Region April 01, 2005

Statutes Waived: Waiver Expiration Date:
1902(a)(10)(B) Comparability of Services March 31, 2013
1902(a)(1) Statewideness

Service Delivery

Target Group: Disabled
Aged and Disabled
Mentally Retarded
Developmental Disabled
Mentally Retarded and Developmentally Disabled
Seriously Mentally Ill or Substance Use Disorders

Level of Care:
Hospital
ICFMR

ADDITIONAL INFORMATION

The Mental Health, Developmental Disabilities and Substance Abuse Services Health Plan (NC MH/DD/SAS), which is a 1915(b) waiver, and the NC Innovations waiver operate concurrently and has been authorized to allow for expansion of the capitated program to other areas of the state over time. The MH/DD/SAS waiver enables the State to mandate beneficiaries into a single Prepaid Inpatient Health Plan (PIHP). The PIHP is the State’s MH/DD/SAS authority that serves the counties covered by the waivers. Thus, NC Innovations home and community based services are administered by the MH/DD/SAS authority in a capitated, managed care environment along with Medicaid State Plan mental health and substance abuse services.

QUALITY ACTIVITIES FOR PIHP
State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines
- Monitoring of PIHP Standards
- Network Data
- Non-Duplication Based on Accreditation
- On-Site Reviews
- 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:
- State Approved Survey

Use of Collected Data:
- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Use of HEDIS:
- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
- State use/requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality:
- Ambulatory follow up within 7 days after discharge from mental health facility
- Ambulatory follow up within 7 days after discharge from substance abuse facility
- Follow-up after hospitalization for mental illness
- Number of Consumers moved from institutional care to community care
- Readmission rates for mental health
- Readmission rates for substance abuse

Health Status/Outcomes Quality:
- Patient satisfaction with care

Access/Availability of Care:
- Call Abandonment
- Call Answer Timeliness
- Initiation and Engagement of Alcohol and other drug dependence treatment
- Out of Network Services
- Service Availability/Accessibility
- Timeliness of initial service delivery

Use of Services/Utilization:
- Chemical dependency services utilization
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- MH Utilization percentage of members receiving inpatient, day/night, ambulatory and other support services
- Percentage of members receiving inpatient, day/night, ambulatory and support services for chemical dependency
- Utilization management of the provision of high use services

Health Plan Stability/Financial/Cost of Care:
- Actual reserves held by plan
- Days cash on hand
- Days in unpaid claims/claims outstanding
- Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- Net worth
- State minimum reserve requirements

Beneficiary Characteristics:
- Diversity of Medicaid Membership

Health Plan/Provider Characteristics:
- Network Capacity

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.

### Non-Clinical Topics:
- Improved provider compliance with coordination of benefits and sliding fee schedules.

### Standards/Accreditation

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<th>PIHP Standards:</th>
<th>Accreditation Required for Participation:</th>
<th>EQRO Name:</th>
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<tbody>
<tr>
<td>CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare</td>
<td>None</td>
<td>Carolina Centers for Medical Excellence (CCME)</td>
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<table>
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<tr>
<th>Non-Duplication Based on Accreditation:</th>
<th>EQRO Mandatory Activities:</th>
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<tr>
<td>Accreditation Agencies Recognized by CMS for Non-Duplication</td>
<td>Review of PIHP compliance with structural and operational standards established by the State</td>
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<tr>
<th>EQRO Organization:</th>
<th>EQRO Optional Activities</th>
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<td>Quality Improvement Organization (QIO)</td>
<td>None</td>
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TEXAS
STAR+PLUS

CONTACT INFORMATION

State Medicaid Contact: Joe Vesowate
Texas Health and Human Services Commission
(512) 491-1379

State Website Address: http://www.hhsc.state.tx.us/starplus/starplus.html

PROGRAM DATA

Program Service Area: County
Initial Waiver Approval Date: January 30, 1998

Operating Authority: 1915(b)/1915(c)
Implementation Date: January 01, 1998

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
Waiver Expiration Date: December 11, 2011

Enrollment Broker: Maximus
Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Amount, Duration and Scope
-1902(a)(23) Freedom of Choice

For All Areas Phased-In: Yes
Sections of Title XIX Costs Not Otherwise Matchable Granted: None

Guaranteed Eligibility: No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT,
Family Planning, Hearing, Home Health, Immunization,
Inpatient Mental Health, Inpatient Substance Use Disorders,
Laboratory, Long Term Care, Outpatient Hospital, Outpatient
Mental Health, Outpatient Substance Use Disorders,
Physician, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Clinics (RHCs)
TEXAS
STAR+PLUS

Enrollment

Populations Voluntarily Enrolled:
- Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
- Aged and Related Populations
- Blind/Disabled Adults and Related Populations
- Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligibles
- Reside in a Nursing Facility or ISF/MR, Reside in a state school or other 24 hour facility, Participating in a HCBS waiver other than the 1915 (c) Nursing Facility Waiver

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Lock-in Provision:
No lock-in

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Dept. of Aging and Disability Services (DADS)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup (STAR+PLUS)
Bravo
Evercare
Molina (STAR+Plus)
Superior HealthPlan (STAR+Plus)

ADDITIONAL INFORMATION

Blind/disabled/aged adults who are SSI or deemed SSI by CMS are mandatory to participate in the MCO model. Blind/disabled children who are SSI or deemed SSI by CMS have the choice of participating in the MCO model or the PCCM model.

Concurrent Operating 1915(c) Program
TEXAS
STAR+PLUS

CONTACT INFORMATION

State Medicaid Agency Contact: DJ Johnson
STAR+Plus Project Specialist
Health & Human Services Commission
(512) 491-1301

State Operating Agency Contact:

PROGRAM DATA

Program Service Area:
County

Initial Waiver Effective Date:
February 01, 1998

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness

Waiver Expiration Date:
August 31, 2012

Service Delivery

Target Group: Level of Care:
Aged and Disabled Nursing Home

ADDITIONAL INFORMATION

Both b&c waivers are operating through the STAR&Plus program which integrates acute and long term care services for SSI enrollees in Harris County. In February 2011, the STAR+Plus 1915(b) ad 1915(c) waivers expanded to the Harris contiguous, Bexar, Nueces and Travis SDA. In February 2011, the Star+Plus 1915(b) and 1915(c) waivers expanded to the Dallas and Tarrant SDA

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Focused Studies
- MCO Standards (see below for details)
- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data:
- Contract Standard Compliance
- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Track Health Service provision

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Adult Medicaid SSI Questionnaire
- State-developed Survey

Use of HEDIS:
- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

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TEXAS
STAR+PLUS

- State use/requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements:
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for data validation
- Requirements for MCOs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications:
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-04, NCPDP, ADA)
- Guidelines for frequency of encounter data submission
- Guidelines for initial encounter data submission
- Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms:
- NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- UB-04 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation - Methods:
- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO commercial utilization rates, comparisons to national norms, comparisons to submitted bills)
- Medical record validation
- Per member per month analysis and comparisons across MCOs

MCO/HIO conducts data accuracy check(s) on specified data elements:
- Date of Service
- Date of Processing
- Date of Payment
- Provider ID
- Type of Service
- Diagnosis Codes
- Procedure Codes
- Revenue Codes
- Age-appropriate diagnosis/procedure
- Gender-appropriate diagnosis/procedure
- Medicaid Eligibility
- Plan Enrollment
- Preparing HEDIS and risk adjustment software

State conducts general data completeness assessments:
- Yes

Performance Measures

Process Quality:
- Adolescent immunization rate
- Adolescent well-care visit rate
- Asthma care - medication use
- Cervical cancer screening rate
- Check-ups after delivery
- Chlamydia screening in women
- Depression management/care
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Hearing services for individuals less than 21 years of age
- Immunizations for two year olds
- Initiation of prenatal care - timeliness of

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of low birth weight infants

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## TEXAS STAR+PLUS

- 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:
- 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.

#### Non-Clinical Topics:
- None

#### Clinical Topics:
- Diabetes care and management
- Influenza Immunizations

### 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

**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
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: Initial Waiver Approval Date:
Region by MCO Contract January 01, 2001

Operating Authority: Implementation Date:
1915(b)/1915(c) January 01, 2001

Statutes Utilized: Waiver Expiration Date:
1915(b)(2), Locality as Central Broker December 31, 2011
1915(b)(4), Selective Contracting

Enrollment Broker: Sections of Title XIX Waived:
Aging and Disability Resource Centers -1902(a)(1) Statewidenss

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
No Granted:

Guaranteed Eligibility: None

SERVICE DELIVERY

Family Care PIHPs - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:
1915(c) Waiver, Case Management, Disposable Medical
-Not applicable, primary care is carved out
Supplies, Durable Medical Equipment, Duty Nursing, Home
Health, ICF-MR, In-home Psychotherapy, Language
Pathology, 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 Therapy, Transportation

Enrollment

Populations Voluntarily Enrolled: 651

Populations Mandatorily Enrolled:
WISCONSIN
Family Care

- Adults with Developmental Disability or Mental Retardation
- Aged and Related Populations
- Blind/Disabled Adults and Related Populations
- Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in Another Managed Care Program
- Have an Eligibility Period that Is Only Retroactive

Lock-In Provision:

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- All Target Groups Are Persons with Complex Special Needs

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Education Agency
- Mental Health Agency
- Physicians & Clinics
- Protective Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

- Care Wisconsin First, Inc. (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
CONTACT INFORMATION

State Medicaid Agency Contact: Monica Deignan
Deputy Director Office of Family Care Expansion
WI Department of Health Services
(608) 261-7807

State Operating Agency Contact:

PROGRAM DATA

Program Service Area: Region by PIHP Contract
Initial Waiver Effective Date: January 01, 2001

Statutes Waived:
1902(a)(10)(B) Comparability of Services
1902(a)(1) Statewideness
Wavier Expiration Date: December 31, 2014

Service Delivery

Target Group: Aged and Disabled
Mentally Retarded
Developmental Disabled
Level of Care: Nursing Home
ICFMR

ADDITIONAL INFORMATION

The 1915(b) waiver allows for restriction of freedom of choice of providers under the Family Care risk-based prepaid inpatient health plan contract, which allows Family Care PIHPs to deliver care through a managed care model. Services provided include 1915(c) waiver services and the longterm care Medicaid State Plan services - nursing home and ICF-MR, home health, personal care, therapies, mental health services, AODA services, durable medical equipment, medical supplies and transportation services (except ambulance).

QUALITY ACTIVITIES FOR PIHP

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Individualized Service Plan Reviews
-Monitoring of PIHP Standards
-On-Site Reviews
-Performance Improvement Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation

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**WISCONSIN**  
**Family Care**

- PIHP Standards (see below for details)  
- Provider Data  
- Structured Member Outcome Interviews

### Consumer Self-Report Data:
- Member satisfaction survey  
- Structured Member Outcome Interviews

### Use of HEDIS:
- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
- State modifies/requires PIHPs to modify some or all NCQA specifications in ways other than continuous enrollment

### Encounter Data

#### Collection: Requirements:
- Certification  
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)  
- Requirements for PIHPs to collect and maintain encounter data  
- Specifications for the submission of encounter data to the Medicaid agency  
- Standards to ensure complete, accurate, timely encounter data submission

#### Collections: Submission Specifications:
- Certification of Data Submissions  
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing  
- Deadlines for regular/ongoing encounter data submission(s)  
- Guidelines for frequency of encounter data submission  
- Use of Medicaid Identification Number for beneficiaries

#### Collection: Standardized Forms:
None

#### Validation - Methods:
- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)  
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)  
- Medical record validation

#### PIHP conducts data accuracy check(s) on specified data elements:
- Date of Service  
- Date of Processing  
- Date of Payment  
- Provider ID  
- Medicaid Eligibility  
- Plan Enrollment  
- Procedure Codes  
- Revenue Codes

#### State conducts general data completeness assessments:
Yes

### Performance Measures

#### Process Quality:
- Member LTC outcomes present  
- Support for member LTC outcomes provided

#### Access/Availability of Care:
- State assessment of adequate network capacity

#### Health Plan Stability/Financial/Cost of Care:
- Actual reserves held by plan  
- State minimum reserve requirements

#### Health Status/Outcomes Quality:
- Member health and safety outcomes present  
- Patient satisfaction with care  
- Support for member health and safety outcomes provided

#### Use of Services/Utilization:
- NF and ICF-MR utilization

#### Health Plan/Provider Characteristics:
- Board Certification  
- State review for cultural competency

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WISCONSIN
Family Care

Beneficiary Characteristics:
- Information of beneficiary ethnicity/race
- PIHP/IPCP-specific disenrollment rate

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:
- Fall Prevention

Non-Clinical Topics:
- Increasing employment
- Notice of Action
- Service Authorization

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 measures

EQRO Optional Activities
- Administration or validation of consumer or provider surveys
- Calculation of performance measures
- Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
- Technical assistance to PIHPs to assist them in conducting quality activities

Performance Measures - Others:
- Structured Member Outcome Interviews
FLORIDA
Nursing Home Diversion Program

CONTACT INFORMATION

State Medicaid Contact: GP Mendie
Florida Agency for Health Care Administration
(850) 412-4252

State Website Address: http://ahca.myflorida.com

PROGRAM DATA

Program Service Area: Statewide
Initial Waiver Approval Date: Not Applicable

Operating Authority: 1915(a)/1915(c)
Implementation Date: December 01, 1998

Statutes Utilized: 1915(b)(4), Selective Contracting
Waiver Expiration Date: Not Applicable

Enrollment Broker: No
Sections of Title XIX Waived:
1902(a)(1) Statewideness
1902(a)(10)(b) Comparability of Services

For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable
Granted: None

Guaranteed Eligibility: 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

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Subpopulations Excluded from Otherwise Included Populations:
- Adults age 64 or younger
- Poverty Level Pregnant Woman
- Reside in Nursing Facility or ICF/MR
- Special Needs Children (BBA defined)
- Special Needs Children (State defined)
- Title CHIP XXI

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Department of Children and Family Services
- Department of Elder Affairs

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

American Eldercare
Humana Medical Plan
Life Hope Care
Neighborly Care Network
Sunrise Home Health
United Health Care (NHD)
Universal Health Care (NHD)
Vista Independence Plan
YourCare Brevard

Amerigroup (NHD)
Humana Senior's Choice
Little Havana Activities and Nutrition Centers
Project Independence at Home
Sunshine State Health Plan, Inc. (NHD)
United Home Care Services
Urban Jacksonville
World Net, Inc.

ADDITIONAL INFORMATION

None

Concurrent Operating 1915(c) Program
**FLORIDA**

Nursing Home Diversion Program

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**CONTACT INFORMATION**

**State Medicaid Agency Contact:**

GP Mendie  
Medical Health Care Program Analyst  
Agency for Healthcare Administration  
(850) 412-4252

**State Operating Agency Contact:**

Laura Noyes  
Analyst  
Florida Department of Elder Affairs  
(850) 414-2335

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**PROGRAM DATA**

**Program Service Area:**  
Statewide

**Initial Waiver Effective Date:**  
July 01, 1998

**Waiver Expiration Date:**  
September 28, 2011

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**Service Delivery**

**Target Group:**  
65 or older  
Medicare Dual Eligibles

**Level of Care:**  
Nursing Home

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**ADDITIONAL INFORMATION**

The 1915 (a) authority permits managed care organizations to offer home and community care services to program recipients through their provider networks. The Nursing Home Diversion waiver coordinates acute and long-term care services for dual eligible beneficiaries through managed care organizations under the 1915(a) waiver authority. Under the 1915(c) authority, the waiver provides home and community-based services to recipients in order to prevent or delay nursing home placement.

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**QUALITY ACTIVITIES FOR PIHP**

**State Quality Assessment and Improvement Activities:**

- Encounter Data (see below for details)  
- Focused Studies  
- On-Site Reviews  
- Performance Improvement Projects (see below for details)  
- Performance Measures (see below for details)

**Use of Collected Data:**

- Monitor Quality Improvement  
- Plan Reimbursement  
- Program Evaluation

**Consumer Self-Report Data:**

None

**Use of HEDIS:**

- The State DOES NOT use any of the HEDIS measures  
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
FLORIDA
Nursing Home Diversion Program

Encounter Data

Collection: Requirements:
- Requirements for data validation
- Requirements for PIHPs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications:
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Deadlines for regular/ongoing encounter data submission(s)
- Guidelines for initial encounter data submission

Collection: Standardized Forms:
None

Collections: Submission Specifications:
- 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)

Validation - Methods:
- 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

Use of Services/Utilization:
None

Access/Availability of Care:
None

Use of Services/Utilization:
None

Health Status/Outcomes Quality:
- Patient satisfaction with care

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
**FLORIDA**

**Nursing Home Diversion Program**

### 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

**EQRO Optional Activities**
- Assessment of MCO Organizations
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)/1915(c)

Statutes Utilized:  
Not Applicable

Enrollment Broker:  
No

For All Areas Phased-In:  
No

Guaranteed Eligibility:  
No guaranteed eligibility

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  
- Obstetricians/Gynecologists or Gynecologists  
- Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:  
-Aged and Related Populations

Populations Mandatorily Enrolled:  
None
MASSACHUSETTS
Senior Care Options (SCO)

- Blind/Disabled Adults and Related Populations
- Medicare Dual Eligibles

Subpopulations Excluded from Otherwise Included Populations:
- A Medicare dual eligible who is excluded would be buy in only.
- Diagnosed with End Stage Renal Disease (ESRD)
- Enrolled in Another Managed Care Program
- Medically Needy Individuals with Spend-down
- Medicare Dual Eligibles
- Reside in ICF/MR
- Special Needs Children (BBA defined)
- Under 65 years old

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI

Lock-In Provision:
1 month lock-in

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Standard Prescription Drug

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- Agents when used for symptomatic relief of cough and colds
- Barbiturates
- Benzodiazepines
- Nonprescription drugs
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Smoking Cessation (except dual eligibles as Part D will cover)

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Housing Agencies
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Commonwealth Care Alliance
NaviCare

Evercare SCO
Senior Whole Health (Upham's)
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(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:  
Ken Smith  
Director of Long Term Services and Supports  
Office of Medicaid  
(617) 222-7508

State Operating Agency Contact:  
Not Applicable

PROGRAM DATA

Program Service Area:  
County

Initial Waiver Effective Date:  
January 01, 2009

Waiver Expiration Date:  
December 31, 2013

Service Delivery

Target Group:  
Aged  
Disabled individuals age 65 and older  
Mentally Retarded age 65 and older  
Developmental Disabled age 65 and older  
 Seriously Mentally Ill age 65 and older  
 Serious Emotional Disturbance age 65 and older

Level of Care:  
Nursing Home  
Hospital  
ICFMR

ADDITIONAL INFORMATION

The commonwealth offers a variety of services to consumers under a home and community-based services waiver program and the number of services that can be provided is not limited. These programs may provide a combination of both traditional medical services (i.e. dental services, skilled nursing) as well as non-medical services (i.e. respite, case management, environmental modifications).

QUALITY ACTIVITIES FOR MCO/HIO
## State Quality Assessment and Improvement Activities:

- Focused Studies
- 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

## Use of Collected Data:

- Contract Standard Compliance
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation
- Regulatory Compliance/Federal Reporting

## Consumer Self-Report Data:

None

## Use of HEDIS:

- The State uses SOME of the HEDIS measures listed for Medicaid
- State use/require 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

#### 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

#### Beneficiary Characteristics:

- Beneficiary need for interpreter
- Information on primary languages spoken by beneficiaries
- MCO/PCP-specific disenrollment rate

#### 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/Provider Characteristics:

- Board Certification
- Languages Spoken (other than English)
- Provider turnover

#### 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
MASSACHUSETTS
Senior Care Options (SCO)

- 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 Abuse Disorders treatment after detoxification service
- Treatment of myocardial infarction
- Tuberculosis screening and treatment

Non-Clinical Topics:
None

Standards/Accreditation

MCO Standards:
- NCQA (National Committee for Quality Assurance)
  Standards
- State-Developed/Specified Standards

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None

EQRO Name:
- APS Healthcare

EQRO Organization:
- QIO-like entity

EQRO Mandatory Activities:
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects

EQRO Optional Activities:
- Administration or validation of consumer or provider surveys
- Assessment of MCO information systems
- Calculation of performance measures

Pay for Performance (P4P)

Implementation of P4P:
The State HAS NOT implemented a Pay-for-Performance program with the MCO

Program Payers:
Not Applicable
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<tr>
<th>Population Categories Included:</th>
<th>Not Applicable</th>
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<tr>
<td>Clinical Conditions:</td>
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<td>Initial Year of Reward:</td>
<td>Not Applicable</td>
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<tr>
<td>Member Incentives:</td>
<td>Not Applicable</td>
</tr>
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<td>Rewards Model:</td>
<td>Not Applicable</td>
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<td>Measurement of Improved Performance:</td>
<td>Not Applicable</td>
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<td>Evaluation Component:</td>
<td>Not Applicable</td>
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MINNESOTA
Minnesota Senior Health Options

CONTACT INFORMATION

State Medicaid Contact: David Godfrey
Minnesota Department of Human Services
(651) 431-2319

State Website Address: http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
Statewide Not Applicable

Operating Authority: Implementation Date:
1915(a)/1915(c) March 01, 1997

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
No 1902(a)(10)(b) Comparability of Services

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
Yes Granted:

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:
Case Management, Chiropractic, Community Based -Not Applicable; Contractors Not Required to Identify PCPs
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

Enrollment

Populations Voluntarily Enrolled:
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None
MINNESOTA
Minnesota Senior Health Options

- 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

### Part D Benefit

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
No

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
- Agents when used for symptomatic relief of cough and colds
- Barbiturates
- Benzodiazepines
- Nonprescription drugs
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Smoking Cessation (except dual eligibles as Part D will cover)

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Aging Agency
- Mental Health Agency
- Social Services Agencies

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

| Blue Plus | Medica |
| Metropolitan Health Plan | PrimeWest Health System |
| South Country Health Alliance | UCARE |

### ADDITIONAL INFORMATION

None

### Concurrent Operating 1915(c) Program
## CONTACT INFORMATION

| State Medicaid Agency Contact: | Pamela Parker  
| Special Needs Purchasing Manager  
| Minnesota Department of Human Se  
| (651)431-2512 |
| State Operating Agency Contact: | Not Applicable |

## PROGRAM DATA

| Program Service Area: | Initial Waiver Effective Date: |
| Statewide | March 01, 1997 |
| Waiver Expiration Date: | June 30, 2013 |

## Service Delivery

| Target Group: | Level of Care: |
| Aged | Nursing Home |

## 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
MINNESOTA
Minnesota Senior Health Options

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
- Chlamydia 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

Clinical Topics:
- Aspirin therapy
MINNESOTA
Minnesota Senior Health Options

choosing
- 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

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

Initial Waiver Approval Date: Not Applicable

Operating Authority: 1932(a)/1915(c)

Implementation Date: January 01, 1999

Statutes Utilized: Not Applicable

Waiver Expiration Date: Not Applicable

Enrollment Broker: Aging and Disability Resource Centers

Sections of Title XIX Waived: Not Applicable

For All Areas Phased-In: Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted: None

Guaranteed Eligibility: No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Risk-based Capitation

Service Delivery

Included Services:
1915(c) Waiver Services, Case Management, Clinic, Dental, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Internists

Enrollment

Populations Voluntarily Enrolled:
-Adults with Developmental Disability or Mental Retardation
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
None
**WISCONSIN**

**Wisconsin Partnership Program**

**Subpopulations Excluded from Otherwise Included Populations:**
- Enrolled in Another Managed Care Program
- Medicare Dual Eligibles - Have an eligibility period there is only retroactive.

**Lock-In Provision:**
No lock-in

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB
SLMB, QI, and QDWI

**Part D Benefit**

**MCE has Medicare Contract:**
Yes

**Provides Part D Benefits:**
Yes

**Scope of Part D Coverage:**
Standard Prescription Drug

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
- Barbiturates
- Benzodiazepines
- Part D excluded drugs that are covered under the Medicaid State Plan
- Selected classes of over the counter drugs by prescription

**SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS**

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
- All target groups are persons with complex special needs
- Uses eligibility data to identify members of these groups
- Uses provider referrals to identify members of these groups

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Aging Agency
- Developmental Disabilities Agency
- Education Agency
- Mental Health Agency
- Protective Services Agency
- Social Services Agency

**PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS**

| Care Wisconsin Health Plan, Inc. (Partnership) | 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 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
WISCONSIN
Wisconsin Partnership Program

health care. Other special characteristics: same goals as PACE Program; nurse practitioners play a key role in linking services; recipients can bring their own provider as PCP; external committee evaluation data techniques.

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:
Monica Deignan
Deputy Director of Family Care Expansion
DHS/DLTC
(608) 261-7807

State Operating Agency Contact:
Not Applicable

PROGRAM DATA

Program Service Area:
Region by MCO Contract

Initial Waiver Effective Date:
January 01, 2001

Waiver Expiration Date:
December 31, 2014

Service Delivery

Target Group:
Aged and Disabled
Mentally Retarded and Developmentally Disabled

Level of Care:
Nursing Home
ICFMR

ADDITIONAL INFORMATION

The 1932(a) program incorporates all state plan services including the services available under the 1915(c) waiver program.

QUALITY ACTIVITIES FOR MCO/HIO

State Quality Assessment and Improvement

Activities:
-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 Improvement

Consumer Self-Report Data:
-Consumer satisfaction survey
-Consumer/Beneficiary Focus Groups
-Member satisfaction 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
Wisconsin Partnership Program

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

Validation - Methods:
- Automated analysis of encounter data submission to help determine 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:
- Member LTC outcomes present
- Support for member LTC outcomes provided

Health Status/Outcomes Quality:
- Member health and safety outcomes present
- Patient satisfaction with care
- Support for member health and safety outcomes provided

Access/Availability of Care:
- State assessment of adequate network capacity

Use of Services/Utilization:
- Emergency room visits/1,000 beneficiary
- Number of hospital admissions per member per year
- Number of hospital days per member per year
- Percentage of beneficiaries with at least one dental visit
WISCONSIN
Wisconsin Partnership Program

Health Plan Stability/Financial/Cost of Care:
- Percentage of people living at home, CBRF/group home, nursing home
- Actual reserves held by plan
- State minimum reserve requirements

Beneficiary Characteristics:
- Information of beneficiary ethnicity/race
- MCO/PCP specific disenrollment rate

Health Plan/Provider Characteristics:
- Board Certification
- State review for cultural competency

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:
- Colorectal cancer screening
- Diabetes
- Medication Management
- Reducing readmission to mental health hospital

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:
- 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

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

Measurement of Improved Performance:
Not Applicable
### WISCONSIN

**Wisconsin Partnership Program**

<table>
<thead>
<tr>
<th><strong>Initial Year of Reward:</strong></th>
<th><strong>Evaluation Component:</strong></th>
</tr>
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<tbody>
<tr>
<td>Not Applicable</td>
<td>Not Applicable</td>
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</tbody>
</table>

**Member Incentives:**

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:  Initial Waiver Approval Date:
Statewide  Not Applicable

Operating Authority:  Implementation Date:
1937  May 25, 2006

Statutes Utilized:  Waiver Expiration Date:
Not Applicable  Not Applicable

Enrollment Broker:  Sections of Title XIX Waived:
No  None

For All Areas Phased-In:  Sections of Title XIX Costs Not Otherwise Matchable
No  Granted:

Guaranteed Eligibility:
Continuous eligibility for children under age 19

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Disease Management, Durable Medical Equipment, EPSDT, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physical Therapy, Physician, Speech Therapy, X-Ray

Allowable PCPs:
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-General Practitioners
-Indian Health Service (IHS) Providers
-Internists
-Nurse Midwives
-Nurse Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Physician Assistants
-Rural Health Centers (RHCs)

Enrollment

Populations Voluntarily Enrolled:  Populations Mandatorily Enrolled:
678

678
IDAHO
Healthy Connections

- 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

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Initial screening upon eligibility and enrollment in PCCM program; also during annual redetermination
- Reviews complaints and grievances to identify members of these groups
- Screen for participation in certain programs

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Child Welfare Agency
- Developmental Disabilities Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Connections
Enrollment is mandatory in 42 counties out of 44 counties. Clark and Custer Counties are voluntary.

### QUALITY ACTIVITIES FOR PCCM

<table>
<thead>
<tr>
<th>Quality Oversight Activities:</th>
<th>Use of Collected Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Consumer Self-Report Data  (see below for details)</td>
<td>- Contract Standard Compliance</td>
</tr>
<tr>
<td>- Enrollee Hotlines</td>
<td>- Monitor Quality Improvement</td>
</tr>
<tr>
<td>- Performance Measures (see below for details)</td>
<td>- Program Evaluation</td>
</tr>
<tr>
<td>- Provider Data</td>
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</tr>
</tbody>
</table>

**Consumer Self-Report Data:**
- State-developed Survey

**Performance Measures**

**Process Quality:**
- Diabetes management/care
- Immunizations for two year olds

**Health Status/Outcomes Quality:**
- None

**Access/Availability of Care:**
- 24/7 access to live Health Care Professional
- Average wait time for an appointment with primary care case manager
- Children’s access to primary care practitioners
- Ratio of primary care case managers to beneficiaries

**Use of Services/Utilization:**
- None

**Provider Characteristics:**
- None

**Beneficiary Characteristics:**
- Disenrollment rate
- Disenrollment reasons

**Performance Measures - Others:**
- None
IDAHO
Idaho Smiles

CONTACT INFORMATION

State Medicaid Contact: Sara Stith
Bureau of Medical Care
(208) 287-1173

State Website Address: http://www.healthandwelfare.idaho.gov

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
Statewide Not Applicable

Operating Authority: Implementation Date:
1937 September 01, 2007

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
No None

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
No Granted:

Guaranteed Eligibility: None

SERVICE DELIVERY

Dental PAHP - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:
Dental - Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled: Populations Mandatorily Enrolled:
None - American Indian/Alaska Native

- Medicare Dual Eligibles
- Participate in HCBS Waiver
- Poverty-Level Pregnant Women
- Resides in Nursing Facility or ICF/ID
- 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
IDAHO
Idaho Smiles

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligibles
- Medicare-Medicaid Coordinated Plan

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Excluded:
QMB, SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross of Idaho

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
- Encounter Data (see below for details)
- Enrollee Hotlines
- Monitoring of PAHP Standards
- On-Site Reviews
- PAHP Standards (see below for details)

Use of Collected Data:
- Contract Standard Compliance
- Data Mining
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

682
### Consumer Self-Report Data:
None

### Use of HEDIS:
- The State DOES NOT use any of the HEDIS measures

---

### Encounter Data

**Collection: Requirements:**
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for data validation
- Requirements for PAHPs to collect and maintain encounter data
- Specifications for the submission of encounter data to the Medicaid agency
- Standards to ensure complete, accurate, timely encounter data submission

**Collections - Submission Specifications:**
- 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

**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: Initial Waiver Approval Date:
Statewide Not Applicable

Operating Authority: Implementation Date:
1937 April 01, 2007

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
No None

For All Areas Phased-In:
No

Sections of Title XIX Costs Not Otherwise Matchable
Granted:
None

Guaranteed Eligibility:
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
IDAHO
Medicare-Medicaid Coordinated Plan

Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in Another Managed Care Program
- Medicare Dual Eligibles
- Participate in HCBS Waiver
- Poverty Level Pregnant Woman
- Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
Yes

Provides Part D Benefits:
Yes

Scope of Part D Coverage:
Basic Alternative Coverage

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- None - managed care entity provides standard prescription drug coverage

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medicare-Medicaid Coordinated Plan

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)

Use of Collected Data:
- Program Modification, Expansion, or Renewal

Consumer Self-Report Data:
- Perceived problems with program participation

Use of HEDIS:
- The State DOES NOT use any of the HEDIS measures

Standards/Accreditation

PAHP Standards:
None

Accreditation Required for Participation:
None

Non-Duplication Based on Accreditation:
None
WASHINGTON
Chronic Care Management Program (ADSA)

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
Initial Waiver Approval Date: Not Applicable

Operating Authority: 1937
Implementation Date: April 01, 2010

Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable

Enrollment Broker: No
Sections of Title XIX Waived:

For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable Granted:

Guaranteed Eligibility:
No guaranteed eligibility

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
WASHINGTON
Chronic Care Management Program (ADSA)

Medicare Dual Eligibles Included: None
Medicare Dual Eligibles Excluded: Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract: Not Applicable
Provides Part D Benefits: Not Applicable
Scope of Part D Coverage: Not Applicable
Part D - Enhanced Alternative Coverage: Not Applicable
Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs: Yes

Strategies Used to Identify Persons with Complex (Special) Needs: Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Health Care Provider
- Housing Agencies
- Longterm Care Services and Supports (HCS)
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Area Agencies on Aging

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.

QUALITY ACTIVITIES FOR OTHER

Quality Oversight Activities: None
Use of Collected Data: None
Consumer Self-Report Data: None
WEST VIRGINIA
Mountain Health Choices

CONTACT INFORMATION

State Medicaid Contact:  Brandy Pierce
Office of Managed Care, Bureau for Medical Service
(304) 356-4912

State Website Address:  http://www.wvdhhr.org/bms

PROGRAM DATA

Program Service Area:  Initial Waiver Approval Date:
Statewide

Operating Authority:  Implementation Date:
1937  March 01, 2007

Statutes Utilized:  Waiver Expiration Date:
Not Applicable

Enrollment Broker:  Sections of Title XIX Waived:
Automated Health Systems, Inc  None

For All Areas Phased-In:  Sections of Title XIX Costs Not Otherwise Matchable
No

Guaranteed Eligibility:
12 months of guaranteed eligibility for children

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
- Obstetricians/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
WEST VIRGINIA
Mountain Health Choices

Subpopulations Excluded from Otherwise Included Populations:
- Foster Care Children
- Medically Needy
- Medicare Dual Eligibles
- Participate in HCBS Waiver
- Poverty Level Pregnant Woman
- Reside in Nursing Facility or ICF/MR
- Special Needs Children (BBA defined)
- Special Needs Children (State defined)
- Subsidized Adoptions under Titles IV-B and IV-E

Lock-in Provision:
12 month lock-in

Medicare Dual Eligibles Included:
None

Medicare Dual Eligibles Excluded:
Exclude all categories of Medicare Dual Eligibles

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carelink Health Plan
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

Use of Collected Data:
- Contract Standard Compliance
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation
- Regulatory Compliance/Federal Reporting
WEST VIRGINIA
Mountain Health Choices

- On-Site Reviews
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Consumer Self-Report Data:
- CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Child Medicaid AFDC Questionnaire
  - Child with Special Needs Questionnaire

Use of HEDIS:
- The State uses SOME of the HEDIS measures listed for Medicaid
- The State DOES NOT generate from encounter data any of the HEDIS 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)

State conducts general data completeness assessments:
Yes

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

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
- Chlamydia screening in women
- Cholesterol screening and management
- Controlling high blood pressure
- Frequency of outgoing prenatal care
- Immunizations for two year olds
- Initiation of prenatal care - timeliness of
- Lead screening rate

Health Status/Outcomes Quality:
- Patient satisfaction with care
- Percentage of beneficiaries who are satisfied with their ability to obtain care
WEST VIRGINIA
Mountain Health Choices

- 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

**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 Organization:**
- Quality Improvement Organization (QIO)

**EQRO Name:**
Delmarva Foundation for Medical Care

**EQRO Mandatory Activities:**
- Review of MCO compliance with structural and operational standards established by the State
- Validation of performance improvement projects
- Validation of performance measures

**EQRO Optional Activities:**
None

**Pay for Performance (P4P)**

**Implementation of P4P:**
The State HAS NOT implemented a Pay-for-Performance program with the MCO

**Program Payers:**
Not Applicable

**Population Categories Included:**
Not Applicable

**Rewards Model:**
Not Applicable
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## 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  
| Initial Waiver Approval Date: | Not Applicable  
| Operating Authority: | 1902(a)(70)  
| Implementation Date: | October 19, 2008  
| Statutes Utilized: | Not Applicable  
| Waiver Expiration Date: | Not Applicable  
| Enrollment Broker: | No  
| Sections of Title XIX Waived: | None  
| For All Areas Phased-In: | No  
| Sections of Title XIX Costs Not Otherwise Matchable Granted: | None  
| Guaranteed Eligibility: | None |

## SERVICE DELIVERY

### Transportation PAHP - Non-risk Capitation

#### Service Delivery

| Included Services: | Non-Emergency Transportation  
| Allowable PCPs: | -Not applicable, contractors not required to identify PCPs |

#### Enrollment

| Populations Voluntarily Enrolled: | -Special Needs Children (BBA defined)  
| | -Special Needs Children (State defined)  
| |  
| Populations Mandatorily Enrolled: | -Aged and Related Populations  
| | -Blind/Disabled Adults and Related Populations  
| | -Blind/Disabled Children and Related Populations  
| | -Foster Care Children  
| | -Medicare Dual Eligibles  
| Subpopulations Excluded from Otherwise Included Populations: | -Enrolled in Another Managed Care Program  
| | -Medicare Dual Eligibles  
| Lock-In Provision: | No lock-in |
DISTRICT OF COLUMBIA
Non-Emergency Medical Transportation Program

Medicare Dual Eligibles Included:
- QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
- QMB
- SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
- No

Scope of Part D Coverage:
- Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
- None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
- Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Developmental Disabilities Agency
- Mental Health Agency
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medical Transportation Management

ADDITIONAL INFORMATION

This program serves the FFS population only.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines
- Network Data
- Ombudsman
- Performance Improvement Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data:
- Program Evaluation
- Program Modification, Expansion, or Renewal

Consumer Self-Report Data:
- State-developed Survey

Use of HEDIS:
- The State DOES NOT use any of the HEDIS measures
DISTRICT OF COLUMBIA
Non-Emergency Medical Transportation Program

Performance Measures

Process Quality: None

Health Status/Outcomes Quality: None

Access/Availability of Care: None

Use of Services/Utilization: Transportation to PCP

Health Plan Stability/ Financial/Cost of Care: None

Health Plan/ Provider Characteristics: None

Beneficiary Characteristics: None

Performance Measures - Others: None

Performance Improvement Projects

Project Requirements:
- Individual PAHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics:
- None

Non-Clinical Topics:
- Transportation service to PCP

Standards/Accreditation

PAHP Standards: None

Accreditation Required for Participation: None

Non-Duplication Based on Accreditation: None
GEORGIA
Non-Emergency Transportation Brokerage Program

CONTACT INFORMATION

State Medicaid Contact: Barbara Lowe
GA Department of Community Health
(404) 656-4451

State Website Address: http://www.dch.ga.gov

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
Statewide Not Applicable

Operating Authority: Implementation Date:
1902(a)(70) January 01, 2007

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
No None

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
No Granted:

Guaranteed Eligibility:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:
Non-Emergency Transportation -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:
Non-Emergency Transportation Brokerage Program

- Emergency Medical Assistance Members
- Medicare Dual Eligibles
- Title XXI CHIP (PeachCare)

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, Qi, and QDWI

Part D Benefit

MCE has Medicare Contract: No

Scope of Part D Coverage: Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs: Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation Brokerage

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
- Encounter Data (see below for details)
- Enrollee Hotlines
- On-Site Reviews
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data:
- Contract Standard Compliance
- Fraud and Abuse
- Monitor Quality Improvement
- Regulatory Compliance/Federal Reporting

Use of HEDIS:
- The State DOES NOT use any of the HEDIS measures
- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Consumer Self-Report Data:
None
GEORGIA
Non-Emergency Transportation Brokerage Program

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

PAHP conducts data accuracy check(s) on specified data elements:
None

Validation - Methods:
- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)

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 sufficient 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

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: Initial Waiver Approval Date:
Statewide Not Applicable

Operating Authority: Implementation Date:
1902(a)(70) September 01, 2010

Statutes Utilized: Waiver Expiration Date:
Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
American Medical Response None

For All Areas Phased-In:
Sections of Title XIX Costs Not Otherwise Matchable
No

Guaranteed Eligibility:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:
Non-Emergency Transportation -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
IDAHO
Non-Emergency Medical Transportation

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
SLMB, QI, and QDWI
QMB

Lock-in Provision:
No lock-in

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Provides Part D Benefits:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access2Care

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)

Consumer Self-Report Data:
- CAHPS
  Adult Medicaid SSI Questionnaire

Use of Collected Data:
- Contract Standard Compliance

Use of HEDIS:
- The State DOES NOT use any of the HEDIS measures
IDAHO  
Non-Emergency Medical Transportation

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
Initial Waiver Approval Date: Not Applicable
Operating Authority: 1902(a)(70)
Implementation Date: October 01, 2010
Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable
Enrollment Broker: TMS Management Group, Inc.
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

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)
IOWA
Non-Emergency Medical Transportation

Subpopulations Excluded from Otherwise Included Populations:
- Eligible only for TB-related Services
- Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Scope of Part D Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

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
IOWA
Non-Emergency Medical Transportation

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 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: Initial Waiver Approval Date:
Statewide Not Applicable

Operating Authority: Implementation Date:
1902(a)(70) November 01, 2009

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
No None

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
Granted:
No None

Guaranteed Eligibility:
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)
KANSAS
Non-Emergency Medical Transportation (NEMT)

Subpopulations Excluded from Otherwise Included Populations:
- American Indian/Alaskan Native
- Medicare Dual Eligibles

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Lock-In Provision:
No lock-in

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Developmental Disabilities Agency
- Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medical Transportation Management Inc. (MTM)

ADDITIONAL INFORMATION

The Broker handles scheduling of NEMT transportation statewide and authorizes the least expensive and most appropriate ancillary services based on confirmed eligibility. The Broker enlists a network of transportation providers across the state to provide service utilizing sedan, lift van, and public transportation when appropriate. The Broker has internal controls, policies and procedures in place to prevent, detect, and review and report to the Medicaid state agency instances of suspected fraud and abuse by providers, subcontractors and recipients.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)

Use of Collected Data:
- Beneficiary Plan Selection
**KANSAS**  
Non-Emergency Medical Transportation (NEMT)  

**Encounter Data**  
- 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

**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

**Access/Availability of Care:**  
- Adult's access to preventive/ambulatory health services

**Health Status/Outcomes Quality:**  
- Not Applicable

**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 on beneficiary ethnicity/race  
- Information on primary languages spoken by beneficiaries

**Performance Measures - Others:**  
None
Non-Emergency Medical Transportation (NEMT)

- Percentage of beneficiaries who are auto-assigned to PAHPs

Performance Improvement Projects

**Project Requirements:**
- PAHPs are required to conduct a project(s) of their own choosing

**Clinical Topics:**
None

**Non-Clinical Topics:**
- Adults access to preventive/ambulatory health services

Standards/Accreditation

**PAHP Standards:**
- State-Developed/Specified Standards

**Accreditation Required for Participation:**
None

**Non-Duplication Based on Accreditation:**
None
# MISSISSIPPI

## Non-Emergency Transportation Broker Program

### CONTACT INFORMATION

<table>
<thead>
<tr>
<th>State Medicaid Contact:</th>
<th>Alicia Crowder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Division of Medicaid</td>
</tr>
<tr>
<td></td>
<td>(601) 359-5243</td>
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| State Website Address: | www.medicaid.ms.gov |

### PROGRAM DATA

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<tr>
<th>Program Service Area:</th>
<th>Statewide</th>
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<tr>
<td>Operating Authority:</td>
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<td>Statutes Utilized:</td>
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<tr>
<td>Enrollment Broker:</td>
<td>No</td>
</tr>
<tr>
<td>For All Areas Phased-In:</td>
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</tr>
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| 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**

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Emergency Transportation</td>
<td>-Not applicable, contractors not required to identify PCPs</td>
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</table>

#### Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
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<table>
<thead>
<tr>
<th>Populations Mandatorily Enrolled:</th>
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<tbody>
<tr>
<td>Aged and Related Populations</td>
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<tr>
<td>Foster Care Children</td>
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<tr>
<td>Medicare Dual Eligibles</td>
</tr>
<tr>
<td>Section 1931 Adults and Related Populations</td>
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<tr>
<td>Section 1931 Children and Related Populations</td>
</tr>
<tr>
<td>Special Needs Children (BBA defined)</td>
</tr>
</tbody>
</table>
### MISSISSIPPI
#### Non-Emergency Transportation Broker Program

**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

### Part D Benefit

**MCE has Medicare Contract:**
No

**Provides Part D Benefits:**
Not Applicable

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- DOES NOT coordinate with any other Agency

**Strategies Used to Identify Persons with Complex (Special) Needs:**
- DOES NOT identify members of these groups

### 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
## MISSISSIPPI
### Non-Emergency Transportation Broker Program

### Encounter Data

<table>
<thead>
<tr>
<th>Collection: Requirements:</th>
<th>Collections - Submission Specifications:</th>
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<tbody>
<tr>
<td>Requirements for PAHPs to collect and maintain encounter data</td>
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<tr>
<th>Collection: Standardized Forms:</th>
<th>Validation - Methods:</th>
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<tr>
<td>None</td>
<td>-Per member per month analysis and comparisons across PAHPs</td>
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<table>
<thead>
<tr>
<th>PAHP conducts data accuracy check(s) on specified data elements:</th>
<th>State conducts general data completeness assessments:</th>
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</thead>
</table>
| -Date of Service  
-Date of Payment  
-Provider ID  
-Type of Service  
-Medicaid Eligibility  
-Plan Enrollment | Yes |

### Standards/Accreditation

<table>
<thead>
<tr>
<th>PAHP Standards:</th>
<th>Accreditation Required for Participation:</th>
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</thead>
<tbody>
<tr>
<td>State-Developed/Specified Standards</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Duplication Based on Accreditation:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
MISSOURI
Non-Emergency Medical Transportation Program (NEMT)

CONTACT INFORMATION

State Medicaid Contact: Kristin Edwards
Department of Social Services, MO HealthNet Division
(573) 751-9290

State Website Address: http://www.dss.mo.gov

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
Statewide Not Applicable

Operating Authority: Implementation Date:
1902(a)(70) October 01, 2006

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
No None

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:
Non-Emergency Transportation -Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled: Populations Mandatorily Enrolled:
None -Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Section 1931 Adults and Related Populations
-Foster Care Children
-Section 1931 Children and Related Populations
-Medicare Dual Eligibles
-Title XXI CHIP

Lock-In Provision:
MISSOURI
Non-Emergency Medical Transportation Program (NEMT)

| -Enrolled in Another Managed Care Program | Does not apply because State only contracts with one managed care entity |
| -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 | |

Medicare Dual Eligibles Included: QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded: QMB, SLMB, QI, and QDWI

**Part D Benefit**

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
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</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
</tr>
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</table>

Scope of Part D Coverage: Not Applicable

Part D - Enhanced Alternative Coverage: Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts: None

**SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS**

Program Includes People with Complex (Special) Needs: Yes

Strategies Used to Identify Persons with Complex (Special) Needs: DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program: DOES NOT coordinate with any other Agency

**PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS**

Medical Transportation Management

**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

713
MISSOURI
Non-Emergency Medical Transportation Program (NEMT)

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

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

Validation - Methods:
- Automated analysis of encounter data submission to help determine data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
- Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments:
Yes

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

<table>
<thead>
<tr>
<th>State Medicaid Contact:</th>
<th>Greg W. Tanner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Division of Health Care Financing and Policy, Managed Care</td>
</tr>
<tr>
<td></td>
<td>(775) 684-3708</td>
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| State Website Address: | http://www.nv.gov |

### PROGRAM DATA

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<tr>
<th>Program Service Area:</th>
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<td>Statewide</td>
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<table>
<thead>
<tr>
<th>Enrollment Broker:</th>
<th>Sections of Title XIX Waived:</th>
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<tr>
<td>No</td>
<td>None</td>
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<tr>
<th>For All Areas Phased-In:</th>
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<tbody>
<tr>
<td>No</td>
<td>None</td>
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<tr>
<th>Guaranteed Eligibility:</th>
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<tbody>
<tr>
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### SERVICE DELIVERY

#### Transportation PAHP - Risk-based Capitation

**Service Delivery**

<table>
<thead>
<tr>
<th>Included Services:</th>
<th>Allowable PCPs:</th>
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<tbody>
<tr>
<td>Non-Emergency Transportation</td>
<td>-Not applicable, contractors not required to identify PCPs</td>
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#### Enrollment

<table>
<thead>
<tr>
<th>Populations Voluntarily Enrolled:</th>
<th>Populations Mandatorily Enrolled:</th>
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<tbody>
<tr>
<td>None</td>
<td>-Aged and Related Populations</td>
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<tr>
<td></td>
<td>-American Indian/Alaska Native</td>
</tr>
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<td></td>
<td>-Blind/Disabled Adults and Related Populations</td>
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<td>-Medicare Dual Eligibles</td>
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<td>-Poverty-Level Pregnant Women</td>
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<td></td>
<td>-Section 1931 Adults and Related Populations</td>
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<td>-Section 1931 Children and Related Populations</td>
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<td></td>
<td>-Special Needs Children (BBA defined)</td>
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</tbody>
</table>
NEVADA
Mandatory Non-Emergency Transportation Broker Program

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligibles

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB, SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Logisticare

ADDITIONAL INFORMATION

Non-emergency transportation program open to Medicaid eligibles on a capitated basis with the exception of Nursing Facility and Stretcher non-emergent transportation which is conducted on a fee-for-service basis.

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
### NEVADA
**Mandatory Non-Emergency Transportation Broker Program**

<table>
<thead>
<tr>
<th>Consumer Self-Report Data:</th>
<th>Use of HEDIS:</th>
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<tbody>
<tr>
<td>None</td>
<td>- The State DOES NOT use any of the HEDIS measures</td>
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<td>- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid</td>
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#### Encounter Data

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<tr>
<th>Collection: Requirements:</th>
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<tr>
<td>- Requirements for PAHPs to collect and maintain encounter data</td>
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<th>Collection: Standardized Forms:</th>
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<th>PAHP conducts data accuracy check(s) on specified data elements:</th>
<th>State conducts general data completeness assessments:</th>
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<tbody>
<tr>
<td>- Date of Service</td>
<td>Yes</td>
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<tr>
<td>- Date of Payment</td>
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<td>- Provider ID</td>
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<td>- Type of Service</td>
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<td>- Medicaid Eligibility</td>
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#### Standards/Accreditation

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<tr>
<th>PAHP Standards:</th>
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<tr>
<td>- State-Developed/Specified Standards</td>
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<tbody>
<tr>
<td>None</td>
<td>None</td>
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NEW JERSEY
Non-Emergency Transportation Broker Program

CONTACT INFORMATION

State Medicaid Contact: Richard Hurd
Office of Managed Health Care
(609) 588-2550

State Website Address: http://www.state.nj.us/humanservices/dmahs/index.h

PROGRAM DATA

Program Service Area: Initial Waiver Approval Date:
Statewide Not Applicable

Operating Authority: Implementation Date:
1902(a)(70) July 01, 2009

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
No None

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
No

Guaranteed Eligibility:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:
Non-Emergency Transportation -Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Aged and Related Populations
-American Indian/Alaska Native
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Special Needs Children (BBA defined)
-Special Needs Children (State defined)
-Title XXI CHIP
NEW JERSEY
Non-Emergency Transportation Broker Program

Subpopulations Excluded from Otherwise Included Populations:
- No populations are excluded

Lock-in Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Does NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LogistiCare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
- 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
Initial Waiver Approval Date: Not Applicable

Operating Authority: 1902(a)(70)
Implementation Date: June 01, 2009

Statutes Utilized: Not Applicable
Waiver Expiration Date: Not Applicable

Enrollment Broker: No
Sections of Title XIX Waived: None

For All Areas Phased-In: No
Sections of Title XIX Costs Not Otherwise Matchable Granted: None

Guaranteed Eligibility: None

SERVICE DELIVERY

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)
OKLAHOMA
SoonerRide

-Title XXI CHIP

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligibles
- Participate in HCBS Waiver

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

Medicare Dual Eligibles Included:
QMB Plus, SLMB Plus, and Medicaid only

Medicare Dual Eligibles Excluded:
QMB
SLMB, QI, and QDWI

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Education Agency
- Employment Agencies
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agencies
- Substance Abuse Agency
- Transportation Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

SoonerRide

ADDITIONAL INFORMATION

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 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

State conducts general data completeness assessments:
Yes
### Standards/Accreditation

<table>
<thead>
<tr>
<th>PAHP Standards:</th>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- State-Developed/Specified Standards</td>
<td>- None</td>
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**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: Initial Waiver Approval Date:
County Not Applicable

Operating Authority: Implementation Date:
1902(a)(70) November 01, 2005

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:
Non-Emergency Transportation -Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
- Aged and Related Populations
- American Indian/Alaska Native
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Foster Care Children
- Medicare Dual Eligibles
- Poverty-Level Pregnant Women
- Section 1931 Adults and Related Populations
- Section 1931 Children and Related Populations
- Special Needs Children (BBA defined)
- Special Needs Children (State defined)

Populations Mandatorily Enrolled:
None
PENNSYLVANIA
Medical Assistance Transportation Program

Subpopulations Excluded from Otherwise Included Populations:
- Reside in Nursing Facility or ICF/MR

Lock-in Provision:
No lock-in

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit

MCE has Medicare Contract:
No

Provides Part D Benefits:
Not Applicable

Scope of Part D Coverage:
Not Applicable

Part D - Enhanced Alternative Coverage:
Not Applicable

Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Logisticare Solutions, LLC

ADDITIONAL INFORMATION

The Medical Assistance Transportation Program only provides non-emergency transportation to medical assistance consumers.

Special Needs Children: (state defined) Broadly defined non-categorical to include all children. Skilled Nursing Facility is provided for the first 30 days. Transportation services only includes emergency ambulance services.

QUALITY ACTIVITIES FOR PAHP

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines
- On-Site Reviews
- Performance Measures (see below for details)
- Trip Summary Detail File

Use of Collected Data:
- Contract Standard Compliance
- Monitor Quality Improvement

Consumer Self-Report Data:
- Third Party Phone Survey

Use of HEDIS:
- The State DOES NOT use any of the HEDIS measures

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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: Initial Waiver Approval Date:  
Statewide  
Not Applicable

Operating Authority: Implementation Date:  
1902(a)(70) May 01, 2007

Statutes Utilized: Waiver Expiration Date:  
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:  
Logisticare None

MTM

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable Granted:  
No None

Guaranteed Eligibility: None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:  
Non-Emergency Transportation -Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled: Populations Mandatorily Enrolled:  
None -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)
SOUTH CAROLINA
Non-Emergency Transportation Program

Subpopulations Excluded from Otherwise Included Populations:
- No populations are excluded

Medicare Dual Eligibles Included:
Include all categories of Medicare Dual Eligibles

Medicare Dual Eligibles Excluded:
None

Part D Benefit
MCE has Medicare Contract:
No
Scope of Part D Coverage:
Not Applicable
Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:
None

Provides Part D Benefits:
Not Applicable
Part D - Enhanced Alternative Coverage:
Not Applicable

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs:
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Education Agency
- Family Connections
- Mental Health Agency
- Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS
Logisticare Medical Transportation Management (MTM)

ADDITIONAL INFORMATION

The state contracts with two transportation brokers. The Transportation brokerage services is divided into six regions: Logisticare covers 2/3 of the state and MTM covers 1/3 of the state.

Children with special health care needs are those who have a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

QUALITY ACTIVITIES FOR PAHP
## SOUTH CAROLINA
### Non-Emergency Transportation Program

<table>
<thead>
<tr>
<th>State Quality Assessment and Improvement Activities:</th>
<th>Use of Collected Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Advisory Committee</td>
<td>- Track Health Service provision</td>
</tr>
<tr>
<td>- Consumer Self-Report Data (see below for details)</td>
<td></td>
</tr>
<tr>
<td>- Encounter Data (see below for details)</td>
<td></td>
</tr>
<tr>
<td>- On-Site Reviews</td>
<td></td>
</tr>
<tr>
<td>- Performance Measures (see below for details)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consumer Self-Report Data:</th>
<th>Use of HEDIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- State-developed Survey</td>
<td>- The State DOES NOT use any of the HEDIS measures</td>
</tr>
<tr>
<td></td>
<td>- The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid</td>
</tr>
</tbody>
</table>

### Encounter Data

<table>
<thead>
<tr>
<th>Collection: Requirements:</th>
<th>Collections - Submission Specifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Specifications for the submission of encounter data to the Medicaid agency</td>
<td>- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing</td>
</tr>
<tr>
<td>- Standards to ensure complete, accurate, timely encounter data submission</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Collection: Standardized Forms:</th>
<th>Validation - Methods:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)</td>
</tr>
<tr>
<td></td>
<td>- Automated edits of key fields used for calculation (e.g. codes within an allowable range)</td>
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</table>

<table>
<thead>
<tr>
<th>PAHP conducts data accuracy check(s) on specified data elements:</th>
<th>State conducts general data completeness assessments:</th>
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</thead>
<tbody>
<tr>
<td>- Date of Service</td>
<td>Yes</td>
</tr>
<tr>
<td>- Date of Processing</td>
<td></td>
</tr>
<tr>
<td>- Date of Payment</td>
<td></td>
</tr>
<tr>
<td>- Type of Service</td>
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</tr>
<tr>
<td>- Medicaid Eligibility</td>
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### Performance Measures

<table>
<thead>
<tr>
<th>Process Quality:</th>
<th>Health Status/Outcomes Quality:</th>
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</thead>
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<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Access/Availability of Care:</th>
<th>Use of Services/Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>- Emergency room visits/1,000 beneficiary</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Health Plan Stability/ Financial/Cost of Care:</th>
<th>Health Plan/ Provider Characteristics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Beneficiary Characteristics:</th>
<th>Performance Measures - Others:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
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</tbody>
</table>

### Standards/Accreditation

730
### SOUTH CAROLINA
Non-Emergency Transportation Program

<table>
<thead>
<tr>
<th>PAHP Standards:</th>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**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: Initial Waiver Approval Date:
Statewide Not Applicable

Operating Authority: Implementation Date:
1902(a)(70) April 01, 2007

Statutes Utilized: Waiver Expiration Date:
Not Applicable Not Applicable

Enrollment Broker: Sections of Title XIX Waived:
No None

For All Areas Phased-In: Sections of Title XIX Costs Not Otherwise Matchable
No Granted:

Guaranteed Eligibility:
None

SERVICE DELIVERY

Transportation PAHP - Risk-based Capitation

Service Delivery

Included Services: Allowable PCPs:
Non-Emergency Transportation -Not applicable

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Medicare Dual Eligibles

Populations Mandatorily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Home and Community Based Waivers
-Poverty-Level Pregnant Women
-Section 1931 Adults and Related Populations
-Section 1931 Children and Related Populations
-Title XXI CHIP
**VIRGINIA**
Virginia Non-Emergency Transportation Services

<table>
<thead>
<tr>
<th>Subpopulations Excluded from Otherwise Included Populations:</th>
<th>Lock-In Provision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Enrolled in a Managed Care Program</td>
<td>No lock-in</td>
</tr>
<tr>
<td>- Medicare Dual Eligibles</td>
<td></td>
</tr>
</tbody>
</table>

**Medicare Dual Eligibles Included:**
QMB Plus, SLMB Plus, and Medicaid only

**Medicare Dual Eligibles Excluded:**
QMB SLMB, QI, and QDWI

### Part D Benefit

<table>
<thead>
<tr>
<th>MCE has Medicare Contract:</th>
<th>Provides Part D Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

**Scope of Part D Coverage:**
Not Applicable

**Part D - Enhanced Alternative Coverage:**
Not Applicable

**Coverage of Part D Excluded Drugs in Medicaid Managed Care Contracts:**
None

### SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

**Program Includes People with Complex (Special) Needs:**
Yes

**Strategies Used to Identify Persons with Complex (Special) Needs:**
- Not applicable

**Agencies with which Medicaid Coordinates the Operation of the Program:**
- Not applicable

### PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

LogistiCare Solutions

### ADDITIONAL INFORMATION

None

### QUALITY ACTIVITIES FOR PAHP

<table>
<thead>
<tr>
<th>State Quality Assessment and Improvement Activities:</th>
<th>Use of Collected Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- None</td>
<td>- Not Applicable</td>
</tr>
</tbody>
</table>

**Consumer Self-Report Data:**
None

**Use of HEDIS:**
- The State DOES NOT use any of the HEDIS measures
**VIRGINIA**

Virginia Non-Emergency Transportation Services

### Standards/Accreditation

<table>
<thead>
<tr>
<th>PAHP Standards:</th>
<th>Accreditation Required for Participation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
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</table>

**Non-Duplication Based on Accreditation:**

None
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 provide 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 |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>State Website Address:</td>
<td><a href="http://www.dhcs.ca.gov">http://www.dhcs.ca.gov</a></td>
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#### PACE Organization

<table>
<thead>
<tr>
<th>Approved PACE Organization Name:</th>
<th>AltaMed Health Services Corporation dba Altamed Senior BuenaCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Agreement Effective Date:</td>
<td>November 01, 2002</td>
</tr>
</tbody>
</table>
| PACE Contact: | Castulo de la Rocha  
2040 Camfield Avenue  
Los Angeles, CA 90040  
(323) 889-7310 |

<table>
<thead>
<tr>
<th>Approved PACE Organization Name:</th>
<th>Sutter Health Sacramento Sierra Region dba Sutter SeniorCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Agreement Effective Date:</td>
<td>November 01, 2003</td>
</tr>
</tbody>
</table>
| PACE Contact: | John Boyd  
7000 Franklin Boulevard, Suite 1020  
Sacramento, CA 95823  
(916) 386-3010 |

<table>
<thead>
<tr>
<th>Approved PACE Organization Name:</th>
<th>Coalition Center of Elders Independence dba Center for Elders Independence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Agreement Effective Date:</td>
<td>November 01, 2003</td>
</tr>
</tbody>
</table>
| PACE Contact: | Peter Szutu  
510 17th Street, Suite 400  
Oakland, CA 94612  
(510) 433-1160 x8821 |
CALIFORNIA
Program of All-inclusive Care for the Elderly (PACE)

<table>
<thead>
<tr>
<th>Approved PACE Organization Name:</th>
<th>Community Eldercare of San Diego dba St. Pauls PACE</th>
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</thead>
<tbody>
<tr>
<td>Program Agreement Effective Date:</td>
<td>February 01, 2008</td>
</tr>
<tr>
<td>PACE Contact:</td>
<td>Cheryl Wilson</td>
</tr>
<tr>
<td></td>
<td>328 Maple Street</td>
</tr>
<tr>
<td></td>
<td>San Diego, CA 92103</td>
</tr>
<tr>
<td></td>
<td>(619) 239-6900</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Approved PACE Organization Name:</th>
<th>On Lok Senior Health Services dba On Lok Lifeways</th>
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<tbody>
<tr>
<td>Program Agreement Effective Date:</td>
<td>November 01, 2003</td>
</tr>
<tr>
<td>PACE Contact:</td>
<td>Robert Edmondson</td>
</tr>
<tr>
<td></td>
<td>1333 Bush Street</td>
</tr>
<tr>
<td></td>
<td>San Francisco, CA 94109</td>
</tr>
<tr>
<td></td>
<td>(415) 292-8888</td>
</tr>
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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 Ulrich
Contract Manager
Department of Health Care Policy and Financing
(303)866-2148

State Website Address: http://www.colorado.gov/hcpf

PACE Organization

Approved PACE Organization Name: Total Long Term Care
Program Agreement Effective Date: April 01, 2003
PACE Contact: Maureen Hewitt
8950 E. Lowry Boulevard
Denver, CO 802030
(303) 869-4664

Approved PACE Organization Name: VOANS PACE, Inc
Program Agreement Effective Date: August 01, 2008
PACE Contact: Craig Ammermann
2377 Robins Way
Montrose, CO 81401
(970) 252-0522

Approved PACE Organization Name: Rocky Mountain PACE
Program Agreement Effective Date: December 01, 2008
PACE Contact: Laurie Tebo
2335 Robinson Street
Colorado Springs, CO 80904
(719) 457-0660 ext 1

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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
Medical Health Care Program Analyst
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: Sandy Stewart
5200 Northeast 2nd Avenue
Miami, FL 33137
(305) 795-8410 Ext.

Approved PACE Organization Name: Hope PACE
Program Agreement Effective Date: March 01, 2008
PACE Contact: Mary Curtis
2668 Winkler Avenue
Fort Myers, FL 33901
(239) 985-6400

Approved PACE Organization Name: Neighborly PACE
Program Agreement Effective Date: September 01, 2009
PACE Contact: Betty Oldanie
5771 Roosevelt Blvd
Clearwater, FL 33760
(727) 573-2116

ADDITIONAL INFORMATION

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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

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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KANSAS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact: Tracy Conklin
Manager
Division of Health Care Policy
(785) 296-7788

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

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: July 01, 2008
PACE Contact: Stephanie Smith
4201 N. Rampert
New Orlean, LA 70117
(504) 945-1531

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.state.md.us

PACE Organization

Approved PACE Organization Name:
Hopkins Elder Plus

Program Agreement Effective Date:
November 01, 2002

PACE Contact:
Karen Armacost
4940 Eastern Ave.
Baltimore, MD 21224
410-550-7044

ADDITIONAL INFORMATION

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MASSACHUSETTS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact: Robert Holmes
Commonwealth of Massachusetts
Office of Elder Affairs
(617) 222-7750

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: Upham's Elder Service Plan
Program Agreement Effective Date: November 01, 2002
PACE Contact: Jay Trivedi
1140 Dorchester Ave
Dorchester, MA 02125
(617) 288-0970
MASSACHUSETTS
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Elder Service 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

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

ADDITIONAL INFORMATION

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### CONTACT INFORMATION

**State Medicaid Contact:**
- Peggy Peckham  
  Medicaid Services Administrator  
  Department of Community Health  
  (517) 335-5202

**State Website Address:**
- http://www.michigan.gov/mdch

### PACE Organization

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<th>Approved PACE Organization Name:</th>
<th>Henry Ford Health System Center for Senior Independence</th>
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| PACE Contact:  
  Michael Carson  
  7800 W. Outer Drive, Suite 240  
  Detroit, MI 48255  
  (313) 543-6320 | |

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| PACE Contact:  
  Tom Muszynski, Executive Director  
  1471 Grace Street, SE  
  Grand Rapids, MI 49506  
  (616) 913-2006 | |

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| PACE Contact:  
  Robert Mills, Executive Director  
  560 Seminole Road  
  Muskegon, MI 49444  
  (231) 733-8686 | |
MICHIGAN  
Program of All-Inclusive Care for the Elderly (PACE)  

**Approved PACE Organization Name:** Comprehensive Senior Care Corporation  

**Program Agreement Effective Date:** April 01, 2009  

**PACE Contact:** Rod Auton, Executive Director  
200 W. Michigan Ave Ste 103  
Battle Creek, MI 49017  
(269) 441-9300  

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**ADDITIONAL INFORMATION**  

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MISSOURI
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact: Shelley Farris
Operations Manager - MO HealthNet Managed Care
Department of Social Services, MO HealthNet Division
(573) 526-4274

State Website Address: http://www.dss.mo.gov

PACE Organization

Approved PACE Organization Name: Alexian Brothers Community Services

Program Agreement Effective Date: November 01, 2001

PACE Contact: Mel Causey
3900 South Grand
St. Louis, MO 63118
(314) 771-5800 x127

ADDITIONAL INFORMATION

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NEW JERSEY
Program of All-inclusive Care for the Eldelry (PACE)

CONTACT INFORMATION

State Medicaid Contact: Paul Sullivan
County Liaison
NJ Department of Health and Senior Services
(609) 292-0217

State Website Address: http://www.state.nj.us/health/senior/pace.shtml

PACE Organization

Approved PACE Organization Name: LIFE at Lourdes
Program Agreement Effective Date: May 01, 2009
PACE Contact: Margaret Sullivan
2475 McClellan Avenue
Pennsauken, NJ 08109
(856) 675-3663

Approved PACE Organization Name: LIFE St. Francis
Program Agreement Effective Date: April 01, 2009
PACE Contact: Jill Viggiano
1435 Liberty Street
Hamilton, NJ 08629
(609) 475-4701

Approved PACE Organization Name: Lutheran Senior Life
Program Agreement Effective Date: July 01, 2010
PACE Contact: Beth Eichfeld
377 Jersey Avenue, 3rd floor
Jersey City, NJ 07302
(201) 706-2091

ADDITIONAL INFORMATION

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NEW JERSEY
Program of All-inclusive Care for the Eldelry (PACE)

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NEW MEXICO
Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact: Victoria Parrill
Healthcare Operations Manager
NM HSD/Medical Assistance Division
(505) 476-7257

State Website Address: http://www.state.nm.us/hsd/mad/Index.html

PACE Organization

Approved PACE Organization Name: Total Community Care
Program Agreement Effective Date: July 01, 2004
PACE Contact: Maria Zemora-Hughes
904 A los Lomas NE
Albuquerque, NM 87102
(505)924-2606

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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# NEW YORK

**Program of All-inclusive Care for the Elderly (PACE)**

## CONTACT INFORMATION

| State Medicaid Contact: | Linda Gowdy  
Director, Bureau of Continuing Care Initiatives  
Division of Long Term Care  
(518) 474-6965 |
<table>
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<tr>
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<tr>
<td>State Website Address:</td>
<td><a href="http://www.nyhealth.gov">http://www.nyhealth.gov</a></td>
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## PACE Organization

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<th>Approved PACE Organization Name:</th>
<th>Independent Living for Seniors, Inc.</th>
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<tr>
<td>Program Agreement Effective Date:</td>
<td>November 01, 2003</td>
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| PACE Contact: | Kathryn McGuire  
2066 Hudson Ave.  
Rochester, NY 14617  
(585) 922-2800 |

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<tr>
<th>Approved PACE Organization Name:</th>
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<tbody>
<tr>
<td>Program Agreement Effective Date:</td>
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| PACE Contact: | Penny Abulencia  
100 Malta Lane  
North Syracuse, NY 13212  
(315) 452-5800 |

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<tr>
<th>Approved PACE Organization Name:</th>
<th>Eddy Senior Care</th>
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<td>Program Agreement Effective Date:</td>
<td>November 01, 2002</td>
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</table>
| PACE Contact: | Bernadette Hallam  
504 State Street  
Schenectady, NY 12305  
(518) 382-3290 |
NEW YORK
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Comprehensive Care Management (CCM)
Program Agreement Effective Date: November 01, 2003
PACE Contact: Joseph Healy, Jr
1250 Waters Place, 6th floor
Bronx, NY 10467
(347) 640-6020

Approved PACE Organization Name: Total Senior Care
Program Agreement Effective Date: October 01, 2008
PACE Contact: Carol Mahoney
1225 West State St.
Olean, NY 14760
(716) 372-2106

Approved PACE Organization Name: ArchCare Senior Life
Program Agreement Effective Date: September 01, 2009
PACE Contact: Marcia Konrad
1432 Fifth Avenue
New York, NY 10026
(646) 289-7722

Approved PACE Organization Name: Catholic Health - LIFE
Program Agreement Effective Date: September 01, 2009
PACE Contact: Thomas Schifferli
55 Melroy Avenue
Lackawanna, NY 14218
(716) 819-5102

ADDITIONAL INFORMATION

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NEW YORK
Program of All-inclusive Care for the Elderly (PACE)

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### NORTH CAROLINA
Program of All-inclusive Care for the Eldelry (PACE)

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## CONTACT INFORMATION

<table>
<thead>
<tr>
<th>State Medicaid Contact</th>
<th>Joseph Breen</th>
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<tbody>
<tr>
<td></td>
<td>Section Chief, Home and Community Care</td>
</tr>
<tr>
<td></td>
<td>North Carolina Department of Health and Human Services</td>
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<td></td>
<td>(919) 855-4365</td>
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| State Website Address | http://www.ncdhhs.gov/dma/ |

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### PACE Organization

<table>
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</tr>
<tr>
<td>PACE Contact</td>
<td>Marianne Ratcliff</td>
</tr>
<tr>
<td></td>
<td>1214 Vaughn Road, P.O. Box 1033</td>
</tr>
<tr>
<td></td>
<td>Burlington, NC 27217</td>
</tr>
<tr>
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<td>(336) 532-0000</td>
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</tr>
<tr>
<td>PACE Contact</td>
<td>Larry Reinhart</td>
</tr>
<tr>
<td></td>
<td>2222 South 17th Street</td>
</tr>
<tr>
<td></td>
<td>Wilmington, NC 28401</td>
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<td>(910) 343-8209</td>
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<th>Approved PACE Organization Name</th>
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<td>PACE Contact</td>
<td>Ursula Robinson</td>
</tr>
<tr>
<td></td>
<td>1471 E. Cone Blvd.</td>
</tr>
<tr>
<td></td>
<td>Greensboro, NC 27405</td>
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<td>(336) 550-4040</td>
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NORTH DAKOTA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact: Tania Hellman
Administrator, Managed Care
Department of Human Services Medical Services Division
(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

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provides pre-paid, capitated, comprehensive health care services to frail elders.

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OHIO
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact: Matthew Hobbs, Aging Policy
Bureau of Long Term Care Services and Supports
Ohio Department of Job and Family Services
(614) 752-3553

State Website Address: http://jfs.ohio.gov/OHP/index.stm

PACE Organization

Approved PACE Organization Name: 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: December 01, 2002
PACE Contact: Brett Kirkpatrick
619 Oak Street
Cincinnati, OH 45206
(513) 569-6673

ADDITIONAL INFORMATION

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OKLAHOMA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact: Ashley Herron
Pace Research Analyst
Oklahoma Health Care Authority
(405) 522-7902

State Website Address: http://www.okhca.org

PACE Organization

Approved PACE Organization Name: Cherokee Elder Care
Program Agreement Effective Date: August 01, 2008
PACE Contact: Rick Richards
1387 W. 4th Street
Tahlequah, OK 74464
(918)453-5554

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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OREGON
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact: Mike McCormick
Deputy Director
APD, Department of Human Services
(503) 945-6229

State Website Address: http://www.dhs.state.or.us

PACE Organization

Approved PACE Organization Name: Providence Elder Place

Program Agreement Effective Date: November 01, 2003

PACE Contact:
Ellen Garcia
4531 SE Belmont, Suite 100
Portland, OR 97215
(503) 215-3612

ADDITIONAL INFORMATION

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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## Program of All-inclusive Care for the Elderly (PACE)

### CONTACT INFORMATION

**State Medicaid Contact:**
Randy Nolen  
Director, Division of Field Operations  
PA Department of Public Welfare, Office of Long Term Living  
(717) 772-2543

**State Website Address:**  
http://www.state.pa.us

### PACE Organization

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| PACE Contact: | Terry Shade  
840 5th Avenue  
Chambersburg, PA 17201  
717) 264-8178 |

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| PACE Contact: | Mark Irwin  
401 South Broad Street, Suite 100  
Johnstown, PA 15905  
814) 535-6000 |

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| PACE Contact: | Mary Austin  
6970 Germantown Avenue  
Philadelphia, PA 19119  
215) 951-4405 |
## PENNSYLVANIA
### Program of All-inclusive Care for the Elderly (PACE)

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<tr>
<td>PACE Contact:</td>
<td>John Paul Marosy</td>
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<tr>
<td></td>
<td>2045 Westgate Drive, Suite 100</td>
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<td>Bethlehem, PA 18017</td>
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<td>Emily Amerman</td>
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<td>Trevose, PA 19053</td>
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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
## Approved PACE Organization Name:

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## PACE Contact:

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<tr>
<th>Contact</th>
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<tbody>
<tr>
<td>Lou Ann Shively</td>
<td>90 Maplewood Drive, Lewisburg, PA 17837</td>
<td>(570) 522-2853</td>
</tr>
<tr>
<td>Daniel Drake</td>
<td>4508 Chestnut Street, Philadelphia, PA 19139</td>
<td>(215) 573-7200</td>
</tr>
<tr>
<td>Joann Gago</td>
<td>875 Greentree Road, Suite 200, One Parkway Center, Pittsburgh, PA 15220</td>
<td>(412) 388-8042</td>
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<tr>
<td>Robert McQuillan</td>
<td>100 North Academy Avenue, Danville, PA 17822</td>
<td>(570) 271-5531</td>
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</tbody>
</table>
PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: LIFE at Home
Program Agreement Effective Date: July 01, 2007
PACE Contact: Jonathan Aistrop
1100 Spruce Street
Kulpmont, PA 17834
570) 373-2100

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provide pre-paid, capitated, comprehensive health care services to frail elders.

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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
Institutional/Comm 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: Cindy Pedersen
Pace Program Administrator
South Carolina Dept of Health and Human Services
(803) 898-2033

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: Carolyn Fulghum  
Director of Quality and Administration  
TennCare  
(615) 507-6671

State Website Address: http://www.tn.gov/tenncare

PACE Organization

Approved PACE Organization Name: Alexian Brothers Community Services

Program Agreement Effective Date: November 01, 2002

PACE Contact:  
Viston Taylor  
425 Cumberland Street Suite 110  
Chattanooga, TN 37404  
(423) 698-0802

ADDITIONAL INFORMATION

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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: La Paloma
Program Agreement Effective Date: May 01, 2010
PACE Contact: Annette Gary
4010 22nd Street
Lubbock, TX 79410
(806) 740-1500

Approved PACE Organization Name: The Basics at Jan Werner
Program Agreement Effective Date: March 01, 2004
PACE Contact: Krissy Jones
3108 South Fillmore
Amarillo, TX 79110
(806) 374-5516

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VERMONT
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact: Kathy Rainville
Aging and Disability Program Supervisor
Department of Disabilities, Aging, and Independent Living
(802) 786-5052

State Website Address: http://dail.vermont.gov

PACE Organization

Approved PACE Organization Name: PACE Vermont

Program Agreement Effective Date: March 01, 2007

PACE Contact: Sharon Essi
786 College Parkway
Colchester, VT 05446
(802) 655-6700

ADDITIONAL INFORMATION

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## 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

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| **PACE Contact:** | Bruce Robertson  
251 Newtown Road  
Norfolk, VA 23502  
(757) 892-5400 |

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| **PACE Contact:** | Tony Lawson  
P.O. Box 888  
Big Stone Gap, VA 24219  
(276) 523-0599 |

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| **PACE Contact:** | Dana Collins  
P.O. Box 765  
Cedar Bluff, VA 24609  
(276) 964-4915 |
Approved PACE Organization Name: Centra
Program Agreement Effective Date: February 01, 2009
PACE Contact: Debra Maddox
407 Federal Street
Lynchburg, VA 24501
(434) 200-6516

Approved PACE Organization Name: Riverside PACE
Program Agreement Effective Date: February 01, 2008
PACE Contact: Stacy Brinkley
1300 MacTavish Ave
Richmond, VA 23230
(804) 977-5900

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.

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.
**Wisconsin**

Program of All-inclusive Care for the Elderly (PACE)

### Contact Information

**State Medicaid Contact:**
Dana Badger  
Contract Administrator  
Wisconsin Department of Health Services  
(608) 261-6751

**State Website Address:**
http://dhs.wisconsin.gov

### PACE Organization

**Approved PACE Organization Name:**  
Community Care Organization

**Program Agreement Effective Date:**  
November 01, 2003

**PACE Contact:**
Kirby Shoaf  
1555 South Layton Boulevard  
Milwaukee, WI 53215  
(414) 385-6600

### Additional Information

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provide prepaid, capitated, comprehensive health care services to frail elders.

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Arkansas
- SafetyNet Benefit Program, 1115 program is now Connectcare.

California
- Effective November 1, 2010 CMS approved “California's Bridge to Reform” section 1115 Medicaid Demonstration waiver. As part of the demonstration waiver the State incorporated 4 out of their 5 1915(b) waivers into the 1115. These 4 former 1915(b) waivers that now have authority through the 1115 were the: 1) Health Plan San Mateo Waiver, 2) Santa Barbara San Lois Obispo Waiver, 3) Health Insuring Organizations Waiver, and 4) Two Plan/Geographic Managed Care (formerly California Children Services/Sacramento Dental Geographic Managed Care) Waiver. The “Bridge to Reform” Demonstration also gave authority to the State to expand coverage to eligible low income adults through the Low Income Health Program (LIHP). LIHP is an optional, county-based program. There were 10 LIHPs offering coverage for residents up to 200% of the federal poverty level as of July 1, 2011. The program summary has been reformatted from the 2010 report to reflect the elimination of the four 1915(b) waivers and the creation of the LIHPs. The 1115 Demonstration Waiver has managed care model subsections since each model type has different service delivery requirements, plans, and quality standards.

Colorado
- Accountable Care Collaborative (ACC) Program is a new 1932(a) program.

District of Columbia
- Childless Adults 1115 Demonstration is a new program.
- Health Services for Children with Special Needs program, 1915(a) program is now Children and Adolescent Supplemental Security Income Program.

Hawaii
- The PACE program was terminated.

Idaho
- Non-Emergency Transportation (NEMT) is a new 1902(a)(70) program.

Illinois
- Integrated Care Program is a new 1932(a) is a new program.

Indiana
- Care Select program (PCCM) has converted from a 1915(b) to a 1932(a).

Iowa
- Non-Emergency Transportation (NEMT) is a new program operating under waiver authority 1902(a)(70).

Kentucky
- KY's Human Service Transportation Delivery Program and plan was converted from 1902(a)(70) to a 1915(b) program.

Minnesota
- Minnesota Disability Health Options (MNDHO), 1915(a) program was terminated.

Mississippi
- MississippiCan is a new 1932(a)/1915(c) program.

Montana
- The PACE program was terminated.
Nebraska
- The Nebraska Medicaid Medical Home Pilot is a new program operating under waiver authority 1932(a).
- The Nebraska Health Connection Combined Waiver – 1915(b) and the Nebraska Health Connection Combined Waiver – 1932(a) both discontinued their PCCM portion.

New York
- The Partnership Plan – Family Health Plus, 1115 program’s PPO managed care entity type no longer operates under this program.

North Carolina
- Mental Health Developmental Disabilities & Substance Abuse Waiver, 1915b/c is now Mental Health Developmental Disabilities & Substance Abuse Services Health Plan.

Puerto Rico
- Puerto Rico Health Care Plan, 1915(a) program was changed to Mi Salud.

Rhode Island
- Global Consumer Choice Compact, 1115, is now reported as Rite Care. Effective January 16, 2009 RI Global Consumer Choice Compact 1115 Demonstration encompasses almost the entire RI Medicaid Program. It includes Connect Care Choice, Rhody Health Partners, Rite Smiles, and Rite Care.

Texas
- Texas Medicaid Enhanced Care Program, 1915(b) program was terminated and replaced by Texas Medicaid Wellness Program, 1915(b) program.
- The Non-Emergency Transportation program was operating under the 1915(4) and the reimbursement arrangement was fee-for-service. The program started a pilot to use two full-risk brokers for two service areas operating under 1902(a)(70).

Washington
- The Chronic Care Management Program (ADSA) is a new 1937 program.
- Bridge to Reform: The Basic Health Plan demonstration program is a new 1115(a) program.
- Bridge to Reform: Medical Care Services demonstration program is a new 1115(a) program.
National Summary of State Medicaid Managed Care Programs
Glossary as of July 1, 2011

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
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-For-Service</td>
<td>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.</td>
</tr>
<tr>
<td>Risk-based Capitation</td>
<td>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.)</td>
</tr>
<tr>
<td>Non-risk Capitation</td>
<td>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.</td>
</tr>
<tr>
<td>Accreditation for Deeming</td>
<td>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 &quot;deemed compliance&quot; with a standard.</td>
</tr>
<tr>
<td>Accreditation for Participation</td>
<td>State requirement that plans must be accredited to participate in the Medicaid managed care program.</td>
</tr>
<tr>
<td>Consumer Self-Report Data</td>
<td>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.</td>
</tr>
<tr>
<td>Encounter Data</td>
<td>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 &quot;shadow claims&quot;.</td>
</tr>
<tr>
<td>Enrollee Hotlines</td>
<td>Toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they need assistance.</td>
</tr>
</tbody>
</table>
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
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.