

**2011 NATIONAL SUMMARY DATA DICTIONARY
FOR THE
MEDICAID MANAGED CARE DATA COLLECTION SYSTEM
(MMDCS)**

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID, CHIP, AND SURVEY & CERTIFICATION
DATA AND SYSTEMS GROUP
DIVISION OF INFORMATION, ANALYSIS, AND TECHNICAL ASSISTANCE
2011 MEDICAID MANAGED CARE DATA COLLECTION

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I. CATEGORY: PROGRAM IMPACT

DATA ELEMENT: STATE NAME

Definition:

The name of the State that operates the program.

Valid Choices:

List of all states, territories and the District of Columbia (alpha order).

Edit Conditions:

1. Must select one valid choice.
2. May only select one valid choice.

DATA ELEMENT: PROGRAM NAME

Definition:

The name of the Medicaid Managed Care Program. Please use the name that would most clearly distinguish the program from any others in the State (i.e. the name used for any waiver approval). Report all programs that

- operate under Section 1915(b) authority,
- are comprehensive statewide health care reform demonstrations operating under section 1115,
- operate under Section 1932(a) authority,
- operate under Section 1915(a) as a voluntary managed care program,
- have an approved Section 1915(b) waiver operating concurrently with an approved Section 1915(c) waiver,
- operate under Section 1915(a) concurrently with an approved Section 1915(c) waiver
- operate under Section 1932(a) State plan option concurrently with an approved Section 1915(c) waiver
- operate a Program of All-inclusive Care for the Elderly (PACE) under the authority of sections 1894 and 1934 of the Social Security Act,
- operate under Section 1905(t) of the Act for voluntary PCCM programs.
- operate under Section 1937 Benchmark Benefit Program.
- operate under Section 1902(a)(70) of the Act for non-emergency medical transportation program.

Report programs for which a signed agreement exists between the State and the plan or provider as of DATA COLLECTION EFFECTIVE DATE. For purposes of this survey, a program may include capitated and Primary Care Case Management (PCCM) elements, as well as comprehensive and non-comprehensive contracts (carve-out). **Programs may operate under more than one authority but States should report the authorities separately.** For example, if a state has an 1115 demonstration program that includes both PCCM and comprehensive managed care organization (MCO) elements, that program may be reported as one program. But if a PCCM program operates under a 1915(b) waiver and the comprehensive MCOs operate under an 1115 demonstration program, then they must be reported as separate programs. States **should not report** non-comprehensive section 1115(a), (e.g. family planning and pharmacy). All text should be spelled out completely; no abbreviations should be used.

Valid Choices:

Text box:

Provide a text box with the statement: "Please enter the name of the managed care program in initial capital format. Do not use abbreviations."

Edit Conditions:

1. All text should be spelled out completely; no abbreviations should be used.
2. Field must be completed.

3. Allow an entry of up to 100 characters.

DATA ELEMENT: STATE WEBSITE ADDRESS

Definition:

The website address of the state Medicaid agency.

Valid Choices:

Text box:

Provide a text box with the statement "Please enter the State Medicaid agency's website address in the format: http://...."

Edit Conditions:

1. May be left blank.
2. If entry is made it must be in format: http//.....
3. Allow an entry of up to 50 characters.

DATA ELEMENT: STATE MEDICAID AGENCY CONTACT

Definition:

Name, title, organization, and 10-digit telephone number of State Medicaid person responsible for the **Medicaid program**. All text should be spelled out completely; no abbreviations should be used; enter text in initial capital format. **(This information will be published.)**

Valid Choices:

Provide text boxes for entering the following information:

- Text box 1. Last Name of State Medicaid Contact Person
- Text box 2. First Name of State Medicaid Contact Person
- Text box 3. Title of State Medicaid Contact Person
- Text box 4. Organization of State Medicaid Contact Person
- Text box 5. State Medicaid Contact Telephone Number, in the format, (XXX) XXX-XXXX x
XXXX

Edit Conditions:

1. Text boxes 1-5 must be completed.
2. 10-Digit telephone number must be entered in the specified format, area code in parentheses. 4-Digit extension is optional.
3. All text must be spelled out completely; no abbreviations may be used; text must be entered in initial capital format.
4. Allow up to 30 characters for Text box 1, up to 20 characters for Text box 2, 50 characters for Text box 3, and 50 characters for Text box 4.

DATA ELEMENT: PROGRAM SERVICE AREA

Definition:

The geographic area served by the program may be Statewide, or if less than Statewide, may be defined by County, City, Region, or other type of geographic area. This element asks States to report how they define the program (not the individual plan or Primary Care Case Management (PCCM) provider service area) as of DATA COLLECTION EFFECTIVE DATE.

- A program's service area is **Statewide**, if the program operates throughout the entire State.
- A program's service area is defined by **County**, if the program serves a county or several counties within the State. If the program serves all counties in a State, then report the program as Statewide.
- A program's service area is defined by **City**, if the program serves a city or several cities within the State.
- A program's service area is defined by **Region**, if the program serves a region or regions not defined by individual counties within the State.

Valid Choices:

1. Statewide
2. County
3. City
4. Region
5. Other

Text box:

If "5" is selected, provide a text box with the statement "Please describe Other; do not use abbreviations; enter the text in initial capital format. If more than one Other, click "Enter" between entries".

Edit Conditions:

1. Must select one valid choice.
2. May select more than one valid choice.
3. If "5" is selected, must complete text box. Allow up to 40 characters per entry.

DATA ELEMENT: OPERATING AUTHORITY

Definition:

Enter the Authority under which the program is operating.

Valid Choices:

1. **1915(b) waiver program** – waivers of most provisions of Section 1902 of the Social Security Act in order to limit beneficiaries' freedom of choice of provider; selectively contract with providers; or provide additional services to beneficiaries (State may include BBA special populations).
2. **1115 demonstration waiver program** – demonstration projects under which most provisions of Section 1902 of the Social Security Act are waived and/or expenditures that would not otherwise be eligible for FFP are authorized. States use these to expand eligibility, restructure Medicaid coverage and secure programmatic flexibility.
3. **1932(a) state plan option to use a managed care delivery system** – mandatory managed care programs implemented through the State plan (State must exclude or permit voluntary enrollment of specific populations)
4. **1915(a) voluntary managed care program** – a MCO, PIHP, or PAHP managed care program in which enrollment is voluntary and therefore does not require a waiver.
5. **Concurrent 1915(b)/1915(c) waivers** – programs that provide home and community-based services under 1915(c) waiver authority coupled with 1915(b) authority to mandate a managed care delivery system.
6. **Concurrent 1915(a)/1915(c) waivers** - programs that provide home and community-based services under 1915(c) waiver authority coupled with 1915(a) authority to provide a voluntary managed care delivery system.
7. **Concurrent 1932(a)/1915(c) waivers** - programs that provide home and community-based services under 1915(c) waiver authority coupled with 1932(a) State plan authority to mandate a managed care delivery system (except for specific populations).
8. **PACE** – program that provides pre-paid, capitated comprehensive, health care services to the frail elderly.
9. **1905(t) voluntary PCCM program** – A PCCM managed care program in which enrollment is voluntary and therefore does not require a waiver.
10. **1937 benchmark benefit program**—programs to provide benefits that differ from Medicaid state plan benefits using managed care and implemented through the State plan.

11. **1902(a)(70) non-emergency medical transportation program** –non-emergency medical transportation brokerage programs implemented through the state plan which can vary scope of services, operate on a less-than-statewide basis, and limit freedom of choice.

Edit Conditions:

1. May only select one valid choice.
2. Must select one valid choice.
3. If “5, 6 or 7” is selected, must complete “Concurrent Operating 1915(c) Program” section.
4. If “8” is selected, must complete “PACE Program” section.
5. If “9” is selected, must select “PCCM Provider” for Managed Care Entity type.
6. If “11” is selected, must select “Transportation PAHP” for Managed Care Entity type.

DATA ELEMENT: 1915(b) AUTHORITY USED

Definition:

Select the specific 1915(b) authority(s) used:

- **1915(b)(1), Freedom of Choice** --States may require beneficiaries to obtain services from specific providers.
- **1915(b)(2), Locality as Central Broker**--Localities may assist beneficiaries in selecting a primary care provider.
- **1915(b)(3), Sharing of Cost Savings**--States may share savings, in the form of additional services, with beneficiaries.
- **1915(b)(4), Selective Contracting**--States may limit the number of providers that are contracted with the State to provide services (i.e. selective contracting)

Valid Choices:

1. 1915(b)(1), Freedom of Choice
2. 1915(b)(2), Locality as Central Broker
3. 1915(b)(3), Sharing of Cost Savings
4. 1915(b)(4), Selective Contracting

Edit Conditions:

1. Skip, if OPERATING AUTHORITY is not "1915(b)".
2. At least one valid choice must be selected, if OPERATING AUTHORITY is "1915(b)".
3. May select more than one valid choice.
4. Must select "1" if ENROLLMENT BASIS for POPULATION INCLUDED "Foster Care Children" is mandatory and OPERATING AUTHORITY is "1915(b)".
5. Must select "1" if "Blind/Disabled Children and Related" or "Aged and Related" is mandatory and POPULATION CATEGORIES EXCLUDED does not include "Dual Eligibles" and OPERATING AUTHORITY is "1915(b)".
6. Must select "1" if MANAGED CARE ENTITY TYPE is "PCCM" and OPERATING AUTHORITY is "1915(b)".

DATA ELEMENT: 1915(b)(4) WAIVER AUTHORITY

Definition: A state may obtain a 1915(b)(4) waiver to use selective contracting in selecting the most cost effective and efficient providers of services. It may be used to selectively contract with fee-for-service providers, (e.g. inpatient hospital services, drugs, transportation). For example, States may decide to selectively contract only with certain hospitals in a specified area. These programs differ from other 1915(b) waiver programs in that they have no formal enrollment process and the state contracts with a provider that is not a managed care entity. 1915(b)(4) authority may also be used in voluntary or mandatory managed care programs to selectively contract with MCOs, PIHPs, PAHPs or PCCMs.

Valid Choices:

1. Uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement. Do not choose this option for any type of MCO, PIHP, PAHP, or PCCM program.
2. Uses 1915(b)(4) in conjunction with managed care programs (includes voluntary and mandatory MCO, PIHP, PAHP, and PCCM programs).

Text Box:

If “1” is selected, provide a text box with the statement: “Please describe reimbursement arrangement waiver”.

Edit Conditions:

1. Must complete, if 1915(b) AUTHORITY USED only includes 1915(b)(4).
2. Skip the Quality Section, if “1” is selected.
3. One valid choice must be selected, if 1915(b) AUTHORITY USED includes “1915(b)(4)”.
4. May only select one valid choice.
5. If “1” is selected, an entry must be made in the text box. This information will appear in the UNIQUE CIRCUMSTANCES box in the format: The reimbursement arrangement waiver is described as: (Text box entry).
6. If “1” is selected, the state must complete only the following DATA ELEMENTs (after this element): INITIAL WAIVER APPROVAL DATE, IMPLEMENTATION DATE, WAIVER EXPIRATION DATE, STATUTES WAIVED, and UNIQUE CIRCUMSTANCES. All other subsequent elements **must** be skipped.

DATA ELEMENT: INITIAL WAIVER APPROVAL DATE

Definition:

Date the federal waiver under which the program operates was initially approved. If the program converted to another operating authority, the initial waiver approval date should reflect the new authority approval date.

Valid Choices:

Numeric Field

8-digit waiver approval date in format MM/DD/YYYY

Edit Conditions:

1. Skip if OPERATING AUTHORITY is "1932(a)", "1915(a)", "PACE", "1905(t)", "1937", "1902(a)(70)".
2. Must complete if OPERATING AUTHORITY is "1115", "1915(b)", "1915(b)/(c)", "1915(a)/(c)" or "1932(a)/(c)".
3. Enter 8-digit waiver approval date: 2-digit Month, 2-digit Day, 4-digit Year of the program.
4. Do not accept dates after DATA COLLECTION DATE.

DATA ELEMENT: IMPLEMENTATION DATE

Definition:

Effective date of the first enrollment into the program. (Not the date the waiver or SPA was approved.) If the program converted to another operating authority, the effective date should reflect the date the program was effective under the new authority.

Valid Choices:

Numeric Field

8-Digit implementation date in the format MM/DD/YYYY

Edit Conditions:

1. Enter 8-digit implementation date: 2-digit Month, 2-digit Day, 4-digit Year.
2. Do not accept years prior to 1972 (1972 is acceptable).
3. An entry must be made.

DATA ELEMENT: WAIVER EXPIRATION DATE

Definition:

Date the current federal waiver authority (including temporary waiver extensions), under which the program operates, expires.

Valid Choices:

Numeric Field

8-digit expiration date in format MM/DD/YYYY

Edit Conditions:

1. Skip if OPERATING AUTHORITY is "1932(a)", "1915(a)", "PACE", "1905(t)", "1937", "1902(a)(70)".
2. Must complete if OPERATING AUTHORITY is "1115", "1915(b)", "1915(b)/(c)", "1915(a)/(c)" or "1932(a)/(c)".
3. Enter 8-digit expiration date: 2-digit Month, 2-digit Day, 4-digit Year of the program.
4. Do not accept dates prior to DATA COLLECTION DATE.

DATA ELEMENT: SECTIONS OF TITLE XIX WAIVED

Definition:

Programs that operate under a waiver frequently request the waiver of one or more provisions of Section 1902 of the Social Security Act under 1915(b), 1915(c) or 1115 authority. In this DATA ELEMENT, States should specify which of these provisions have been waived for the program.

- **1902(a)(1) Statewideness**--This section of the Social Security 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)(4) Proper and Efficient Administration of the State Plan** --This section of the Social Security Act requires a Medicaid state plan to be administered effectively. This provision has been used to authorize the application of managed care rules to prepaid health plans (PIHPs/PAHPs). A waiver of this provision can be used to:
 - Require Medicaid beneficiaries to receive services from only one PIHP or PAHP
 - Target the Medicaid Eligibility and Quality Control Program to specific populations and/or topics; and
 - Limit transportation services.
- **1902(a)(10)(B) Amount, Duration and Scope of Services**--This section of the Social Security Act requires Medicaid State 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 different from those offered to beneficiaries not enrolled in the program.
- **1902(a)14) Cost-Sharing Requirements**-- This section of the Social Security Act requires a Medicaid state plan to limit Medicaid beneficiary cost-sharing under Section 1916 of the Act. A waiver of 1902(a)(14) permits States to charge higher premiums, enrollment fees, and co-payments to Medicaid beneficiaries.
- **1902(a)(17) Financial Eligibility Standards** -This section of the Social Security Act requires Medicaid State plans to determine eligibility using specific criteria. Waiving 1902(a)(17) indicates that the State is using different criteria to make Medicaid eligibility determinations.
- **1902(a)(23) Freedom of Choice**--This section of the Social Security Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. By waiving 1902(a)(23), free choice of providers is restricted.
- **1902(a)(34) Retroactive Eligibility** - This section of the Social Security Act requires Medicaid State plans to provide up to three months of retroactive eligibility from the date of an individual's application for Medicaid coverage. By waiving 1902(a)(34), a State can provide less than three months of retroactive eligibility to beneficiaries.

Valid Choices:

1. 1902(a)(1) Statewideness
2. 1902(a)(4) Proper and Efficient Administration of the State Plan

3. 1902(a)(10)(B) Amount, Duration and Scope of Services
4. 1902(a)14) Cost-Sharing
5. 1902(a)(17) Financial Eligibility Standards
6. 1902(a)(23) Freedom of Choice
7. 1902(a)(34) Retroactive Eligibility
8. Other

Text box:

If "8" is selected, provide a text box, with the statement: "Please specify other statutes waived. Use the format: 19__(_)(_). If more than one other statute is waived, click "Enter" between entries"

Edit Conditions:

1. Skip, if OPERATING AUTHORITY was "1932(a)", "1915(a)", "PACE" or "1905(t), 1902(a)(70)".
2. Must select one valid choice if OPERATING AUTHORITY was "1115", "1915(b)", "1915(b)/(c)".
3. May select more than one valid choice.
4. If "8" is selected, must complete text box.
5. Allow entries of up to 40 characters each in the text box.
6. If "5" is selected, only 1902 provisions are valid for 1915(b) waivers and 1115 demonstrations.

DATA ELEMENT: ENROLLMENT BROKER

Definition:

The State uses a third party entity (including any State agency other than the Medicaid agency) for marketing, choice counseling, and enrolling of beneficiaries.

Valid Choices:

1. Program USES an Enrollment Broker
2. Program DOES NOT USE an Enrollment Broker

Edit Conditions:

1. Skip if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must select one valid choice.
3. May not select more than one valid choice.

DATA ELEMENT: ENROLLMENT BROKER NAME

Definition:

Name(s) of the enrollment broker organization(s) used by the State.

Valid Choices:

Text box:

Provide a text box with the statement: "Please specify the name(s) of the Enrollment Broker(s) used by your State. Do not use abbreviations. Enter text in initial capital format. If more than one, click "Enter" after each organization. Allow up to 5 organizations.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangements.
2. Skip if State does not use Enrollment Broker.
3. Allow for entries of up to 80 characters each. Make at least one entry.

DATA ELEMENT: COMPLETION OF PHASED-IN IMPLEMENTATION

Definition:

This element reports the status of phased-in implementation. If program has area(s) that are still being phased-in, DO NOT report as “all areas are phased-in”.

Valid Choices:

1. All areas are phased-in
2. All areas are not phased-in

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must select one valid choice.
3. Must select “all areas are phased-in”, if PROGRAM SERVICE AREA is “Statewide”.
4. May not select more than one valid choice.

DATA ELEMENT: TITLE XIX EXPENDITURE AUTHORITIES

Definition: In Section 1115 demonstrations only, the Secretary has the authority under Section 1115(a)(2) to make expenditures that would otherwise not be eligible for FFP under the requirements of Section 1903 of the Social Security Act matchable under the Medicaid program (sometimes referred to as “costs not otherwise matchable” or CNOM).

It can be used to provide FFP to States for the costs of expanding coverage to individuals not otherwise eligible for Medicaid (non-pregnant childless adults). In addition, it is frequently used to permit FFP for the costs of managed care organization (MCO) contracts which don't meet one or more of the MCO contract requirements in Sections 1903(m) and/or 1932 of the Act.

Valid Choices:

1. MCO Definition {1903(m)(1)(A)}
2. Secretary Definition of MCO {1903(m)(2)(A)(i)}
3. MCO Limits Disenrollment Rights{1903(m)(2)(A)(vi)}
4. MCO Payments to FQHC/RHC {1903(m)(A)(ix)}
5. MCO Choice {1932(a)(3)}
6. Other MCO Requirement
7. Drug Expenditures {1903(i)(10)}
8. Eligibility Expansion
9. Guaranteed Eligibility Expenditures
10. Family Planning Expenditures
11. Institution For Mental Disease Expenditures
12. Indigent/Clinic Expenditures
13. Uncompensated Care Expenditures
14. Exemption from MEQC disallowances {1903(u)}
15. Insurance Reimbursement
16. Premium Matching
17. Graduate Medical Education
18. Designated State Health Programs
19. Chemical Dependency Treatment 1905(a)(13)
20. Other

Text box:

If “21” is selected, provide a text box, with the statement: “Please specify other Expenditure Authorities granted. If more than one authority, click “Enter” between entries”.

Edit Conditions:

1. Skip, if OPERATING AUTHORITY is not “1115”.
2. At least one valid choice must be selected, if OPERATING AUTHORITY is “1115”.
3. May select more than one valid choice.

II. CATEGORY: SERVICE DELIVERY ORIENTATION

DATA ELEMENT: MANAGED CARE ENTITY TYPES

Definition:

Under a single program States may contract with Primary Care Case Management (PCCM) providers, Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), Managed Care Organizations (MCOs), or Health Insuring Organizations (HIOs). This element asks states to report which of these types of entities provide services to program enrollees.

- **Primary Care Case Manager (PCCM)** – A PCCM is a provider (usually a physician, physician group practice, nurse practitioners, nurse midwives, or physician assistants, but can also be an entity employing or having other arrangements with such providers) who contracts directly with the State to locate, coordinate, and monitor covered primary care. This category includes any PCCMs and those PAHPs which act as PCCMs. If both individual physicians and/or group practices, as well as an entity, serve as a PCCM in the State, select this choice to reflect the individual physician/group practice PCCM. Select “other” below to reflect the entity PCCM.
- **Comprehensive Managed Care Organization (MCO)** – A MCO is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare Advantage organization, a provider sponsored organization or any other private or public organization, which meets the requirements of §1903(m).. An eligible organization must provide a comprehensive benefit package under a risk contract.
- **Health Insuring Organization (HIO)** – An HIO is a managed care entity which, by law, is exempt from certain rules governing MCO program operation such as the requirement for beneficiaries to have a choice of at least two managed care entities in mandatory programs. An HIO must provide a comprehensive benefit package under a risk contract and operate in California only
- **Prepaid Inpatient Health Plan (PIHP)** – A PIHP is a prepaid **inpatient** health plan that provides less than comprehensive services under a risk contract or other than state plan reimbursement basis or comprehensive services under a non-risk contract; and provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are defined in 42 CFR 438.2}
- **Prepaid Ambulatory Health Plan (PAHP)** – A PAHP is a prepaid **ambulatory** health plan that provides less than comprehensive services on an at-risk, non-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}

- **PACE** - a program that provides pre-paid, capitated comprehensive, health care services to the frail elderly and which combines both Medicaid and Medicare benefits and payment.
- **Other** - The structure of the managed care entity is not considered a PCCM, PIHP, PAHP, Commercial MCO, Medicaid-only MCO, HIO, or PACE, but may include an entity which serves as a PCCM provider..

Valid Choices:

1. PCCM Provider
2. Comprehensive MCO
3. HIO
4. Medical-only PIHP (risk or non-risk/non-comprehensive/with inpatient hospital or institutional services)
5. Medical-only PAHP (risk or non-risk/non-comprehensive/no inpatient hospital or institutional services)
6. Long Term Care (LTC) PIHP
7. Mental Health (MH) PIHP
8. Mental Health (MH) PAHP
9. Substance Use Disorders (SUD) PIHP
10. Substance Use Disorders (SUD) PAHP
11. Mental Health (MH) and Substance Use Disorders (SUD) PIHP
12. Mental Health (MH) and Substance Use Disorders (SUD) PAHP
13. Dental PAHP
14. Transportation PAHP
15. Disease Management PAHP
16. PACE
17. Other

Text box:

If “17” is selected, provide a text box with the statement “Specify other managed care entity type; do not use abbreviations; Enter text in initial capital format. If more than one, click “Enter” after each type”.

Edit Conditions:

1. Must select one valid choice.
2. May only select one valid choice (except if 1 and 18 need to be selected to reflect the different PCCM arrangements).
3. If “17” is selected, must complete text box. Allow entries of up to 70 characters each.

DATA ELEMENT: REIMBURSEMENT ARRANGEMENT

Definition: The terms under which managed care entities are reimbursed.

Valid Choices:

1. **Risk-based Capitation** -- The managed care entity is paid a fixed amount each month for providing services to enrollees. The managed care entity is responsible for all costs whether or not the fixed amount is sufficient to cover those costs. (There may be other payments under the contract such as incentive arrangements or risk sharing.)
2. **Non-risk Capitation** -- The managed care entity is paid a fixed amount each month 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.
3. **Fee-For-Service**-- The managed care entity is paid on a per-service basis for each health care service.
4. **Primary Care Case Management Fee** - The managed care entity is paid a monthly fee for each enrollee each month to provide primary care case management services.
5. **Other**-- The managed care entity provides services to enrollees through means other than through capitation and fee-for-service reimbursements.

Text box

If "4" is selected, provide a text box with the statement "Specify other Reimbursement Arrangement; do not use abbreviations; enter text in initial capital format."

Edit Condition:

1. If "2" (Comprehensive MCO) or "3" (HIO) is chosen for Managed Care Entity Type, 1 is the only valid option.
2. If "16" (PACE) is chosen for Managed Care Entity Type, 1 is the only valid option.
3. If "17" (Other) is chosen for Managed Care Entity Type, 1, 2, 3 and 4 are all valid options.
4. One number, 1 - 4.

DATA ELEMENT: MCO, HIO, PCCM, AND "OTHER" MCE INCLUDED SERVICES

Definition:

Comprehensive MCOs and HIOs may provide a wide range of services. This element identifies the specific services these entities may include in their contracts. If the entity is capitated, report those services included in the capitation payment. If the entity is paid solely through fee-for-service, report those services that the entity must either authorize or directly provide.

This DATA ELEMENT will be repeated for each of the following MANAGED CARE ENTITY TYPES reported: "Comprehensive MCO", "HIO", "PCCM" and "Other".

Valid Choices:

1. Inpatient Hospital
2. Outpatient Hospital
3. Laboratory
4. X-Ray
5. Skilled Nursing Facility
6. EPSDT (Early and Periodic Screening, Diagnosis and Treatment)
7. Immunization
8. Family Planning
9. Physician
10. Home Health
11. Dental
12. Institutional
13. Inpatient Mental Health
14. Outpatient Mental Health
15. Inpatient Substance Use Disorders
16. Outpatient Substance Use Disorders
17. Case Management
18. Pharmacy
19. Durable Medical Equipment (DME)
20. Hospice
21. Transportation
22. Vision
23. Hearing
24. Disease Management
25. Physical Therapy
26. Speech Therapy
27. Occupational Therapy
28. Chiropractic
29. Podiatry
30. Personal Care
31. Other

Text box 1:

If “31” is selected, provide a text box with the statement: “Define Other; do not use abbreviations; Enter text in initial capital format. If more than one Other, click “Enter” after each service”.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip, if the only MANAGED CARE ENTITY selected is “Medical-only PIHP (risk or non-risk, non-comprehensive)”, “Medical-only PAHP (risk or non-risk, non-comprehensive)”, “MH PIHP” “MH PAHP”, “SUD PIHP”, “SUD PAHP”, “MH/SUD PIHP”, MH/SUD PAHP”, “Dental PAHP”, “Transportation PAHP” or “Disease Management PAHP”.
3. Must select one valid choice.
4. May select more than one valid choice.
5. If “31” is selected, text box 1 must be completed. Allow entries of up to 50 characters each.

DATA ELEMENT: MEDICAL-ONLY PIHP or PAHP INCLUDED SERVICES

Definition:

In this DATA ELEMENT, States should identify which of the following services are provided by Medical-only PIHPs or PAHPs.

This DATA ELEMENT will be repeated for each of the following MANAGED CARE ENTITY TYPES reported: "Medical-only PHP" and "Medical-only PIHP".

Valid Choices:

1. Inpatient Hospital
2. Outpatient Hospital
3. Institutional
4. Laboratory
5. X-ray
6. Skilled Nursing Facility
7. EPSDT
8. Immunization
9. Family Planning
10. Physician
11. Home Health
12. Case Management
13. Pharmacy
14. Durable Medical Equipment (DME)
15. Hospice
16. Transportation
17. Vision
18. Hearing
19. Other

Text box:

If "19" is selected, provide a text box with the statement: "Define Other; do not use abbreviations; Enter text in initial capital format. If more than one other service, click "Enter" after each service".

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip, if MANAGED CARE ENTITY TYPE is not "Medical-only PAHP" or "Medical-only PIHP".
3. Must select one valid choice if MANAGED CARE ENTITY TYPE is "Medical-only PAHP" or "Medical-only PIHP".
4. May select more than one valid choice.
5. If MANAGED CARE ENTITY TYPE is "Medical-only PAHP, "1," "3," or "6" cannot be selected.

6. If MANAGED CARE ENTITY TYPE is “Medical-only PIHP”, “1” or “3” must be selected.
7. If “19” is selected, the text box must be completed. Allow entries of up to 50 characters each.

DATA ELEMENT: MENTAL HEALTH PIHP or PAHP INCLUDED SERVICES

Definition:

Mental Health (MH) PIHPs or PAHPs may provide an array of Mental Health Services.

- **Inpatient Mental Health Services** - inpatient hospital services that are 24-hour services and provide medical intervention for stabilizing acute psychiatric conditions.
- **IMD Services** - services including psychiatric, health, therapeutic, pharmaceutical, and administrative, offered in an institution for Mental Disease for persons age 65 and over or age 21 and under.
- **Crisis** - emergency services, crisis intervention, or crisis stabilization services provided as an alternative to hospitalization that provide short-term psychiatric treatment in structured community-based therapeutic environments.
- **Mental Health Residential** - a non-IMD or non-hospital community-based facility that offers 24-hour residential care as well as treatment and rehabilitation/short-term crisis stabilization or long-term rehabilitation. For example, Therapeutic Group Living - therapeutically planned group living delivered on a 24-hour basis as a step down from inpatient or alternative to hospitalization.
- **Mental Health Outpatient** - mental health services (e.g., individual therapy, family therapy, group therapy) provided in an ambulatory care setting such as a mental health clinic, hospital outpatient department, or community mental health center.
- **Mental Health Rehabilitation** - services to assist individuals to regain lost skills or functioning or improve task and role-related skills, and social and environmental supports needed to perform as successfully and independently as possible in the community.
- **Mental Health Support** - services to promote the ability of enrollees to live as safely and independently as possible in community settings.
- **Pharmacy** - medications prescribed to treat mental conditions.
- **Prevention Programs (MH)** - services designed to reduce the probability that a population group or specific individuals within that group will develop clinically demonstrable mental health problems.
- **Peer Support Services** - services are an evidenced-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders.

This DATA ELEMENT will be presented for the following MANAGED CARE ENTITY TYPE reported: “Mental Health PIHP” or “Mental Health PAHP”.

Valid Choices:

1. Inpatient Mental Health Services
2. IMD Services
3. Crisis
4. Mental Health Residential
5. Mental Health Outpatient
6. Mental Health Rehabilitation
7. Mental Health Support
8. Pharmacy
9. Prevention Programs (MH)
10. Peer Support Services
11. Other

Text box:

If “11” is selected, provide a text box with the statement: “Define Other; do not use abbreviations; Enter text in initial capital format. If more than one Other, click “Enter” after each service”.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip, if MANAGED CARE ENTITY TYPE is not “MH PIHP or “MH PAHP”.
3. Must select one valid choice if MANAGED CARE ENTITY TYPE is “MH PIHP” or “MH PAHP”.
4. Must select “1” if MANAGED CARE ENTITY is “MH PIHP”.
5. May not select “1” or “4” if MANAGED CARE ENTITY is “MH PAHP”.
6. May select more than one valid choice.
7. If “11” is selected, then an entry must be made into the text box. Allow entries of up to 50 characters each.

DATA ELEMENT: SUBSTANCE USE DISORDERS PIHP/PAHP INCLUDED SERVICES

Definition:

Substance Use Disorders (SUD) PIHPs or PAHPs may provide an array of Substance Use Disorders services.

- **Inpatient Substance Use Disorders Services** -- inpatient hospital services that are 24-hour services and provide medical intervention for stabilizing acute substance use disorders.
- **Outpatient Substance Use Disorders Services** -- non-residential ambulatory services provided for the treatment of substance use disorders with or without the use of self-administered medications. This includes intensive outpatient services (all-day care for several days), as well as traditional outpatient counseling (one or a few hours per day, usually weekly or biweekly). May also include Medication Assisted Treatment, such as naltrexone, Campral, disulfiram, or buprenorphine (Suboxone & Subutex). Physicians prescribing buprenorphine drugs must be waived by the Substance Abuse and Mental Health Services Administration (SAMHSA) as provided in the Drug Abuse Addiction Act of 2000”.
- **Detoxification** -- hospital-based, residential, or ambulatory programs usually of very short duration (3 to 14 days) that provide support and/or medical assistance through withdrawal from alcohol or drug dependence. These are not treatment programs, but may either be connected or provide referrals to treatment programs. These services may be provided in standard acute care beds or in specialty detoxification units.
- **Opioid Treatment Programs** -- outpatient maintenance and inpatient detoxification treatment programs certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and registered by the Drug Enforcement Agency (DEA) to administer and dispense either methadone as part of a comprehensive treatment program including psychosocial, drug testing and other relevant services. The programs must be accredited by a private or governmental accreditation organization as a condition of SAMHSA certification.
- **Residential Substance Use Disorders Treatment Programs** -- include non-hospital based 24-hour care settings. These include short-term chemical dependency programs (usually lasting less than a month), longer term residential settings (usually lasting 3 to 6 months), and long term residential programs (usually lasting 6 to 18 months). These latter programs can include Therapeutic Communities and specialty residential treatment settings for women and their children.
- **Pharmacy** -- medications prescribed to treat substance use disorders.

- **Prevention Programs (SUD)** -- services designed to reduce the probability that a population group or specific individuals within that group will develop clinically demonstrable substance use disorders.
- **IMD Services** -- services including psychiatric, substance use disorders, health, therapeutic, pharmaceutical, and administrative, offered in an institution for Mental Disease for persons age 65 and over or age 21 and under.
- **Screening, Brief Intervention, and Treatment (SBIRT)** – services providing screening and brief intervention, generally in six visits or less, for those with hazardous patterns of use of alcohol or drugs for early identification and intervention of substance use disorders.
- **Substance Use Disorders Support Services** – services designed to promote the ability of enrollees to access and engage in treatment and/or maintain treatment gains and live as safely and independently in the community as possible.
- **Peer Support Services for Substance Use Disorders** – services are evidence-based substance use disorder model care which consists of a qualified peer support provider who assists individuals with their recovery from mental health and substance use disorders.

This DATA ELEMENT will be presented for the following MANAGED CARE ENTITY TYPE reported: “Substance Use Disorders PIHP or PAHP”.

Valid Choices:

1. Inpatient Substance Use Disorders Services
2. Outpatient Substance Use Disorders Services
3. Detoxification
4. Opiate Treatment Programs
5. Residential Substance Use Disorders Treatment Programs
6. Pharmacy
7. Prevention Programs (SUD)
8. IMD Services
9. Screening, Brief Intervention, and Treatment (SBIRT)
10. Substance Use Disorders Support Services
11. Peer Support Services for Substance Use Disorders
12. Other

Text box:

If “12” is selected, provide a text box with the statement: “Define Other; do not use abbreviations; enter text in initial capital format. If more than one other, click “Enter” after each service”.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.

2. Skip, if MANAGED CARE ENTITY TYPE is not "SUD PIHP or PAHP".
3. Must select one valid choice if MANAGED CARE ENTITY TYPE is "SUD PIHP or PAHP".
4. Must select "1" if MANAGED CARE ENTITY TYPE is "SUD PIHP".
5. May not select "1" if MANAGED CARE ENTITY TYPE is "SUD PAHP".
6. May select more than one valid choice.
7. If "12" is selected, then an entry must be made into the text box. Allow entries of up to 50 characters each.

DATA ELEMENT: MENTAL HEALTH and SUBSTANCE USE DISORDERS PIHP or PAHP INCLUDED SERVICES

Definition:

Mental Health and Substance Use Disorders (MH/SUD) PIHPs or PAHPs may provide an array of Mental Health and Substance Use Disorders services.

- **Inpatient Mental Health Service** -- inpatient hospital services that are 24-hour services and provide medical intervention for stabilizing acute psychiatric conditions.
- **Inpatient Substance Use Disorders Services** -- inpatient services that are 24-hour services and provide medical intervention for stabilizing acute substance use disorders conditions.
- **IMD Services** -- services including psychiatric, substance use disorders, health, therapeutic, pharmaceutical, and administrative, offered in an institution for Mental Disease for persons age 65 and over or age 21 and under.
- **Crisis** -- emergency services, crisis intervention, or crisis stabilization services provided as an alternative to hospitalization that provide short-term psychiatric treatment or substance use disorders treatment in structured community-based therapeutic environments.
- **Mental Health Residential** -- a non-IMD or non-hospital community-based facility that offers 24-hour residential care as well as treatment and rehabilitation/short-term crisis stabilization or long-term rehabilitation. For example, Therapeutic Group Living -- therapeutically planned group living delivered on a 24-hour basis as a step down from inpatient or alternative to hospitalization.
- **Mental Health Outpatient** -- mental health services (e.g., individual therapy, family therapy, group therapy) provided in an ambulatory care setting such as a mental health clinic, hospital outpatient department, or community mental health center.
- **Outpatient Substance Use Disorders Services** -- non-residential ambulatory services provided for the treatment of substance use disorders with or without the use of self-administered medications. This includes intensive outpatient services (all-day care for several days), as well as traditional outpatient counseling (one or a few hours per day, usually weekly or biweekly). May also include Medication Assisted Treatment, such as naltrexone, Campral, disulfiram, or buprenorphine (Suboxone & Subutex). Physicians prescribing buprenorphine drugs must be waived by the Substance Abuse and Mental Health Services Administration (SAMHSA) as provided in the Drug Abuse Addiction Act of 2000".
- **Mental Health Rehabilitation** -- services to assist individuals to regain lost skills or functioning or improve task and role-related skills, and social and environmental

supports needed to perform as successfully and independently as possible in home, family, school, work, socialization, recreation, and other community living and social contexts.

- **Mental Health Support** -- services to promote the ability of enrollees to live as safely and independently as possible in community settings.
- **Detoxification** -- hospital-based, residential, or ambulatory programs usually of very short duration (3 to 14 days) that provide support and/or medical assistance through withdrawal from alcohol or drug dependence. These are not treatment programs, but may either be connected or provide referrals to treatment programs. These services may be provided in standard acute care beds or in specialty detoxification units.
- **Opioid Treatment Programs** -- outpatient maintenance and inpatient detoxification treatment programs certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and registered by the Drug Enforcement Agency (DEA) to administer and dispense methadone as part of a comprehensive treatment program including psychosocial, drug testing and other relevant services. The programs must be accredited by a private or governmental accreditation organization as a condition of SAMHSA certification.
- **Residential Substance Use Disorders Treatment Programs** -- include non-hospital based 24-hour care settings. These include short chemical dependency programs (usually lasting less than a month), longer- term residential settings (usually lasting 3 to 6 months), and long term residential programs (usually lasting 6 to 18 months). These latter programs can include Therapeutic Communities and specialty residential treatment settings for women and their children.
- **Pharmacy** -- Medications provided to treat mental health or substance use disorders.
- **Prevention Programs (MH)** -- services designed to reduce the probability that a population group or specific individuals within that group will develop clinically demonstrable mental health problem.
- **Prevention Programs (SUD)** -- services designed to reduce the probability that a population group or specific individuals within that group will develop clinically demonstrable substance use disorders.
- **Screening, Brief Intervention, and Treatment (SBIRT)** – services providing screening and brief intervention, generally in six visits or less, for those with hazardous patterns of use of alcohol or drugs for early identification and intervention of substance use disorders.
- **Substance Use Disorders Support Services** – services designed to promote the ability of enrollees to access and engage in treatment and/or maintain treatment gains and live as safely and independently in the community as possible.

- **Peer Support Services for Substance Use Disorders** –service are an evidence –based substance use disorder model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental health and substance abuse use disorders.

This DATA ELEMENT will be presented for the following MANAGED CARE ENTITY TYPE reported: “Mental Health and Substance Use Disorders PIHP or PAHP”.

Valid Choices:

1. Inpatient Mental Health Services
2. Inpatient Substance Use Disorders Services
3. IMD Services
4. Crisis
5. Mental Health Residential
6. Mental Health Outpatient
7. Outpatient Substance Use Disorders Services
8. Mental Health Rehabilitation
9. Mental Health Support
10. Detoxification
11. Opioid Treatment Programs
12. Residential Substance Use Disorders Treatment Programs
13. Pharmacy
14. Prevention Programs (MH)
15. Prevention Programs (SUD)
16. Screening, Brief Intervention, and Treatment (SBIRT)
17. Substance Use Disorders Support Services
18. Peer Support Services for Substance Use Disorders
19. Other

Text box:

If “19” is selected, provide a text box with the statement: “Define Other; do not use abbreviations; enter text in initial capital format. If more than one “Other”, click “Enter” after each service”.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip, if MANAGED CARE ENTITY TYPE is not “MH/SUD PIHP or PAHP”.
3. Must select one valid choice if MANAGED CARE ENTITY TYPE is “MH/SUD PIHP or PAHP”.
4. Must select “1” and/or “2” if MANAGED CARE ENTITY is “MH/SUD PIHP”.
5. May not select “1,” “2,” “5,” or “12” if MANAGED CARE ENTITY is “MH/SUD PAHP”.
6. May select more than one valid choice.
7. If “19” is selected, then an entry must be made into the text box. Allow entries of up to 50 characters each.

DATA ELEMENT: DENTAL PAHP INCLUDED SERVICE

Definition:

Dental PAHPs provide only dental services.

Valid Choices:

1. Dental

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip, if MANAGED CARE ENTITY TYPE is not "Dental PAHP".
3. The system must select "1" if MANAGED CARE ENTITY TYPE is "Dental PAHP".

DATA ELEMENT: DISEASE MANAGEMENT PAHP INCLUDED SERVICE

Definition:

Disease Management PAHPs provide only disease management services.

Valid Choices:

1. Disease Management

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip, if MANAGED CARE ENTITY TYPE is not "Disease Management PAHP".
3. The system must select "1" if MANAGED CARE ENTITY TYPE is "Disease Management PAHP".

DATA ELEMENT: TRANSPORTATION PAHP INCLUDED SERVICE

Definition:

Transportation PAHPs provide only transportation services.

Valid Choices:

1. Non-Emergency Transportation
2. Emergency Transportation

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip, if MANAGED CARE ENTITY TYPE is not "Transportation PAHP".
3. Must select one valid choice if MANAGED CARE ENTITY is "Transportation PAHP".
4. Must select "Non-Emergency Transportation" if Operating Authority is "1902(a)(70)".
5. May select more than one valid choice.

DATA ELEMENT: MH/SUD CONTRACTOR TYPE

Definition:

States have established contracts with several types of public and private entities to deliver mental health (MH) or substance use disorders (SUD) services through PIHPs/PAHPs. These include behavioral health Managed Care Organizations (MCOs) (privately owned companies), entities operated by Community Mental Health Centers (CMHCs), entities operated by Counties, or entities operated by Regional Authorities. Please indicate what type of entity the State contracts with to provide MH and/or SUD services.

This information will be repeated for each of the following MANAGED CARE ENTITY TYPES reported: "MH PIHP or PAHP", "SUD PIHP or PAHP", and "MH/SUD PIHP or PAHP".

Valid Choices:

1. Behavioral Health MCO (Private)
2. CMHC Operated Entity (Public)
3. County Operated Entity (Public)
4. Regional Authority Operated Entity (Public)
5. Other

Text box:

If "5" is selected, provide a text box with the statement: "Specify the other type of entity; do not use abbreviations; enter text in initial format. If more than one, click "Enter" after each type".

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip, if MANAGED CARE ENTITY TYPE does not include "MH PIHP or PAHP", "SUD PIHP or PAHP", or "MH/SUD PIHP or PAHP".
3. Must select one valid choice if MH and/or SUD PIHP/PAHP.
4. May select more than one valid choice.
5. Must complete text box if "5" is selected. Allow entries of up to 50 characters each.

DATA ELEMENT: POPULATION CATEGORIES INCLUDED

Definition:

States may include several different groups of beneficiaries in their managed care programs.

- **Section 1931 Children and Related Populations** are AFDC (sometimes referred to as TANF) -related children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
- **Section 1931 Adults and Related Populations** are AFDC (sometimes referred to as TANF) -related adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
- **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Blind/Disabled Adults who are age 65 or older should be reported in this category, not in Aged.
- **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
- **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.
- **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.
- **Title XXI CHIP** provides States with funding to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. It is an optional group of targeted low income children who are eligible to participate in Medicaid if the State decides to administer the Children's Health Insurance Program (CHIP) through the Medicaid program, as a Medicaid expansion.
- **Special Needs Children (State Defined)** are Medicaid beneficiaries who are special needs children as defined by the State.
- **Special Needs Children (BBA Defined)** are children on SSI, children in foster care or out-of-home placement, and children eligible for and receiving Title V services, and "Katie Beckett" children who are eligible for an institutional level of care.
- **Poverty Level Pregnant Women (SOBRA)** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.
- **Medicare Dual Eligibles** -- Individuals entitled to Medicare and eligible for some or all category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E)).
- **American Indian/Alaska Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

This DATA ELEMENT will be repeated for each MANAGED CARE ENTITY TYPE reported.

Valid Choices:

1. Section 1931 Children and Related Populations
2. Section 1931 Adults and Related Populations
3. Blind/Disabled Adults and Related Populations
4. Blind/Disabled Children and Related Populations
5. Aged and Related Populations
6. Foster Care Children
7. Title XXI CHIP
8. Special Needs Children (State-defined)
9. Special Needs Children (BBA-defined)
10. Poverty-Level Pregnant Women
11. Medicare Dual Eligibles
12. American Indian/Alaska Native
13. Other

Text box:

If "13" is selected, provide a text box with the statement: "Specify other population; do not use abbreviations; enter text in initial capital format. If more than one, click "Enter" after each population".

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must select one valid choice.
3. May select more than one valid choice.
4. If "13" is selected, must complete text box. Allow entries of up to 50 characters each.

DATA ELEMENT: MEDICARE DUAL ELIGIBLES INCLUDED

Definition:

Individuals entitled to Medicare and eligible for some or all category of Medicaid benefits. . States may include several categories of dual eligibles in their managed care program. Indicate which category(ies) are included in the managed care program.

- **QMB Plus, SLMB Plus, and Medicaid only** – Dual eligibles eligible for full Medicaid services (sometimes referred to a full-benefit duals).
- **QMB** – Dual eligibles not eligible for Medicaid services, but eligible for payment of Medicare premiums and Medicare cost-sharing.
- **SLMB, QI, and QDWI** – Dual eligibles not eligible for Medicaid services, but eligible for payment of Medicare premiums only.

This DATA ELEMENT will be repeated for each MANAGED CARE ENTITY TYPE reported.

Valid Choices:

1. QMB Plus, SLMB Plus, and Medicaid only
2. QMB
3. SLMB, QI, and QDWI
4. Includes all categories of Medicare Dual Eligibles
5. Other

Text box:

If “5” is selected, provide a text box with the statement: “Specify other dual eligible category(ies) that are included in the managed care program; do not use abbreviations; enter text in initial capital format. If more than one, click “Enter” after each population”.

Edit Conditions:

1. Skip, if POPULATION CATEGORIES INCLUDED does not include “Medicare Dual Eligibles”.
2. Must select one valid choice.
3. May select more than one valid choice.
4. If "5" is selected, must complete text box. Allow entries of up to 50 characters each.

DATA ELEMENT: ENROLLMENT BASIS

Definition:

Medicaid beneficiaries may be enrolled on a voluntary or mandatory basis. (Do not report the enrollment requirements for those who are re-enrolled with a managed care entity after a break in Medicaid eligibility.)

- **Voluntary** -- enrollees are allowed to choose to remain in fee-for-service Medicaid or enroll in the managed care/PCCM/other program.
- **Mandatory** -- enrollees must enroll in the managed care/PCCM/other program.

This DATA ELEMENT will be repeated for each group selected under POPULATION CATEGORIES INCLUDED. This will result in reporting this information for each combination of MANAGED CARE ENTITY TYPE and POPULATION CATEGORIES INCLUDED reported.

Valid Choices:

1. Voluntary
2. Mandatory

Text box:

If two or more valid choices are selected, provide a text box with the question “On what basis does the State decide which enrollment requirement applies to a member of this INCLUDED POPULATION?”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must select one valid choice.
3. May select more than one valid choice.
4. May not select “2” if OPERATING AUTHORITY is “1915(a)” or “1905(t)”.
5. May only select “1” if OPERATING AUTHORITY is 1932(a) and “Special Needs Children (BBA-defined)”, “Medicare Dual Eligibles”, or “American Indian/Alaskan Native” are selected as POPULATIONS CATEGORIES INCLUDED.
6. Must complete text box if select more than one valid choice.

DATA ELEMENT: POPULATION CATEGORIES EXCLUDED

Definition:

Within the groups identified in POPULATIONS INCLUDED, there may be certain groups of individuals who are excluded from (may not enroll in) the managed care program. For example, the “Aged” population may be required to enroll into the program, but “Dual Eligibles” within that population may not be allowed to participate. Also, “Section 1931 Children” may be able to voluntarily enroll in a managed care program, but “Foster Care Children” within that population may be excluded from that program. Beneficiaries may be excluded for a variety of reasons, such as:

- **Medicare Dual Eligibles**--Individuals entitled to Medicare and eligible for some or all category of Medicaid benefits.
- **Poverty Level Pregnant Women (SOBRA)** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.
- **Medically Needy Individuals with Spend-down** - Individuals who would be categorically eligible for Medicaid if their income or resources were within Medicaid limits but who qualify for Medicaid because their medical expenses reduce their income on a monthly basis to Medicaid levels.
- **Other Insurance**--Medicaid beneficiaries who have other health insurance outside of Medicaid other than Medicare.
- **Reside in Nursing Facility or ICF/MR**--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).
- **Enrolled in Another Managed Care Program**--Medicaid beneficiaries who are enrolled in another Medicaid managed care program
- **Eligibility Less Than 3 Months**--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.
- **Eligible only for TB-related Services**—Medicaid beneficiaries who receive benefits only for tuberculosis-related services.
- **Enrolled in CDC BCCT Program**—Medicaid beneficiaries who are screened and eligible for cancer treatment under the Centers’ for Disease Control breast and cervical cancer treatment program.
- **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
- **American Indian/Alaska Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.
- **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State.
- **Special Needs Children (BBA Defined)**—Children on SSI, children in foster care or out-of-home placement, and children eligible for and receiving Title V services, and “Katie Beckett” children who are eligible for an institutional level of care.

This DATA ELEMENT will be repeated for each MANAGED CARE ENTITY TYPE reported.

Valid Choices:

1. Medicare Dual Eligibles
2. Poverty Level Pregnant Woman
3. Medically Needy Individuals with Spend-down
4. Other Insurance
5. Reside in Nursing Facility or ICF/MR
6. Enrolled in Another Managed Care Program
7. Eligibility Less Than 3 Months
8. Eligible only for TB-related Services
9. Enrolled in CDC BCCT Program
10. Participate in HCBS Waiver
11. American Indian/Alaska Native
12. Special Needs Children (State Defined)
13. Special Needs Children (BBA Defined)
14. No populations are excluded
15. Other

Text box:

If “12” is selected, provide a text box with the text “Please describe other excluded population(s); do not use abbreviations; enter text in initial capital format. If more than one, click “Enter” after each”.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. May not select “1” if MEDICARE DUAL ELIGIBLES INCLUDED is “Includes all categories of Medicare Dual Eligibles.”
3. Must select one valid choice.
4. May select more than one valid choice.
5. If “14” is selected, then no other choice may be selected.
6. If “12” is not selected, then OPERATING AUTHORITY must be “1915(b)” or “1115” or BLIND/DISABLED CHILDREN ENROLLMENT BASIS and FOSTER CARE CHILDREN ENROLLMENT BASIS must not be “Mandatory”.
7. If “11” is not selected and OPERATING AUTHORITY is not “1915(b)” or “1115” the response should be allowed, but the following message should appear: “The Balanced Budget Act of 1997 permits the mandatory enrollment of American Indians/Alaskan Natives only in limited circumstances. Do you wish to change your answer?”
8. If “15” is selected, then the text box must be completed. Allow entries of up to 50 characters each.

DATA ELEMENT: MEDICARE DUAL ELIGIBLES EXCLUDED

Definition:

Individuals entitled to Medicare and eligible for some or all category of Medicaid benefits. States may exclude several categories of dual eligibles in their managed care program. Indicate which category(ies) are excluded in the managed care program.

- **QMB Plus, SLMB Plus, and Medicaid only** – Dual eligibles eligible for full Medicaid services (sometimes referred to a full-benefit duals).
- **QMB** – Dual eligibles not eligible for Medicaid services, but eligible for payment of Medicare premiums and Medicare cost-sharing.
- **SLMB, QI, and QDWI** – Dual eligibles not eligible for Medicaid services, but eligible for payment of Medicare premiums only.

This DATA ELEMENT will be repeated for each MANAGED CARE ENTITY TYPE reported.

Valid Choices:

1. QMB Plus, SLMB Plus, and Medicaid only
2. QMB
3. SLMB, QI, and QDWI
4. Exclude all categories of Medicare Dual Eligibles
5. Other

Text box:

If “5” is selected, provide a text box with the statement: “Specify other dual eligible category(ies) that are excluded from the managed care program; do not use abbreviations; enter text in initial capital format. If more than one, click “Enter” after each population”.

Edit Conditions:

1. Skip, if POPULATION CATEGORIES EXCLUDED does not include “Medicare Dual Eligibles”.
2. Must select one valid choice.
3. May select more than one valid choice.
4. If only valid choice “1” is selected, must complete text box with explanation(s) of why “QMB plus, SLMB Plus, and Medicaid only” are the only excluded Medicare Dual Eligibles.
5. If only valid choice “2” is selected, must complete text box with explanation(s) of why “QMB” is the only excluded Medicare Dual Eligibles.
6. If valid choice “1” and “2” are selected, must complete text box with explanation(s) of why “QMB plus, SLMB Plus, and Medicaid only” and “QMB” are the only excluded Medicare Dual Eligibles.
7. If 1, 2, and/or 3 are already selected under MEDICARE DUAL ELIGIBLES INCLUDED, may not select the same Medicare dual eligible categories.
8. If “5” is selected, must complete text box. Allow entries of up to 50 characters each.

DATA ELEMENT: PCP TYPES

Definition:

States may allow health plans to use a variety of provider types as Primary Care Providers (PCPs). Only include FQHC if by State definition to be a PCP.

This DATA ELEMENT will be repeated for each MANAGED CARE ENTITY TYPE reported.

Valid Choices:

1. Pediatricians
2. General Practitioners
3. Family Practitioners
4. Internists
5. Obstetricians/Gynecologists or Gynecologists
6. Federally Qualified Health Centers (FQHCs)
7. Rural Health Clinics (RHCs)
8. Nurse Practitioners
9. Nurse Midwives
10. Indian Health Service (IHS) Providers
11. Physician Assistants
12. Psychiatrists
13. Psychologists
14. Nurse Practitioners
15. Clinical Social Workers
16. Addictionologists
17. Other Addiction Professionals (i.e. Substance Abuse counselors, alcohol and drug counselors, certified addiction counselors, etc.)
18. Other Specialists Approved on a Case-by-Case Basis
19. Not applicable, contractors not required to identify PCPs
20. Other Providers (do not report those approved on a case-by-case basis)

Text box:

If "20" is selected, provide a text box with the question: "What other provider types may health plans use as PCPs? Do not use abbreviations; Enter text in initial capital format. If more than one, click "Enter" after each type".

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. May select more than one valid choice
3. If "20" is selected, must complete text box. Allow entries of up to 50 characters.
4. May only select "19" for "MH PIHP or PAHP", "SUD PIHP or PAHP", "MH/SUD PIHP or PAHP", "Dental PAHP", "Transportation PAHP", and "Disease Management PAHP".

DATA ELEMENT: LOCK-IN PROVISION

Definition:

The length of time (including the period of initial enrollment where an enrollee may change plans without cause) during which enrollees may not change managed care entities (except for cause).

This DATA ELEMENT will be repeated for each MANAGED CARE ENTITY TYPE reported.

Valid Choices:

1. 12 month lock-in
2. 6 month lock-in
3. 3 month lock-in
4. 1 month lock-in
5. No lock-in
6. Does not apply because State only contracts with one managed care entity
7. Other lock-in

Text box 1:

If “7” is selected, provide a numeric box with the statement: “Enter the lock-in length in months”.

Text box 2:

If two or more valid choices are selected, provide a text box with the question “On what basis does the State decide which lock-in requirement applies to an enrollee of this MANAGED CARE ENTITY TYPE?”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must select one valid choice.
3. May enter more than one valid choice.
4. If “7” is selected, must complete text box. Allow entries of up to 2 numbers. Entry cannot be more than “12”.
5. If “7” is selected, entries of “12”, “6”, “3”, “1” and “0” months are not allowed. If any of these are entered, provide an error message “Valid Choices 1-5 include this time period, please select the appropriate valid choice”.
6. If more than one valid choice is selected, an entry must be made in text box 2. Text box entry must appear in the UNIQUE CIRCUMSTANCES memo field in the format. Reason for multiple lock-in provision choice for MANAGED CARE ENTITY TYPE: (Text box entry).

DATA ELEMENT: GUARANTEED ELIGIBILITY

Definition:

The length of time during which managed care enrollees will not lose Medicaid eligibility, even if their circumstances change.

This DATA ELEMENT will be repeated for each MANAGED CARE ENTITY TYPE reported, except for PIHPs or PAHPs.

Valid Choices:

1. 6 months guaranteed eligibility
2. Continuous eligibility for children under age 19
3. No guaranteed eligibility
4. Other guaranteed eligibility time period

Text box 1:

If "4" is selected, provide a numeric box with the question: "How long is the guaranteed eligibility time period, in months?"

Text box 2:

If more than one choice is selected, provide a text box with the question "On what basis does the State decide which guaranteed eligibility period applies to an enrollee of this MANAGED CARE ENTITY TYPE?"

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip if MANAGED CARE ENTITY TYPE is "Medical-only PIHP", "Medical-only PAHP", "MH PIHP or PAHP", "SUD PIHP or PAHP", "MH/SUD PIHP or PAHP", "Dental PAHP," "Transportation PAHP", or "Disease Management PAHP".
3. One valid choice must be entered.
4. More than one valid choice may be entered.
5. If "4" is selected, then text box 1 must be completed. Allow entries of up to 2 numbers.
6. If "4" is selected, entries of "6" and "0" months are not allowed. If either of these are entered, provide an error message "Valid Choices 1 and 3 include this time period, please select the appropriate valid choice".
7. If the number of months reported in the numeric text box 1 is greater than 6 months, then OPERATING AUTHORITY must be "1115".
8. If more than one valid choice is selected, an entry must be made in text box 2. Text box entry must appear in the UNIQUE CIRCUMSTANCES memo field in the format: Reason for multiple guaranteed eligibility choice for MANAGED CARE ENTITY TYPE: (Text box entry).

**III. CATEGORY: MEDICAID MANAGED-CARE DUAL
ELIGIBLES AND THE PART D BENEFIT**

DATA ELEMENT: MEDICARE CONTRACT

Definition: Medicaid managed-care entity also has a Medicare contract that includes dual eligibles. **State should select valid choice “1” if the specific program they are currently entering data for does contract with Medicare and provides medical services to the Medicaid dual eligible population.**

Valid Choices:

1. The Medicaid managed-care entity also has a Medicare contract that includes dual eligibles.
2. The Medicaid managed-care entity **does not** have a Medicare contract that includes dual eligibles.

Edit Condition:

1. Must select one valid value.
2. May only select one valid value.
- 3.

DATA ELEMENT: MEDICARE CONTRACT and PROVISION of PART D BENEFIT

Definition: Medicaid managed-care entity also has a Medicare contract that includes dual eligibles and provides a Part D benefit.

Valid Choices:

1. The Medicaid managed-care entity also has a Medicare contract that includes dual eligibles and provides a Part D benefit.
2. The Medicaid managed-care entity also has a Medicare contract that includes dual eligibles **but does not provide** a Part D benefit.

Edit Condition:

1. Skip if Medicare Contract is "2".
2. Must select one valid value.
3. May only select one valid value.
4. If "16" (PACE) is chosen as Managed Care Entity Type, "1" is the only valid option.

DATA ELEMENT: MEDICAID MANAGED-CARE ENTITIES': SCOPE of PART D COVERAGE

Definition: Indicates the scope of Part D coverage for the Medicaid managed-care entity with a Medicare contract that includes dual eligibles and provides a Part D benefit.

Valid Choices:

1. The Medicaid managed-care entity provides Part D's Standard Prescription Drug Coverage (i.e., Standard Prescription Drug Coverage consists of coverage of covered Part D drugs subject to an annual deductible, 25 percent coinsurance up to an initial coverage limit, and catastrophic coverage).
2. The Medicaid managed-care entity provides Part D's Alternative Prescription Drug Coverage – Basic Alternative Coverage (Basic Alternative Coverage refers to alternative coverage that is actuarially equivalent to defined standard prescription drug coverage).
3. The Medicaid managed-care entity provides Part D's Alternative Prescription Drug Coverage – Enhanced Alternative Coverage (Enhanced Alternative Coverage refers to alternative coverage that exceeds defined standard coverage by offering supplemental benefits).

Edit Condition:

1. Skip if Medicare Contract is "2".
2. Skip if PACE plan.
3. Skip if MEDICARE CONTRACT and PROVISION of PART D BENEFIT is "2".
4. Must select one valid value.
5. May only select one valid value.

DATA ELEMENT: MEDICAID MANAGED-CARE ENTITIES': PART D - ENHANCED ALTERNATIVE COVERAGE

Definition: The Final Rule for Part D states that “Enhanced alternative coverage includes basic prescription drug coverage and supplemental benefits...Supplemental benefits can consist of: Reductions in cost-sharing that increase the actuarial value of the coverage beyond that of defined standard coverage; or Coverage of drugs that are specifically excluded from the definition of Part D drugs under section 1860D-2(e)(2)(A) of the Act...”. The purpose of this DATA ELEMENT is to learn whether the managed care entity provides supplemental benefits for Part D by covering excluded drugs and/or reducing patient cost-sharing.

This DATA ELEMENT will be repeated for each of the following MANAGED CARE ENTITY TYPES **that include dual eligibles** AND reported **Pharmacy** as an Included Service: “MCO,” “HIO,” “Medical-only PAHP,” “Medical-only PIHP,” “Mental Health PIHP,” “MH/SUD PIHP,” “SUD PAHP,” and “Other.”

Valid Choices:

1. Medicaid managed-care entity offers supplemental coverage of drugs excluded from Part D
2. Medicaid managed-care entity offers reductions in cost-sharing supplemental benefit
3. Medicaid managed-care entity **offers both** supplemental benefit options

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip, if MANAGED CARE ENTITY TYPE is “PCCM Provider” or “PACE.”
3. Skip, if Medicare Contract is “2 – The managed care entity **does not** have a contract to include dual eligibles.”
4. Skip if MEDICARE CONTRACT and PROVISION of PART D BENEFIT is “2”.
5. Skip, if “PCCM, MCO, HIO, AND “OTHER” MCE INCLUDED SERVICES” does not include “17 – Pharmacy.”
6. Skip, if “MEDICAL-ONLY PIHP or PAHP INCLUDED SERVICES” does not include “13 – Pharmacy.”
7. Skip, if “MENTAL HEALTH PIHP or PAHP INCLUDED SERVICES” does not include “8 – Pharmacy.”
8. Skip, if “SUBSTANCE USE DISORDERS PIHP or PAHP INCLUDED SERVICES” does not include “6 – Pharmacy.”
9. Skip, if “MENTAL HEALTH AND SUBSTANCE USE DISORDERS PIHP or PAHP INCLUDED SERVICES” does not include “13 – Pharmacy.”
10. Skip if MEDICAID MANAGED-CARE ENTITIES': SCOPE OF PART D COVERAGE is not “3”.
11. Must select one valid value.
12. May only select one valid value.

DATA ELEMENT: STATE MEDICAID COVERAGE of PART D EXCLUDED DRUGS IN MEDICAID MANAGED CARE ENTITY CONTRACTS

Definition: In this DATA ELEMENT, States should identify which, among the following Medicare Part D excluded drugs, will be covered by the managed care entity at the State's option.

This DATA ELEMENT will be repeated for each of the following MANAGED CARE ENTITY TYPES that include dual eligibles AND reported Pharmacy as an Included Service: "MCO," "HIO," "Medical-only PAHP," "Medical-only PIHP," "Mental Health PIHP," "MH/SUD PIHP," "SUD PIHP," "SUD PAHP," or "Other."

Valid Choices:

1. Agents when used for anorexia, weight loss, weight gain
2. Agents when used to promote fertility
3. Agents when used for cosmetic purposes or hair growth
4. Agents when used for symptomatic relief of cough and colds
5. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
6. Nonprescription drugs
7. Barbiturates
8. Benzodiazepines
9. Drugs used to promote fertility
10. Smoking Cessation (except dual eligibles as Part D will cover)
11. None – managed care entity provides standard prescription drug coverage

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip, if MANAGED CARE ENTITY TYPE is "PCCM Provider or "PACE."
3. Skip, if Medicare Contract is "2 – The managed care entity **does not** have a contract to include dual eligibles."
4. Skip, if "PCCM, MCO, HIO, AND "OTHER" MCE INCLUDED SERVICES" does not include "17 – Pharmacy."
5. Skip, if "MEDICAL-ONLY PIHP or PAHP INCLUDED SERVICES" does not include "13 – Pharmacy."
6. Skip, if "MENTAL HEALTH PIHP or PAHP INCLUDED SERVICES" does not include "8 – Pharmacy."
7. Skip, if "SUBSTANCE USE DISORDERS PIHP or PAHP INCLUDED SERVICES" does not include "6 – Pharmacy."
8. Skip, if "MENTAL HEALTH AND SUBSTANCE USE DISORDERS PIHP or PAHP INCLUDED SERVICES" does not include "13 – Pharmacy."
9. May select more than one valid choice.

IV. CATEGORY: PEOPLE WITH SPECIAL NEEDS

DATA ELEMENT: COVERAGE OF PEOPLE WITH SPECIAL NEEDS

Definition:

Some Medicaid programs may include people with special needs in their managed care programs, while others may exclude them. This DATA ELEMENT asks States to identify their managed care coverage policy for people with special needs, defined by the State and/or BBA.

Valid Choices:

1. Managed care program **includes** people with special needs defined by State and/or BBA.
2. Managed care program **does not include** people with special needs.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must select one valid choice.
3. May not select more than one valid choice.
4. Must select "1" if AGED, BLIND/DISABLED ADULT, BLIND/DISABLED CHILDREN, SPECIAL NEEDS CHILDREN (State-defined), SPECIAL NEEDS CHILDREN (BBA-defined), and/or FOSTER CARE CHILDREN is selected for POPULATIONS INCLUDED.

DATA ELEMENT: IDENTIFYING PERSONS WITH SPECIAL NEEDS

Definition:

Programs that serve persons with special needs or that have a specific disability may want to identify this group of beneficiaries within the more general enrolled populations. This DATA ELEMENT asks States to identify if they do so, and if they do, how they identify members of these groups.

Valid Choices:

1. Asks **advocacy groups** to identify members of these groups
2. Uses **enrollment forms** to identify members of these groups
3. **Reviews complaints and grievances** to identify members of these groups
4. **Surveys enrollees' medical needs** to identify members of these groups
5. Uses **eligibility data** to identify members of these groups
6. Uses **provider referrals** to identify members of these groups
7. DOES NOT identify members of these groups
8. Uses **other means** to identify members of these groups

Text box:

If "8" is selected, provide a text box with the question: "What other strategy(s) does the State use? Do not use abbreviations; enter text in initial capital format. If more than one, click "Enter" after each strategy".

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip if "Managed care program **does not include** people with complex (special) needs" was selected for COVERAGE OF PEOPLE WITH SPECIAL NEEDS.
3. Must select one valid choice.
4. May select more than one valid choice.
5. If "7" is selected, may not select more than one valid choice.
6. If "8" is selected, must complete text box. Allow entries of up to 80 characters each.

DATA ELEMENT: INTERAGENCY COORDINATION

Definition:

On an ongoing basis, Medicaid agencies may coordinate the operation of their managed care program with another State agency that also serves beneficiaries with special needs. Examples of coordination include requesting review of program documents and establishing regularly scheduled meetings to discuss managed care issues.

Valid Choices:

1. Coordinates with the Aging Agency
2. Coordinates with the Maternal and Child Health Agency
3. Coordinates with the Developmental Disabilities Agency
4. Coordinates with the Mental Health Agency
5. Coordinates with the Public Health Agency
6. Coordinates with the Substance Abuse Agency
7. Coordinates with the Education Agency
8. Coordinates with Social Services Agencies
9. Coordinates with Transportation Agencies
10. Coordinates with Housing Agencies
11. Coordinates with Employment Agencies
12. DOES NOT coordinate with any other Agency
13. Coordinates with a Private Agency(s), not listed here
14. Coordinates with a Public Agency(s), not listed here

Text box 1:

If “13” is selected, provide a text box with the question: “What other Private Agency(s) does the State coordinate with? Do not use abbreviations; enter text in initial capital format. If more than one, click “Enter” after each”.

Text box 2:

If “14” is selected, provide a text box with the question: “What other Public Agency(s) does the State coordinate with? Do not use abbreviations; enter text in initial capital format. If more than one, click “Enter” after each”.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip if “Managed care program **does not include** people with special needs” was selected for COVERAGE OF PEOPLE WITH SPECIAL NEEDS.
3. Must select one valid choice.
4. May select more than one valid choice.
5. May not select more than one valid choice if “12” is selected.
6. If “13” is selected, must complete text box 1. Allow entries of up to 80 characters each.
7. If “14” is selected, must complete text box 2. Allow entries of up to 80 characters each.

V. CATEGORY: ADDITIONAL INFORMATION

DATA ELEMENT: MANAGED CARE ENTITY NAME

Definition:

The name of each managed care entity that participates in the managed care program. This includes all managed care entity/programs providing services to Medicaid beneficiaries.

- For MCOs, HIOs, **and Other managed care entity**, provide the name of each individual managed care entity (plan).
- For PIHPs/ PAHPs (especially Mental Health and Substance Use Disorders PIHPs/PAHPs), provide the name of each individual managed care entity (such as Behavioral Health Organizations, CMHC Operated Entity/County Operated Entity/Regional Authority Operated Entity, etc.) that the State contracts with.
- For PCCMs, please provide the name of the program as a whole (not the name of each individual PCP.) **Do not report** the names of individual providers who may be participating as PCCM providers or under 1915(b)4 waivers that have been approved for the purposes of reimbursement arrangements.

All text should be spelled out completely; no abbreviations should be used.

Valid Choices:

Text box:

Provide a text box with the statement: "Please select name(s) of managed care entities from predefined list. If managed care entity is not included in the predefined list, enter name in box using initial capital format. Do not use abbreviations. Click "Enter" after each name"

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip if PCCM is the only selection made for MANAGED CARE ENTITY TYPE.
3. If names are Entered in text box, all text should be spelled out completely; no abbreviations should be used.
4. Field must be completed.
5. May make more than one entry.
6. Allow entries of up to 100 characters each.

DATA ELEMENT: UNIQUE CIRCUMSTANCES

Definition:

Unique Circumstances are those that are not captured in prior DATA ELEMENTs. For example,

- PCCM enrollees may be required to receive all their mental health services through the State's managed mental health care provider, but MCO enrollees receive all their mental health services through their MCO.
- PCPs may be defined by function instead of or in addition to provider type.
- The program converted to different operating authority
- The optional services that are included under the MCO contract.
- The populations that are allowed to enroll and disenroll anytime.

Valid Choices:

Memo field:

Provide a text box with the instructions: "Provide a SHORT description of any unique circumstances that are not captured in prior DATA ELEMENTs. No abbreviations should be used".

Edit Conditions:

1. This element is optional.
2. If an entry is made, all text should be spelled out completely; no abbreviations should be used.

DATA ELEMENT: PROGRAM DESCRIPTION

Definition:

Provide a short narrative describing the overall program. Below are some examples of what to include.

- Describe how the program operates/structure of the program
- Describe the contract process
- Describe the enrollment process

Valid Choices:

Memo field:

Provide a text box with the instructions: "Provide a SHORT narrative description of the program. No abbreviations should be used".

Edit Conditions:

3. This element is required.
4. If an entry is made, all text should be spelled out completely; no abbreviations should be used.

VI. CATEGORY: CONCURRENT 1915(a)/1915(c) WAIVERS

DATA ELEMENT: STATE MEDICAID AGENCY CONTACT

Definition:

Name, title, Name of Agency, organization, and 10-digit telephone number of State Medicaid person **responsible for the Concurrent Operating 1915(c) program**. All text should be spelled out completely; no abbreviations should be used; Enter text in initial capital format. **(This information will be published.)**

Valid Choices:

Provide text boxes for Entering the following information:

- Text box 1. Last Name of State Medicaid Contact Person
- Text box 2. First Name of State Medicaid Contact Person
- Text box 3. Title of State Medicaid Contact Person
- Text box 4. Organization of State Medicaid Contact Person
- Text box 5. State Medicaid Contact Telephone Number, in the format, (XXX) XXX-XXXX x XXXX

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "Concurrent 1915(a)/1915(c) Waivers".
2. Text boxes 1-5 must be completed.
3. 10-Digit telephone number must be entered in the specified format, area code in parentheses. 4-Digit extension is optional.
4. All text must be spelled out completely; no abbreviations may be used; text must be entered in initial capital format.
5. Allow up to 30 characters for Text box 1, up to 20 characters for Text box 2, 50 characters for Text box 3, and 50 characters for Text box 4.

DATA ELEMENT: STATE OPERATING AGENCY CONTACT

Definition:

Name, title, Name of Agency, organization, and 10-digit telephone number of State person (from another agency) that is **responsible for coordinating the daily operation with the State Medicaid Agency Contact for the Concurrent Operating 1915(c) program**. All text should be spelled out completely; no abbreviations should be used; Enter text in initial capital format. **(This information will be published.)**

Valid Choices:

Provide text boxes for entering the following information:

- Text box 1. Last Name of State Operating Agency Contact Person
- Text box 2. First Name of State Operating Agency Contact Person
- Text box 3. Title of State Operating Agency Contact Person
- Text box 4. Name of Operating Agency
- Text box 5. Organization of State Operating Agency Contact Person
- Text box 6. State Operating Agency Contact Telephone Number, in the format, (XXX) XXX-XXXX x XXXX

Edit Conditions:

1. "Optional" if OPERATING AUTHORITY is "Concurrent 1915(a)/1915(c) Waivers."
2. Text boxes 1-6 must be completed.
3. 10-Digit telephone number must be entered in the specified format, area code in parentheses. 4-Digit extension is optional.
4. All text must be spelled out completely; no abbreviations may be used; text must be entered in initial capital format.
5. Allow up to 30 characters for Text box 1, up to 20 characters for Text box 2, 50 characters for Text box 3, 50 characters for Text box 4, and 50 characters for Text box 5.

DATA ELEMENT: PROGRAM SERVICE AREA

Definition:

The geographic area served by the program may be Statewide, or if less than Statewide, may be defined by County, City, Region, or other type of geographic area. This element asks States to report how they define Concurrent Operating 1915(c) program as of DATA COLLECTION EFFECTIVE DATE.

- A program's service area is **Statewide**, if the program operates throughout the entire State.
- A program's service area is defined by **County**, if the program serves a county or several counties within the State. If the program serves all counties in a State, then report the program as Statewide.
- A program's service area is defined by **City**, if the program serves a city or several cities within the State.
- A program's service area is defined by **Region**, if the program serves a region or regions not defined by individual counties within the State.

Valid Choices:

1. Statewide
2. County
3. City
4. Region
5. Other

Text box:

If "5" is selected, provide a text box with the statement "Please describe Other; do not use abbreviations; enter the text in initial capital format. If more than one Other, click "Enter" between entries".

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "Concurrent 1915(a)/1915(c) Waivers."
2. Must select one valid choice.
3. May select more than one valid choice.
4. If "1" is selected may not select any other valid choice.
5. If "5" is selected, must complete text box. Allow up to 40 characters per entry.

DATA ELEMENT: INITIAL WAIVER EFFECTIVE DATE

(Subsequent Renewals do not change this date)

Definition:

Date the Concurrent Operating 1915(c) waiver was effective.

Valid Choices:

Numeric Field

8-digit waiver approval date in format MM/DD/YYYY

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "Concurrent 1915(a)/1915(c) Waivers."
2. Enter 8-digit waiver approval date: 2-digit Month, 2-digit Day, 4-digit Year of the program.
3. Do not accept dates after DATA COLLECTION DATE.

DATA ELEMENT: WAIVER EXPIRATION DATE

Definition:

Date the Concurrent Operating 1915(c) waiver (including temporary waiver extensions), under which the program operates, expires.

Valid Choices:

Numeric Field

8-digit expiration date in format MM/DD/YYYY

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "Concurrent 1915(a)/1915(c) Waivers."
2. Enter 8-digit expiration date: 2-digit Month, 2-digit Day, 4-digit Year of the program.
3. Do not accept dates prior to DATA COLLECTION DATE.

DATA ELEMENT: TARGET GROUP

Definition:

The Waiver of Section 1902(a)(10)(B) of the Act is granted to target services to selected group(s) of individuals who would otherwise be eligible for institutional services. These should match the group(s) listed in the 1915(c) application.

- Aged are individuals age 65 and older
- Disabled are physically disabled under 65, as defined by the State.
- Aged and Disabled is a permitted combination. Individuals may be aged, or disabled, or both.
- Mentally Retarded, as defined by the State.
- Developmental Disabled, as defined by the State.
- Mentally Retarded and Developmental Disabled is a permitted combination. Individuals may have mental retardation, developmental delay, or both.
- Seriously Mentally Ill (age 18 or older)
- Serious Emotional Disturbance (under age 18)
- "Other" are additional targeting criteria that the State has defined and that have been approved by CMS for the waiver.

Valid Choices:

1. Aged
2. Disabled
3. Aged and Disabled
4. Mentally Retarded
5. Developmental Disabled
6. Mentally Retarded and Developmental Disabled
7. Seriously Mentally Ill
8. Serious Emotional Disturbance
9. Other

Text box:

If "9" is selected, provide a text box with the statement: "Specify other population; do not use abbreviations; enter text in initial capital format. If more than one, click "Enter" after each population".

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "Concurrent 1915(a)/1915(c) Waivers)."
2. Must select one valid choice.
3. May select more than one valid choice.
4. If "9" is selected, must complete text box. Allow entries of up to 50 characters each.

DATA ELEMENT: LEVEL OF CARE

Definition:

The 1915(c) waiver program provides home and community-based services to individuals who, but for the provision of those services, would require institutional care that would otherwise be provided by the State's Medicaid program. The 1915(c) benefit therefore is available only to those individuals who meet an institutional level of care need as defined by the State. The waiver program specifies the level(s) of care it will cover in the 1915(c) application.

The three valid choices are the only institutional levels of care applicable to the 1915(c) waiver program. Definitions of these levels of care are established by each State.

Valid Choices:

1. Nursing Home (NF)
2. Hospital
3. Intermediate Care Facility for the Mentally Retarded (ICF/MR)
4. PRTF Psychiatric Residential Treatment Facility

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "Concurrent 1915(a)/1915(c) Waivers".
2. Must select one valid choice.
3. May select more than one valid choice.

DATA ELEMENT: DESCRIPTION OF 1915 (A)/1915 (C) WAIVERS

Definition:

Description of interface between the 1915(a) and the 1915(c) waiver programs. Describe in general terms:

- If the 1915(c) State Operating Agency Contact is not the same as the 1915(a) Agency Contact, describe how the two agencies coordinate administration of the program.

Valid Choices:

Memo field:

Provide a text box with the instructions: "Provide a SHORT description. No abbreviations should be used".

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "Concurrent 1915(a)/1915(c) Waivers".
2. If an entry is made, all text should be spelled out completely; no abbreviations should be used.

VII. CATEGORY: CONCURRENT 1915(b)/1915(c) WAIVERS

DATA ELEMENT: STATE MEDICAID AGENCY CONTACT

Definition:

Name, title, Name of Agency, organization, and 10-digit telephone number of State Medicaid person **responsible for the Concurrent Operating 1915(c) program**. All text should be spelled out completely; no abbreviations should be used; Enter text in initial capital format. **(This information will be published.)**

Valid Choices:

Provide text boxes for Entering the following information:

- Text box 1. Last Name of State Medicaid Contact Person
- Text box 2. First Name of State Medicaid Contact Person
- Text box 3. Title of State Medicaid Contact Person
- Text box 4. Organization of State Medicaid Contact Person
- Text box 5. State Medicaid Contact Telephone Number, in the format, (XXX) XXX-XXXX x XXXX

Edit Conditions:

- 6. Must complete if OPERATING AUTHORITY is “Concurrent 1915(b)(c) Waivers”.
- 7. Text boxes 1-5 must be completed.
- 8. 10-Digit telephone number must be entered in the specified format, area code in parentheses. 4-Digit extension is optional.
- 9. All text must be spelled out completely; no abbreviations may be used; text must be entered in initial capital format.
- 10. Allow up to 30 characters for Text box 1, up to 20 characters for Text box 2, 50 characters for Text box 3, and 50 characters for Text box 4.

DATA ELEMENT: STATE OPERATING AGENCY CONTACT

Definition:

Name, title, Name of Agency, organization, and 10-digit telephone number of State person (from another agency) that is **responsible for coordinating the daily operation with the State Medicaid Agency Contact for the Concurrent Operating 1915(c) program**. All text should be spelled out completely; no abbreviations should be used; Enter text in initial capital format. **(This information will be published.)**

Valid Choices:

Provide text boxes for entering the following information:

- Text box 1. Last Name of State Operating Agency Contact Person
- Text box 2. First Name of State Operating Agency Contact Person
- Text box 3. Title of State Operating Agency Contact Person
- Text box 4. Name of Operating Agency
- Text box 5. Organization of State Operating Agency Contact Person
- Text box 6. State Operating Agency Contact Telephone Number, in the format, (XXX) XXX-XXXX x XXXX

Edit Conditions:

- 6. "Optional" if OPERATING AUTHORITY is "Concurrent 1915(b)/1915(c) Waivers."
- 7. Text boxes 1-6 must be completed.
- 8. 10-Digit telephone number must be entered in the specified format, area code in parentheses. 4-Digit extension is optional.
- 9. All text must be spelled out completely; no abbreviations may be used; text must be entered in initial capital format.
- 10. Allow up to 30 characters for Text box 1, up to 20 characters for Text box 2, 50 characters for Text box 3, 50 characters for Text box 4, and 50 characters for Text box 5.

DATA ELEMENT: PROGRAM SERVICE AREA

Definition:

The geographic area served by the program may be Statewide, or if less than Statewide, may be defined by County, City, Region, or other type of geographic area. This element asks States to report how they define Concurrent Operating 1915(c) program as of DATA COLLECTION EFFECTIVE DATE.

- A program's service area is **Statewide**, if the program operates throughout the entire State.
- A program's service area is defined by **County**, if the program serves a county or several counties within the State. If the program serves all counties in a State, then report the program as Statewide.
- A program's service area is defined by **City**, if the program serves a city or several cities within the State.
- A program's service area is defined by **Region**, if the program serves a region or regions not defined by individual counties within the State.

Valid Choices:

6. Statewide
7. County
8. City
9. Region
10. Other

Text box:

If "5" is selected, provide a text box with the statement "Please describe Other; do not use abbreviations; enter the text in initial capital format. If more than one Other, click "Enter" between entries".

Edit Conditions:

3. Must complete if OPERATING AUTHORITY is "Concurrent 1915(b)/1915(c) Waivers."
4. Must select one valid choice.
3. May select more than one valid choice.
4. If "1" is selected may not select any other valid choice.
5. If "5" is selected, must complete text box. Allow up to 40 characters per entry.

DATA ELEMENT: INITIAL WAIVER EFFECTIVE DATE

(Subsequent Renewals do not change this date)

Definition:

Date the Concurrent Operating 1915(c) waiver was effective.

Valid Choices:

Numeric Field

8-digit waiver approval date in format MM/DD/YYYY

Edit Conditions:

4. Must complete if OPERATING AUTHORITY is "Concurrent 1915(b)/1915(c) Waivers."
5. Enter 8-digit waiver approval date: 2-digit Month, 2-digit Day, 4-digit Year of the program.
6. Do not accept dates after DATA COLLECTION DATE.

DATA ELEMENT: WAIVER EXPIRATION DATE

Definition:

Date the Concurrent Operating 1915(c) waiver (including temporary waiver extensions), under which the program operates, expires.

Valid Choices:

Numeric Field

8-digit expiration date in format MM/DD/YYYY

Edit Conditions:

4. Must complete if OPERATING AUTHORITY is "Concurrent 1915(b)/1915(c) Waivers."
5. Enter 8-digit expiration date: 2-digit Month, 2-digit Day, 4-digit Year of the program.
6. Do not accept dates prior to DATA COLLECTION DATE.

DATA ELEMENT: SECTIONS OF TITLE XIX WAIVED

Definition:

States that operate under a 1915(c) waiver request a waiver of Section 1902(a)(10)(B) and one or both of the following statutory sections. In this DATA ELEMENT, States should specify which of these sections have been waived for the Concurrent Operating 1915(c) program.

- **1902(a)(1) Statewideness**--This section of the Social Security 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 Social Security Act requires Medicaid State 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)(10)(C)(i)(III) Income and Resource Rules**-- This section of the Social Security Act defines income and eligibility rules for the medically needy to receive community Medicaid services. Waiving this provision allows the program to provide community services using institutional eligibility rules.

Valid Choices:

1. 1902(a)(1) Statewideness
2. 1902(a)(10)(B) Comparability of Services
3. 1902(a)(10)(C)(i)(III) Income and Resource Rules

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "Concurrent 1915(b)/1915(c) Waivers."
2. Must select "2" if OPERATING AUTHORITY is "Concurrent 1915(b)/1915(c) Waivers."
3. May select more than one valid choice.

DATA ELEMENT: TARGET GROUP

Definition:

The waiver of Section 1902(a)(10)(B) of the Act is granted to target services to selected group(s) of individuals who would otherwise be eligible for institutional services. These should match the group(s) listed in the 1915(c) application.

- Aged are individuals age 65 and older
- Disabled are physically disabled, as defined by the State.
- Aged and Disabled is a permitted combination. Individuals may be aged, or disabled, or both.
- Mentally Retarded, as defined by the State.
- Developmental Disabled, as defined by the State.
- Mentally Retarded and Developmental Disabled is a permitted combination. Individuals may have mental retardation, developmental delay, or both.
- Seriously Mentally Ill or Substance Use Disorders or both
- "Other" are additional targeting criteria that the State has defined and that have been approved by CMS for the waiver.

Valid Choices:

1. Aged
2. Disabled
3. Aged and Disabled
4. Mentally Retarded
5. Developmental Disabled
6. Mentally Retarded and Developmental Disabled
7. Seriously Mentally Ill or Substance Use Disorders or both
8. Other

Text box:

If "8" is selected, provide a text box with the statement: "Specify other population; do not use abbreviations; enter text in initial capital format. If more than one, click "Enter" after each population".

Edit Conditions:

5. Must complete if OPERATING AUTHORITY is "Concurrent 1915(b)/1915(c) Waivers."
6. Must select one valid choice.
7. May select more than one valid choice.
8. If "8" is selected, must complete text box. Allow entries of up to 50 characters each.

DATA ELEMENT: LEVEL OF CARE

Definition:

The 1915(c) waiver program provides home and community-based services to individuals who, but for the provision of those services, would require institutional care that would otherwise be provided by the State's Medicaid program. The 1915(c) benefit therefore is available only to those individuals who meet an institutional level of care need as defined by the State. The waiver program specifies the level(s) of care it will cover in the 1915(c) application.

The three valid choices are the only institutional levels of care applicable to the 1915(c) waiver program. Definitions of these levels of care are established by each State.

Valid Choices:

1. Nursing Home (NF)
2. Hospital
3. Intermediate Care Facility for the Mentally Retarded (ICF/MR)
4. PRTF Psychiatric Residential Treatment Facility

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "Concurrent 1915(b)/1915(c) Waivers".
2. Must select one valid choice.
3. May select more than one valid choice.

DATA ELEMENT: DESCRIPTION OF 1915 (B)/1915 (C) WAIVERS

Definition:

Description of interface between the 1915(b) and the 1915(c) waiver programs. Describe in general terms:

- If the 1915(c) State Operating Agency Contact is not the same as the 1915(b) Agency Contact, describe how the two agencies coordinate administration of the program.

Valid Choices:

Memo field:

Provide a text box with the instructions: "Provide a SHORT description. No abbreviations should be used".

Edit Conditions:

3. Must complete if OPERATING AUTHORITY is "Concurrent 1915(b)/1915(c) Waivers".
4. If an entry is made, all text should be spelled out completely; no abbreviations should be used.

VIII.CATEGORY: CONCURRENT 1932(a)/1915(c) WAIVERS

DATA ELEMENT: STATE MEDICAID AGENCY CONTACT

Definition:

Name, title, Name of Agency, organization, and 10-digit telephone number of State Medicaid person **responsible for the Concurrent Operating 1915(c) program**. All text should be spelled out completely; no abbreviations should be used; Enter text in initial capital format. **(This information will be published.)**

Valid Choices:

Provide text boxes for Entering the following information:

- Text box 1. Last Name of State Medicaid Contact Person
- Text box 2. First Name of State Medicaid Contact Person
- Text box 3. Title of State Medicaid Contact Person
- Text box 4. Organization of State Medicaid Contact Person
- Text box 5. State Medicaid Contact Telephone Number, in the format, (XXX) XXX-XXXX x XXXX

Edit Conditions:

11. Must complete if OPERATING AUTHORITY is "Concurrent 1932(a)/1915(c) Waivers".
12. Text boxes 1-5 must be completed.
13. 10-Digit telephone number must be entered in the specified format, area code in parentheses. 4-Digit extension is optional.
14. All text must be spelled out completely; no abbreviations may be used; text must be entered in initial capital format.
15. Allow up to 30 characters for Text box 1, up to 20 characters for Text box 2, 50 characters for Text box 3, and 50 characters for Text box 4.

DATA ELEMENT: STATE OPERATING AGENCY CONTACT

Definition:

Name, title, Name of Agency, organization, and 10-digit telephone number of State person (from another agency) that is **responsible for coordinating the daily operation with the State Medicaid Agency Contact for the Concurrent Operating 1915(c) program**. All text should be spelled out completely; no abbreviations should be used; Enter text in initial capital format. **(This information will be published.)**

Valid Choices:

Provide text boxes for entering the following information:

- Text box 1. Last Name of State Operating Agency Contact Person
- Text box 2. First Name of State Operating Agency Contact Person
- Text box 3. Title of State Operating Agency Contact Person
- Text box 4. Name of Operating Agency
- Text box 5. Organization of State Operating Agency Contact Person
- Text box 6. State Operating Agency Contact Telephone Number, in the format, (XXX) XXX-XXXX x XXXX

Edit Conditions:

11. "Optional" if OPERATING AUTHORITY is "Concurrent 1915(b)/1915(c) Waivers."
12. Text boxes 1-6 must be completed.
13. 10-Digit telephone number must be entered in the specified format, area code in parentheses. 4-Digit extension is optional.
14. All text must be spelled out completely; no abbreviations may be used; text must be entered in initial capital format.
15. Allow up to 30 characters for Text box 1, up to 20 characters for Text box 2, 50 characters for Text box 3, 50 characters for Text box 4, and 50 characters for Text box 5.

DATA ELEMENT: PROGRAM SERVICE AREA

Definition:

The geographic area served by the program may be Statewide, or if less than Statewide, may be defined by County, City, Region, or other type of geographic area. This element asks States to report how they define Concurrent Operating 1915(c) program as of DATA COLLECTION EFFECTIVE DATE.

- A program's service area is **Statewide**, if the program operates throughout the entire State.
- A program's service area is defined by **County**, if the program serves a county or several counties within the State. If the program serves all counties in a State, then report the program as Statewide.
- A program's service area is defined by **City**, if the program serves a city or several cities within the State.
- A program's service area is defined by **Region**, if the program serves a region or regions not defined by individual counties within the State.

Valid Choices:

11. Statewide
12. County
13. City
14. Region
15. Other

Text box:

If "5" is selected, provide a text box with the statement "Please describe Other; do not use abbreviations; enter the text in initial capital format. If more than one Other, click "Enter" between entries".

Edit Conditions:

5. Must complete if OPERATING AUTHORITY is "Concurrent 1932(a)/1915(c) Waivers."
6. Must select one valid choice.
3. May select more than one valid choice.
4. If "1" is selected may not select any other valid choice.
5. If "5" is selected, must complete text box. Allow up to 40 characters per entry.

DATA ELEMENT: INITIAL WAIVER EFFECTIVE DATE

(Subsequent Renewals do not change this date)

Definition:

Date the Concurrent Operating 1915(c) waiver was effective.

Valid Choices:

Numeric Field

8-digit waiver approval date in format MM/DD/YYYY

Edit Conditions:

7. Must complete if OPERATING AUTHORITY is "Concurrent 1932(a)/1915(c) Waivers."
8. Enter 8-digit waiver approval date: 2-digit Month, 2-digit Day, 4-digit Year of the program.
9. Do not accept dates after DATA COLLECTION DATE.

DATA ELEMENT: WAIVER EXPIRATION DATE

Definition:

Date the Concurrent Operating 1915(c) waiver (including temporary waiver extensions), under which the program operates, expires.

Valid Choices:

Numeric Field

8-digit expiration date in format MM/DD/YYYY

Edit Conditions:

7. Must complete if OPERATING AUTHORITY is "Concurrent 1932(a)/1915(c) Waivers."
8. Enter 8-digit expiration date: 2-digit Month, 2-digit Day, 4-digit Year of the program.
9. Do not accept dates prior to DATA COLLECTION DATE.

DATA ELEMENT: SECTIONS OF TITLE XIX WAIVED

Definition:

States that operate under a 1915(c) waiver request a waiver of Section 1902(a)(10)(B) and one or both of the following statutory sections. In this DATA ELEMENT, States should specify which of these sections have been waived for the Concurrent Operating 1915(c) program.

- **1902(a)(1) Statewideness**--This section of the Social Security 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 Social Security Act requires Medicaid State 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)(10)(C)(i)(III) Income and Resource Rules**-- This section of the Social Security Act defines income and eligibility rules for the medically needy to receive community Medicaid services. Waiving this provision allows the program to provide community services using institutional eligibility rules.

Valid Choices:

4. 1902(a)(1) Statewideness
5. 1902(a)(10)(B) Comparability of Services
6. 1902(a)(10)(C)(i)(III) Income and Resource Rules

Edit Conditions:

4. Must complete if OPERATING AUTHORITY is "Concurrent 1932(a)/1915(c) Waivers."
5. Must select "2" if OPERATING AUTHORITY is "Concurrent 1932(a)/1915(c) Waivers."
6. May select more than one valid choice.

DATA ELEMENT: TARGET GROUP

Definition:

The waiver of Section 1902(a)(10)(B) of the Act is granted to target services to selected group(s) of individuals who would otherwise be eligible for institutional services. These should match the group(s) listed in the 1915(c) application.

- Aged are individuals age 65 and older
- Disabled are physically disabled, as defined by the State.
- Aged and Disabled is a permitted combination. Individuals may be aged, or disabled, or both.
- Mentally Retarded, as defined by the State.
- Developmental Disabled, as defined by the State.
- Mentally Retarded and Developmental Disabled is a permitted combination. Individuals may have mental retardation, developmental delay, or both.
- Seriously Mentally Ill or Substance Use Disorders or both
- "Other" are additional targeting criteria that the State has defined and that have been approved by CMS for the waiver.

Valid Choices:

1. Aged
2. Disabled
3. Aged and Disabled
4. Mentally Retarded
5. Developmental Disabled
6. Mentally Retarded and Developmental Disabled
7. Seriously Mentally Ill or Substance Use Disorders or both
8. Other

Text box:

If "8" is selected, provide a text box with the statement: "Specify other population; do not use abbreviations; enter text in initial capital format. If more than one, click "Enter" after each population".

Edit Conditions:

9. Must complete if OPERATING AUTHORITY is "Concurrent 1932(a)/1915(c) Waivers)."
10. Must select one valid choice.
11. May select more than one valid choice.
12. If "8" is selected, must complete text box. Allow entries of up to 50 characters each.

DATA ELEMENT: LEVEL OF CARE

Definition:

The 1915(c) waiver program provides home and community-based services to individuals who, but for the provision of those services, would require institutional care that would otherwise be provided by the State's Medicaid program. The 1915(c) benefit therefore is available only to those individuals who meet an institutional level of care need as defined by the State. The waiver program specifies the level(s) of care it will cover in the 1915(c) application.

The three valid choices are the only institutional levels of care applicable to the 1915(c) waiver program. Definitions of these levels of care are established by each State.

Valid Choices:

1. Nursing Home (NF)
2. Hospital
3. Intermediate Care Facility for the Mentally Retarded (ICF/MR)
4. PRTF Psychiatric Residential Treatment Facility

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "Concurrent 1932(a)/1915(c) Waivers".
2. Must select one valid choice.
3. May select more than one valid choice.

DATA ELEMENT: DESCRIPTION OF 1915 (B)/1915 (C) WAIVERS

Definition:

Description of interface between the 1932(a) and the 1915(c) waiver programs. Describe in general terms:

- If the 1915(c) State Operating Agency Contact is not the same as the 1915(b) Agency Contact, describe how the two agencies coordinate administration of the program.

Valid Choices:

Memo field:

Provide a text box with the instructions: "Provide a SHORT description. No abbreviations should be used".

Edit Conditions:

5. Must complete if OPERATING AUTHORITY is "Concurrent 1932(a)/1915(c) Waivers".
6. If an entry is made, all text should be spelled out completely; no abbreviations should be used.

IX. CATEGORY: PROGRAM of ALL-inclusive CARE for the ELDERLY (PACE)

DATA ELEMENT: STATE MEDICAID AGENCY CONTACT

Definition:

Name, title, Name of Agency, organization, and 10-digit telephone number of State Medicaid person **responsible for the PACE program**. All text should be spelled out completely; no abbreviations should be used; Enter text in initial capital format. **(This information will be published.)**

Valid Choices:

Provide text boxes for Entering the following information:

- Text box 1. Last Name of State Medicaid Contact Person
- Text box 2. First Name of State Medicaid Contact Person
- Text box 3. Title of State Medicaid Contact Person
- Text box 4. Organization of State Medicaid Contact Person
- Text box 5. State Medicaid Contact Telephone Number, in the format, (XXX) XXX-XXXX x
XXXX

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "PACE Program."
2. Text boxes 1-5 must be completed.
3. 10-Digit telephone number must be entered in the specified format, area code in parentheses. 4-Digit extension is optional.
4. All text must be spelled out completely; no abbreviations may be used; text must be entered in initial capital format.
5. Allow up to 30 characters for Text box 1, up to 20 characters for Text box 2, 50 characters for Text box 3, and 50 characters for Text box 4.
6. If the OPERATING AUTHORITY is "PACE Program", the Program name must be "Program of All-inclusive Care for the Elderly (PACE)".

DATA ELEMENT: APPROVED PACE ORGANIZATION NAME

Definition:

The name of the approved **PACE** organization that provides pre-paid, capitated, comprehensive health care services to the frail elderly.

Valid Choices:

Text box:

Provide a text box with the statement: "Please enter name of the PACE organization."

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "PACE Program."
2. All text should be spelled out completely; no abbreviations should be used.
3. Allow entry of up to 100 characters.

DATA ELEMENT: CONTACT INFO FOR APPROVED PACE ORGANIZATION

Definition:

Name of contact person, physical location address, and 10-digit telephone number of person (from approved PACE organization) **that is responsible for coordinating the daily operation for PACE Program**. All text should be spelled out completely; no abbreviations should be used; Enter text in initial capital format. **(This information will be published.)**

Valid Choices:

Provide text boxes for entering the following information:

- Text box 1. Last Name of PACE Organization Contact Person
- Text box 2. First Name of PACE Organization Contact Person
- Text box 3. PACE Organization Address
- Text box 4. PACE Contact Telephone Number, in the format, (XXX) XXX-XXXX x XXXX

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "PACE PROGRAM".
2. Text boxes 1-4 must be completed.
3. 10-digit telephone number must be entered in the specified format, area code in parenthesis. 4-Digit extension is optional.
4. All text must be spelled out completely; no abbreviations may be use; text must be entered in initial capital format.
5. Allow up to 30 characters for Text box 1, up to 20 characters for Text box 2, and 50 characters for Text box 3

DATA ELEMENT: PROGRAM AGREEMENT EFFECTIVE DATE

Definition:

Effective date of the approved program agreement between CMS, State, and the **PACE** organization. **(This is NOT the date the program agreement was signed).**

Valid Choices:

Numeric Field

8-digit approval date in format MM/DD/YYYY

Edit Conditions:

1. Must complete if OPERATING AUTHORITY is "PACE Program".
2. Enter 8-digit approval date: 2-digit Month, 2-digit Day, 4-digit Year of the program.

DATA ELEMENT: STANDARD PROGRAM DESCRIPTION

Definition:

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provide pre-paid, capitated, comprehensive health care services to the frail elderly.

To be eligible to enroll, individuals must be 55 years of age or 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 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.

Edit Conditions:

1. Must include this STANDARD PROGRAM DESCRIPTION for all "PACE Programs."

X. CATEGORY: QUALITY ACTIVITIES FOR MANAGED CARE ORGANIZATIONS (MCOs)

DATA ELEMENT: STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES

Definition:

As a result of the Balanced Budget Act (BBA) of 1997, CMS requires that States implement strategies for quality assessment and performance improvement to ensure the delivery of quality care and services by their MCOs contract to the State Medicaid agency. States are required to include certain activities as part of their strategies. Other activities, though not required by the legislation may be performed by States at their option. This element asks for information on whether or not a State has performed the following activities relative to MCOs participating in the State's managed care program.

- **Non-Duplication based on Accreditation** – Non-duplication based on Accreditation may apply when: (1) the MCO is accredited by an organization as meeting a certain access, structure/operation, and/or quality improvement standards, determined by the State to be at least as stringent as State-specific standards required in 42 CFR 438 Subpart D; (2) the State deems the accrediting organization's standards are consistent with the CMS Protocol for "Determining MCO Compliance with Federal Medicaid Managed Care Regulations" (42 CFR 438.350(e)); and (3) the accrediting organization is not contracted as an External Quality Review Organization with the State. If all three conditions are met, some States deem the MCO to be in compliance with one or more state-specific standards in lieu of duplicating the State's oversight.
- **Accreditation for Participation** – State requirement that plans must be accredited to participate in the Medicaid managed care program. Do not include "non-duplication" activities here.
- **Consumer Self-Report Data** – data collected through a survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a MCO. The survey may be conducted by the State or a contractor to the State. Report all beneficiary surveys, regardless of whether the survey includes the entire Medicaid population enrolled in the MCO or only a subpopulation such as individuals with special health care needs or disenrollees. Consumer focus groups should also be included.
- **Encounter Data** – detailed data about individual services provided to individual beneficiaries at the point of the beneficiary's interaction with a MCO institutional or practitioner provider. The level of detail about each reported service is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow" or "pseudo" claims data. If MCOs also report actual claims paid to their providers to the State, consider this to be MCO encounter data.
- **Enrollee Hotlines** – toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their MCO. 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 **period of** time. These projects are usually

based on information extracted from medical records, or MCO administrative data such as enrollment files and encounter or claims data. State staff, EQRO staff, MCO staff or more than one of these entities may perform such studies at the discretion of the State.

- **MCO Standards** – These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each MCO must have in order to participate in the Medicaid program.
- **Monitoring of MCO** – activities related to the monitoring of standards that have been set for access, plan structure, operations, and quality measurement/improvement 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. An Ombudsman is a neutral party who works with the enrollee, the MCO, and the provider (as appropriate) to resolve individual enrollee problems. Select this option only if the ombudsman program 1) is specifically identified by the State Medicaid agency to Medicaid beneficiaries for their use; and 2) provides aggregated data on problems encountered by Medicaid beneficiaries back to the State Medicaid agency.
- **On-Site Reviews** – reviews performed on-site at the MCO health care delivery sites to assess the physical resources and operational practices in place to deliver health care.
- **Performance Improvement Projects** – projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two **points in time** to ascertain if improvement has occurred based on one or more MCO interventions or improvement strategies. These projects are required by the State and can be of the MCO choosing or prescribed by the State
- **Performance Measures** – quantitative 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.
- **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 survey may be conducted by the State or a contractor of the State.
- **Network Data** – data collected on numbers, types and/or location of providers or facilities contracted in relation to enrollees. Network data may include assessment of “open or closed panels”, or average enrollee assignment panel size for Primary Care Physicians.

Valid Choices:

1. Non-Duplication Based on Accreditation
2. Accreditation for Participation
3. Consumer Self-Report Data
4. Encounter Data
5. Enrollee Hotlines
6. Focused Studies
7. MCO Standards
8. Monitoring MCO Standards
9. Ombudsman
10. On-Site Reviews
11. Performance Improvement Projects
12. Performance Measures
13. Provider Data
14. Network Data
15. OTHER

Text box:

If “15” is selected, provide a text box with the question: “What other activity(s) does the State Medicaid agency or its agent perform as part of its State quality assessment and improvement strategy? Do not use abbreviations. Enter text in initial capital format. If more than one other activity is conducted, please click “Enter” after each type.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
3. Must select one valid choice.
4. May select more than one valid choice.
5. If “15” is selected, the text box must be completed. Allow for entries up to 80 characters each.
6. A text box entry that consists only of the term “HEDIS” or “Healthcare Effectiveness Data and Information Set” is not acceptable.

DATA ELEMENT: ENCOUNTER DATA COLLECTION: REQUIREMENTS

Definition:

This DATA ELEMENT asks what State requirements/specifications are in place to ensure the submission of complete, accurate, and timely encounter data by the contracted MCOs.

Valid Choices:

1. State DID NOT provide any requirements for encounter data collection
2. Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
3. Requirements for MCOs to collect and maintain encounter data
4. Specifications for the submission of encounter data to the Medicaid agency
5. Standards for completeness, accuracy, and/or timeliness of encounter data submission
6. Incentives/sanctions to promote completeness, accuracy, and/or timeliness of encounter data submission
7. Requirements for data validation
8. OTHER

Text box:

If “8” is selected, provide a text box with the statement: “Please identify the other encounter data collection requirements. Do not use abbreviations. Enter text in initial capital format. If more than one, click “Enter” after each entry.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not “Encounter Data”.
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is “Encounter Data”.
5. If “1” selected, may not select “2” or “3” or “4” or “5” or “6” or “7” or “8”
6. If “2” or “3” or “4” or “5” or “6” or “7” or “8” selected, may select more than one valid choice.
7. If “8” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: ENCOUNTER DATA COLLECTION: SUBMISSION SPECIFICATIONS

Definition:

This DATA ELEMENT asks what the State specifications are for the submission of encounter data by the contracted MCOs.

Valid Choices:

1. Data submission requirements including documentation describing a set of encounter DATA ELEMENTs, definitions, sets of acceptable values, standards for data processing and editing
2. Use of Medicaid Identification Number for beneficiaries
3. Encounters to be submitted based upon national standardized forms (e.g., UB-04, NCPDP, ASC X12 837, ADA)
4. Use of “home grown” forms
5. Guidelines for frequency of encounter data submission
6. Guidelines for initial encounter data submission
7. Deadlines for regular/ongoing encounter data submission(s)
8. OTHER

Text box:

If “8” is selected, provide a text box with the statement: “Please identify the other encounter data submission specifications. Do not use abbreviations. Enter text in initial capital format. If more than one, click “Enter” after each entry.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip if MANAGED CARE ENTITY is not “MCO” or “HIO”.
3. Skip if ENCOUNTER DATA COLLECTION: REQUIREMENTS is not “Specifications for the submission of encounter data to the Medicaid agency”.
4. Must select one valid choice if ENCOUNTER DATA COLLECTION: REQUIREMENTS is “Specifications for the submission of encounter data to the Medicaid agency”.
5. May select more than one valid choice.
6. If “8” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: ENCOUNTER DATA COLLECTION: STANDARDIZED FORMS

Definition:

Standardized forms are needed to ensure that DATA ELEMENTs are reported uniformly by all providers, and that reports from multiple sources are comparable and can be reliably merged. This element reflects what standardized forms the State requires their contracting MCOs to use.

Valid Choices:

1. 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.
2. 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.
3. ANSI ASC X12 837 – transaction set format for transmitting health care claims data.
4. NCPDP – National Council for Prescription Drug Programs pharmacy claim form
5. ADA – American Dental Association dental claim form
6. OTHER

Text box:

If “6” is selected, provide a text box with the question: “What other standard formats does the State require? Do not use abbreviations. Enter text in initial capital format. If more than one other type of standard format is used, please click “Enter” after each type.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Skip if MANAGED CARE ENTITY is not “MCO” or “HIO”.
3. Skip if ENCOUNTER DATA SUBMISSION SPECIFICATIONS is not “Encounters to be submitted based on national standardized forms”.
4. Must select one valid choice if ENCOUNTER DATA SUBMISSION SPECIFICATIONS is “Encounters to be submitted based on national standardized forms”.
5. May select more than one valid choice.
6. If “6” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: ENCOUNTER DATA VALIDATION: DATA ACCURACY CHECKS

Definition:

This element addresses how data accuracy is addressed, whether the State or its agent conducts the activity or whether the State requires contracting MCOs to perform their own data accuracy assessments on their encounter data.

Data accuracy is defined as having information for the required encounter DATA ELEMENTs that validly represent care delivered. For example, encounters submitted could be checked to ensure that the beneficiary was eligible on the date of service, the encounter is not a duplicate of a previously reported encounter, or the provider type is appropriate for the procedure performed.

For each of the following Encounter DATA ELEMENTs, please enter a valid choice as indicated below:

(Note for programmer: the respondent must enter a "1", "2" or "3" for each of the items listed below. It may be easier for the respondent to complete if the respondent is able to enter the information off of one data entry screen rather than a screen for each element listed.)

- Date of Service
- Date of Processing
- Date of Payment
- Amount 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
- OTHER

Text box:

If "OTHER" is selected, provide a text box with the question: "What other encounter DATA ELEMENT(s) is/are included in the State's Accuracy Checks?" Do not use abbreviations. Enter text in initial capital format. If more than one, click "Enter" after each measure.

Valid Choices:

1. DATA ELEMENT is not a required or optional element in the data content (data set)
2. State/MCO DOES NOT conduct data accuracy check(s) on specified DATA ELEMENT
3. State/MCO conducts accuracy check(s) on specified DATA ELEMENT

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not “Encounter Data”.
4. Must select one valid choice for each of the Encounter DATA ELEMENTs listed if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is “Encounter Data”.
5. May select only one valid choice for each of the Encounter DATA ELEMENTs listed.
6. If “OTHER” is selected, must complete text box entry. Allow for entries of up to 80 characters each.
7. If “OTHER” is selected, may select only one valid choice for each of the “Other” Encounter DATA ELEMENTs provided.

DATA ELEMENT: ENCOUNTER DATA VALIDATION: DATA COMPLETENESS ASSESSMENTS

Definition:

Data completeness is defined as having encounter data that reflects the complete set of services provided to every beneficiary who receives services from an MCO. General data completeness assessments are attempts to assess the completeness of the entire encounter data submissions provided by an MCO. This element asks if the State conducts general completeness assessments.

Valid Choices:

1. State conducts general data completeness assessments
2. State DOES NOT conduct general data completeness assessments

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENTACTIVITIES is not “Encounter Data”.
4. Must select one valid choice for each of the Encounter DATA ELEMENTs listed if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is “Encounter Data”.

DATA ELEMENT: ENCOUNTER DATA VALIDATION: METHODS

Definition:

This element identifies those methods used by a State or its agent when conducting encounter data validation activities:

Valid Choices:

1. Automated edits of key fields used for calculation (e.g. codes within an allowable range)
2. Automated analysis of encounter data submission to help determine data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
3. Medical record validation
4. Specification / source code review, such as a programming language used to create an encounter data file for submission
5. Comparisons 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)
6. Per member per month analysis and comparisons across MCO
7. OTHER

Text box:

If "7" is selected, provide a text box with the question: "What other data validation method(s) does the State or its agent conduct? Do not use abbreviations. Enter text in initial capital format. If more than one other activity is conducted, please click "Enter" after each type."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if ENCOUNTER DATA: DATA ACCURACY CHECKS "2" for all choices and ENCOUNTER DATA: DATA COMPLETENESS ASSESSMENT "1".
4. Must select one valid choice if ENCOUNTER DATA: DATA ACCURACY CHECKS not "2" for all choices and ENCOUNTER DATA: DATA COMPLETENESS ASSESSMENT "1".
5. May select more than one valid choice.
6. If "7" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: TYPES

Definition:

Performance measures (PM) are quantitative measurements of particular aspects of health care quality. They may be used in a quality improvement initiative, or collected separately.

Performance measures may be collected by the State, an agent of the State, or by the MCO and submitted to the State, or they may be calculated by the State or its agent (i.e., using encounter data). This element identifies the types of PMs the State may calculate or require the MCO to collect and/or submit.

- **Process** – measures that assess the actual provision of services for the prevention, diagnosis, and treatment of diseases (e.g., immunization rates, pap smear rates, and retinal examinations for persons with diabetes).
- **Health Status/Outcomes** – measures that assess the results of care provided, which may include, for example, changes in functional and/or health status and patient satisfaction with care.
- **Access/Availability of Care** – measures that assess the degree to which individuals and groups are able to receive needed services from the MCO.
- **Use of Services/Utilization** – measures that provide information on the amount of services utilized by beneficiaries serviced by the MCO.
- **Health Plan Stability/Financial/Cost of Care** – measures that provide information on the MCOs financial stability or solvency (e.g., years in business, total revenue, net income, loss ratio, etc.). These measures can also provide information on cost of care such as trends of the cost of providing services.
- **Health Plan/Provider Characteristics** – measures that provide descriptive information about the number and characteristics of providers contracting with the MCO to provide services to Medicaid beneficiaries. These measures also provide information on the structure and administrative practices of the MCO and may include indicators such as the types of services and facilities available and the qualifications of practitioners.
- **Beneficiary Characteristics** – measures that provide descriptive information about the number and characteristics of beneficiaries served by the MCO.
- **OTHER** - measures that the MCO calculates or collects that do not fall into any of the above categories.

Valid Choices:

1. Process
2. Health Status/Outcomes
3. Access/Availability of Care
4. Use of Services/Utilization
5. Health Plan Stability/Financial/Cost of Care
6. Health Plan/Provider Characteristics
7. Beneficiary Characteristics
8. OTHER

Text box:

If “8” is selected, provide a text box with the question: “What other type(s) of performance measure does the State collect? Please give examples. Do not use abbreviations. Enter text in initial capital format. If more than one other type of data is collected, please click “Enter” after each type.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not “Performance Measures”.
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is “Performance Measures”.
5. May select more than one valid choice.
6. If “8” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: PROCESS

Definition:

PROCESS measures are measures that assess the actual provision of services for the prevention, diagnosis, and treatment of diseases (e.g., immunization rates, pap-smear rates, and retinal examinations for persons with diabetes). For each of the PROCESS performance measures listed below, select the ones that the State calculates, collects or requires its MCO to submit.

Valid Choices:

PROCESS

1. Immunizations for two year olds
2. Adolescent immunization rate
3. Breast cancer screening rate
4. Cervical cancer screening rate
5. Influenza vaccination rate
6. Well-child care visit rates in first 15 months of life
7. Well-child care visit rates in 3, 4, 5, and 6 years of life
8. Adolescent well-care visit rates
9. Dental services
10. Lead screening rate
11. Pregnancy prevention
12. Initiation of prenatal care – timeliness of care
13. Frequency of on-going prenatal care
14. Check-ups after delivery
15. Asthma care – medication use
16. Follow-up after hospitalization for mental illness
17. Initiation or engagement of SUD treatment
18. Hearing services for individuals less than 21 years of age
19. Vision services for individuals less than 21 years of age
20. Smoking prevention or cessation
21. Cholesterol screening or management
22. Percentage of beneficiaries with at least one dental visit
23. HIV/AIDS care
24. Diabetes management/care
25. Depression medication management
26. Chlamydia screening in women
27. Controlling high blood pressure
28. Beta-blocker treatment after heart attack
29. Heart Attack care
30. Heart Failure care
31. Pneumonia care
32. Colorectal Cancer Screening
33. Antidepressant medication management
34. Influenza vaccination
35. Pneumonia vaccination

36. Screening for Human Immunodeficiency Virus
37. AntiD Immune Globulin
38. Appropriate treatment for Children with Upper Respiratory Infection (URI)
39. Appropriate Testing for Children with Pharyngitis
40. Ace Inhibitor/Angiotensin Receptor Blocker Therapy
41. Left Ventricular Function Assessment
42. OTHER

Text box:

If “42” is selected, provide a text box with the question: “What other Process measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Process”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Process”.
5. May select more than one valid choice.
6. If “42” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: HEALTH STATUS/OUTCOMES

Definition:

HEALTH STATUS/OUTCOMES measures are measures that assess the results of care provided, which may include, for example, changes in functional and/or health status and patient satisfaction with care. For each of the HEALTH STATUS/OUTCOMES performance measures listed below, select the ones that the State calculates, collects, or requires its MCO to submit.

Valid Choices:

HEALTH STATUS/OUTCOMES

1. Number of children with diagnosis of rubella (measles) / 1,000 children
2. Percentage of low birth weight infants
3. Patient satisfaction with care delivered
4. Percentage of beneficiaries satisfied with their ability to access care
5. Mortality rates
6. OTHER

Text box:

If “6” is selected, provide a text box with the question: “What other Health Status/Outcomes measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Health Status/Outcomes”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Health Status/Outcomes”.
5. May select more than one valid choice.
6. If “6” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: ACCESS/AVAILABILITY OF CARE

Definition:

ACCESS/AVAILABILITY OF CARE measures are measures that assess the degree to which individuals and groups are able to receive needed services from the MCO. For each of the ACCESS/AVAILABILITY OF CARE performance measures listed below, select the ones that the State calculates, collects or requires its MCO to submit.

Valid Choices:

ACCESS/AVAILABILITY OF CARE

1. Ratio of PCPs to beneficiaries
2. Adult's access to preventive/ambulatory health services
3. Children's access to primary care practitioners
4. Average wait time for an appointment with PCP
5. Average distance to PCP
6. Ratio of mental health providers to number of beneficiaries
7. Ratio of dental providers to beneficiaries
8. Ratio of addiction professionals to number of beneficiaries
9. Percent of PCPs with "Open" or "Closed" Patient Assignment Panels
10. OTHER

Text box:

If "10" is selected, provide a text box with the question: "What other Access/Availability of Care measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if PERFORMANCE MEASURES: TYPES is not "Access/Availability of Care".
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is "Access/Availability of Care".
5. May select more than one valid choice.
6. If "10" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: USE OF SERVICES/UTILIZATION

Definition:

USE OF SERVICES/UTILIZATION measures are measures that provide information on the amount of services utilized by beneficiaries serviced by the MCO. For each of the USE OF SERVICES/UTILIZATION performance measures listed below, select the ones that the State calculates, collects or requires its MCOs to submit.

Valid Choices:

USE OF SERVICES/UTILIZATION

1. Number of PCP visits per beneficiary
2. Number of OB/GYN visits per adult female beneficiary
3. Number of specialist visits per beneficiary
4. Inpatient admissions / 1,000 beneficiaries
5. Emergency room visits / 1,000 beneficiaries
6. Number of days in ICF or SNF per beneficiary over 64 years
7. Drug Utilization
8. Percentage of beneficiaries with at least one dental visit
9. Number of home health visits per beneficiary
10. Inpatient admissions for MH/SUD conditions / 1,000 beneficiaries
11. Average number of visits to MH/SUD providers per beneficiary
12. Re-admission rates of MH/SUD
13. Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
14. OTHER

Text box:

If "14" is selected, provide a text box with the question: "What other Use of Services/Utilization measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if PERFORMANCE MEASURES: TYPES is not "Use of Services/Utilization".
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is "Use of Services/Utilization".
5. May select more than one valid choice.
6. If "14" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

**DATA ELEMENT: PERFORMANCE MEASURES: HEALTH PLAN
STABILITY/FINANCIAL/COST OF CARE**

Definition:

HEALTH PLAN STABILITY/FINANCIAL/COST OF CARE measures are measures that provide information on the MCO's financial stability and the MCO solvency (e.g., years in business, total revenue, net income, loss ratio, etc.). These measures can also provide information on cost of care such as information on trends of the cost of providing services. For each of the HEALTH PLAN STABILITY/FINANCIAL/COST OF CARE performance measures listed below, select the ones that the State calculates, collects or requires its MCOs to submit.

Valid Choices:

HEALTH PLAN STABILITY/FINANCIAL/COST OF CARE

1. Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
2. Total revenue
3. Net income
4. Medical loss ratio
5. Actual reserves held by plan
6. State minimum reserve requirements
7. Days cash on hand
8. Days in unpaid claims / claims outstanding
9. Net worth
10. OTHER

Text box:

If "10" is selected, provide a text box with the question: "What other Health Plan Stability/Financial/Cost of Care measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if PERFORMANCE MEASURES: TYPES is not "Health Plan Stability/Financial/Cost of Care".
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is "Health Plan Stability/Financial/Cost of Care".
5. May select more than one valid choice.
6. If "10" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: HEALTH PLAN/PROVIDER CHARACTERISTICS

Definition:

HEALTH PLAN/PROVIDER CHARACTERISTICS measures are measures that provide descriptive information about the number and characteristics of providers contracting with the MCO to provide services to Medicaid beneficiaries. These measures also provide information on the structure and administrative practices of the MCO and may include indicators such as the types of services and facilities available and the qualifications of practitioners. For each of the HEALTH PLAN/PROVIDER CHARACTERISTICS performance measures listed below, select the ones that the State calculates, collects or requires its MCOs to submit.

Valid Choices:

HEALTH PLAN/PROVIDER CHARACTERISTICS

1. Provider turnover
2. Board Certification
3. Languages spoken (other than English)
4. OTHER

Text box:

If “4” is selected, provide a text box with the question: “What other Health Plan/Provider Characteristics measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Health Plan/Provider Characteristics”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Health Plan/Provider Characteristics”.
5. May select more than one valid choice.
6. If “4” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: BENEFICIARY CHARACTERISTICS

Definition:

BENEFICIARY CHARACTERISTICS measures are measures that provide descriptive information about the number and characteristics of beneficiaries served by the MCO. For each of the BENEFICIARY CHARACTERISTICS performance measures listed below, select the ones that the State calculates, collects or requires its MCOs to submit.

Valid Choices:

BENEFICIARY CHARACTERISTICS

1. Percentage of beneficiaries who are auto-assigned to MCOs
2. MCO/PCP-specific disenrollment rate
3. Information of beneficiary ethnicity/race
4. Information on primary languages spoken by beneficiaries
5. Beneficiary need for interpreter
6. Weeks of pregnancy at time of enrollment in MCO, for women giving birth during the reporting period
7. Percentage of beneficiaries auto-assigned to PCP
8. OTHER

Text box:

If “8” is selected, provide a text box with the question: “What other Beneficiary Characteristics measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Beneficiary Characteristics”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Beneficiary Characteristics”.
5. May select more than one valid choice.
6. If “8” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: USE OF HEDIS MEDICAID MEASURES

Definition:

The **Healthcare Effectiveness Data** and Information Set (HEDIS) is a collection of performance measures and their specifications are produced by the National Committee for Quality Assurance (NCQA). Some State Medicaid agencies have chosen to have their MCOs report (or have a State contractor calculate and report) some or all of the HEDIS measures. In this element, a State is considered to use HEDIS measures if the measure was listed in HEDIS, even if the State modified the measure's specifications.

Valid Choices:

1. The State uses ALL of the HEDIS measures listed for Medicaid
2. The State uses SOME of the HEDIS measures listed for Medicaid
3. The State DOES NOT use any of the HEDIS measures

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Must select one valid choice.
4. May not select more than one valid choice.
5. May not select "1" or "2" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Measures". "3" is automatically selected if "Performance Measures" is not included under the STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES.

DATA ELEMENT: PERFORMANCE MEASURES: CALCULATION OF HEDIS MEASURES FROM ENCOUNTER DATA

Definition:

Some States have elected to generate HEDIS measures from encounter data as opposed to having the MCO generate HEDIS measures.

Valid Choices:

1. The State DOES NOT generate from encounter data any of the HEDIS measures listed for Medicaid
2. The State generates from encounter data ALL of the HEDIS measures listed for Medicaid
3. The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
4. 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

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Encounter Data" and "Performance Measures".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Encounter Data" and "Performance Measures".
5. May not select more than one valid choice.

DATA ELEMENT: PERFORMANCE MEASURES: HEDIS MEASURE SPECIFICATIONS

Definition:

Some States use or require their contracting MCOs to report some or all HEDIS measures specifications exactly as developed by NCQA. Some other States modify the HEDIS measures specifications. In this element, States that do not modify the HEDIS measures, other than to use only selected measures, should report that they use NCQA specifications.

Valid Choices:

1. State uses / requires MCOs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects
2. 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
3. State modifies / requires MCOs to modify some or all NCQA specifications in ways other than continuous enrollment

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if PERFORMANCE MEASURES: USE OF HEDIS MEDICAID MEASURES is "The State DOES NOT use any of the HEDIS measures".
4. Must select only one valid choice.
5. If "1" is selected, cannot select 2 or 3.
6. 2 and 3 can both be selected, if 1 not selected.

DATA ELEMENT: CONSUMER SELF-REPORT DATA

Definition:

Consumer self-report data is information collected through a survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a MCO. The survey may be conducted by the State or a contractor to the State. Report all beneficiary surveys, regardless of whether the survey includes the entire Medicaid population enrolled in the MCO or only a subpopulation such as individuals with special health care needs or disenrollees. Consumer focus groups should also be included. The State collects the following Consumer Assessment of Health Plans Survey (CAHPS) and/or "Other" types of Consumer Self-Report data:

Valid Choices:

1. CAHPS Adult Medicaid AFDC Questionnaire
2. CAHPS Child Medicaid AFDC Questionnaire
3. CAHPS Adult Medicaid SSI Questionnaire
4. CAHPS Child Medicaid SSI Questionnaire
5. CAHPS Adult with Special Needs Questionnaire
6. CAHPS Child with Special Needs Questionnaire
7. Consumer Oriented Mental Health Report Card
8. State-developed Survey
9. Disenrollment Survey
10. Consumer/Beneficiary Focus Groups
11. OTHER

Text box:

If "11" is selected, provide a text box with the question: "What other type(s) of consumer self-report data does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other type of data is collected, please click "Enter" after each type."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Consumer Self-Report Data".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Consumer Self-Report Data".
5. May select more than one valid choice.
6. If "11" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE IMPROVEMENT PROJECT REQUIREMENTS

Definition:

Performance improvement projects seek to improve the quality of care and services provided to Medicaid beneficiaries. MCOs may be required to conduct quality assessment and performance improvement projects relating to topics selected by the State or projects of their own choosing. Please indicate the State's requirements for the conduct of performance improvement projects by its MCOs.

Valid Choices:

1. MCOs are required to conduct a project(s) of their own choosing
2. All MCOs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency
3. 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. (For instance: regional projects).
4. Individual MCOs are required to conduct a project prescribed by the State Medicaid agency

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Improvement Projects".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Performance Improvement Projects".
5. May select more than one valid choice.

DATA ELEMENT: PERFORMANCE IMPROVEMENT PROJECTS

Definition:

Performance improvement projects seek to improve the quality of care and services provided to Medicaid beneficiaries. Please indicate the types of common performance improvement project(s) that *some or all* of the MCOs participating in the managed care program are required to conduct. The projects can be clinical, as well as non-clinical in focus.

- **Clinical Performance Improvement Projects** include projects focusing on Primary, Secondary, and/or Tertiary Prevention of Acute Conditions; Secondary, and/or Tertiary Prevention of Chronic Conditions; Care of Acute Conditions; Care of Chronic Conditions; High-Volume Services, High-Risk Services; and Continuity and Coordination of Care
- **Non-Clinical Performance Improvement Projects** include projects focusing on Availability, Accessibility, and Cultural Competency of Services; Interpersonal Aspects of Care; and Appeals, Grievances, and Other Complaints

Valid Choices:

1. Clinical Performance Improvement Projects
2. Non-Clinical Performance Improvement Projects

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Improvement Projects".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Performance Improvement Projects".
5. May select more than one valid choice.

DATA ELEMENT: CLINICAL PERFORMANCE IMPROVEMENT TOPICS

Definition:

For each clinical project required by the State, please provide the specific study topic area(s) to be addressed by the project.

Valid choices for Clinical Project Areas:

1. Well Child Care / EPSDT
2. Adolescent Well Care / EPSDT
3. Childhood Immunization
4. Adolescent Immunization
5. Child/Adolescent Hearing and Vision Screening and Services
6. Child/Adolescent Dental Screening and Services
7. Otitis Media management
8. Asthma management
9. Diabetes management
10. HIV Status/Screening
11. HIV/AIDS Prevention and/or Management
12. Smoking prevention and cessation
13. Adult hearing and vision screening
14. Cholesterol screening and management
15. Cervical cancer screening (Pap Test)
16. Cervical cancer treatment
17. Breast cancer screening (Mammography)
18. Breast cancer treatment
19. Pregnancy Prevention
20. Low birth-weight baby
21. Pre-natal Care
22. Inpatient maternity care and discharge planning
23. Post-natal Care
24. Newborn screening for heritable diseases
25. (Newborn) Failure to thrive
26. Emergency Room service utilization
27. Hospital Discharge Planning
28. Motor vehicle accidents
29. Domestic violence
30. Hip fractures
31. Prevention of Influenza
32. Medical problems of frail elderly
33. Treatment of myocardial infarction
34. Beta Blocker treatment after a heart attack
35. Coronary artery disease prevention
36. Coronary artery disease treatment
37. ETOH and other Substance Use Disorders screening and treatment
38. Substance Use Disorders treatment after detoxification service
39. Prescription drug abuse

40. Pharmacy Management
41. Depression management
42. Coordination of Primary and Behavioral Health care
43. Lead toxicity
44. Tuberculosis screening and treatment
45. Sickle cell anemia management
46. Hypertension management
47. Sexually transmitted disease screening
48. Sexually transmitted disease treatment
49. Hepatitis B screening and treatment
50. Hysterectomy
51. Coordination of care for persons with physical disabilities
52. OTHER

Text box:

If “52” is selected, provide a text box with the question: “What other common Clinical Performance Improvement Project Topics does the State address? Do not use abbreviations. Enter text in initial capital format. If more than one other topic is addressed, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
3. Skip if PERFORMANCE IMPROVEMENT PROJECTS is not “Clinical Performance Improvement Projects”.
4. Must select one valid choice if PERFORMANCE IMPROVEMENT PROJECTS is “Clinical Performance Improvement Projects”.
5. May select more than one valid choice.
6. If “52” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: NON-CLINICAL PERFORMANCE IMPROVEMENT TOPICS

Definition:

For each performance improvement project required by the State, please provide the specific study topic area(s) to be addressed by the project.

Valid Choices for Non-Clinical Project Area:

1. Availability of language interpretation services
2. Adults access to preventative/ambulatory health services
3. Children's access to primary care practitioners
4. Health information technology (e.g., state implementation of immunization and other registries, telemedicine initiatives or Regional Health Information Organization [RHIO] participation)
5. Reducing health care disparities via health literacy/education campaigns or other initiatives
6. OTHER

Text box:

If "6" is selected, provide a text box with the question: "What other **common** Non-Clinical Performance Improvement Topics does the State address? Do not use abbreviations. Enter text in initial capital format. If more than one other topic is addressed, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if PERFORMANCE IMPROVEMENT PROJECTS is not "Non-Clinical Performance Improvement Projects".
4. Must select one valid choice if PERFORMANCE IMPROVEMENT PROJECTS is "Non-Clinical Performance Improvement Projects".
5. May select more than one valid choice.
6. If "6" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: MCO STANDARDS

Definition:

Subpart D or 42 CFR Part 438 specifies State quality assessment and performance improvement strategies will address certain standards that States must implement to ensure the delivery of quality health care by all MCOs. States may impart additional structural and operational requirements on their MCO contractors. This element asks States to identify any additional quality standards that it requires its MCOs to meet, in part or in whole.

Valid Choices:

1. CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
2. NAIC (National Association of Insurance Commissioners) Standards
3. NCQA (National Committee for Quality Assurance) Standards
4. JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
5. URAC Standards
6. State-Developed/Specified Standards
7. OTHER

Text box:

If "7" is selected, must complete text entry box. Allow for entries of up to 80 characters each.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "MCO Standards".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "MCO Standards".
5. May select more than one valid choice.
6. If "7" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: ACCREDITATION REQUIRED FOR PARTICIPATION

Definition:

Several private organizations accredit MCOs. This DATA ELEMENT asks States to identify the organization(s) whose accreditation they require for the MCOs participating in the managed care program.

Valid Choices:

1. NCQA (National Committee for Quality Assurance)
2. JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
3. AAAHC (Accreditation Association for Ambulatory Health Care)
4. URAC
5. OTHER

Text box:

If "5" is selected, provide a text box with the question: "What other agency's accreditation process is accepted by the State? Do not use abbreviations; Enter text in initial capital format. If more than one, click "ENTER" after each agency."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Accreditation for Participation".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Accreditation for Participation".
5. May select more than one valid choice.
6. If "5" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: NON-DUPLICATION BASED ON ACCREDITATION

Definition:

Several organizations accredit managed care entities. This DATA ELEMENT asks States to identify the organization(s) with standards the State has determined are at least as stringent as the State-specific standard required in 42 CFR438 Subpart D, and whose accreditation the State uses, in part or in whole, to deem the MCO to be in compliance in lieu of duplicating the State's oversight.

Valid Choices:

1. NCQA (National Committee for Quality Assurance)
2. JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
3. AAAHC (Accreditation Association for Ambulatory Health Care)
4. COA (Council on Accreditation of Families & Children)
5. URAC
6. OTHER

Text box:

If "6" is selected, provide a text box with the question: "What other agency's accreditation process is accepted by the State? Do not use abbreviations; enter text in initial capital format. If more than one, click "Enter" after each agency."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Non-duplication based on Accreditation".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Non-Duplication based on Accreditation".
5. May select more than one valid choice.
6. If "6" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: EQRO ORGANIZATION

Definition:

Federal law requires States to provide for an external quality review of the access to, timeliness of, and quality outcomes of the services included in the MCO contract. States can contract with entities that meet competency requirements and tests of independence from the State Medicaid agency and from the MCO under review.

Valid Choices:

1. Quality Improvement Organization (QIO)
2. QIO-like entity
3. Private accreditation organization
4. State entity
5. Other

Text box:

If "5" is selected, provide a text box describing the other type of entity(ies) used for external quality review.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Must select one valid choice.
4. May select more than one valid choice.
5. If "5" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: EQRO NAME

Definition:

Name(s) of the EQRO agency or the State agency used by the State.

Valid Choices:

Text box:

Provide a text box with the statement: "Please specify the name(s) of the EQRO(s) used by your State. Do not use abbreviations. Enter text in initial capital format. If more than one, click "Enter" after each organization. Allow up to 5 organizations."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Allow for entries of up to 80 characters each.
4. Must make at least one entry.

DATA ELEMENT: MANDATORY EQRO ACTIVITIES

Definition:

Each State Medicaid agency that contracts with an MCO must ensure that a qualified EQRO perform an annual external quality review for each contracting MCO. The information used to carry out the review must be obtained from three mandatory EQRO-related activities. This DATA ELEMENT asks which mandatory activity(ies) are conducted by the EQRO.

Valid Choices:

1. Validation of performance improvement projects
2. Validation of performance measures
3. Review of MCO compliance with structural and operational standards established by the State

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. Must select one valid choice.
4. May select more than one valid choice.
5. May not select "1" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Improvement Projects".
6. May not select "2" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Measures".

DATA ELEMENT: OPTIONAL EQRO ACTIVITIES

Definition:

Each State Medicaid agency that contracts with an MCO must ensure that a qualified EQRO perform an annual external quality review for each contracting MCO. In addition to the three mandatory activities, there are five *optional* activities. This DATA ELEMENT asks which of the following optional services will be conducted by the EQRO.

Valid Choices:

1. Validation of encounter data
2. Administration or validation of consumer or provider surveys
3. Calculation of performance measures
4. Conduct of performance improvement projects
5. Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services (i.e. focused studies).
6. Technical assistance to MCOs to assist them in conducting quality activities.
7. Assessment of MCO Information Systems.
8. OTHER

Text box:

"If "8" is selected, provide a text box with the question: "What other "optional" external quality review activities does the State have their EQRO conduct? Do not use abbreviations. Enter text in initial capital format. If more than one, click "Enter" after each entry.

Edit Conditions:

1. Skip, if 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
3. May select more than one valid choice.
4. May not select "1" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Encounter Data".
5. May not select "2" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Consumer Self-Report Data" or "Provider Survey Data".
6. May not select "3" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Measures".
7. May not select "4" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Improvement Projects".
8. May not select "5" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Focused Studies".
9. If "8" is selected, must complete text box entry. Allow for entries up to 40 characters.

DATA ELEMENT: USE OF COLLECTED DATA

Definition:

States can use data they collect from quality activities in a number of ways to improve or assure quality of care. This element asks States to identify how it uses collected data.

- **Track Health Service Provision (Access and Utilization)** – Utilization data can be used to track the provision of health services over time and/or compare trends between managed care entities participating in the Medicaid program or managed care and FFS.
- **Monitor Quality Improvement** – Process and outcome data can be used to monitor whether MCOs improve the quality of care provided to Medicaid enrollees.
- **Beneficiary Plan Selection** – Quality and satisfaction data can be provided to beneficiaries to help them select a MCO.
- **Plan Reimbursement** – States may use the information they collect to help set capitation rates. States may also use the information to determine incentives and/or penalties based on plan performance.
- **Contract Standard Compliance** – States may use data they collect to monitor plan compliance with contract standards (e.g., waiting times for appointments).
- **Program Modification, Expansion, or Renewal** – States may use data they collect to make decisions about program modification, changes in coverage or benefits, or to support waiver renewal applications.
- **Program Evaluation** – States may use data they collect to assess program results or to evaluate the effectiveness of the programs they have in place.
- **Regulatory Compliance/Federal Reporting** – States may use data they collect to demonstrate compliance with regulations, for Federal reporting on waiver-related activities, or for general Federal reporting requirements.
- **Health Services Research** – States may use data they collect to conduct health services research or they may provide data to external entities for the conduct of health services research.
- **Fraud and Abuse** – States may use data they collect to identify potential instances of fraud and abuse by providers, managed care entities, etc.
- **Data Mining** – States may use data they collect to sort through data to identify and establish relationships. The key idea of the process is not hypothesis-driven, but attempts to identify unsuspected associations, clustering, forecasting, etc., that permits effective action to be taken in the absence of an explanation for the existence of the pattern.
- **ANOVA (Analysis of Variance)** – A mathematical process for separating the variability of a group of observations into assignable causes and setting up various significance tests.
- **Enhance/Revise State Managed Care Medicaid Quality Strategy** – States may use data they collect to revise State improvement initiatives, MCO quality standards, or MCO reporting specifications/requirements for performance measurement reporting or performance improvement projects
- **Do Not Use the Data Collected**

Valid Choices:

1. Track Health Service Provision
2. Monitor Quality Improvement
3. Beneficiary Plan Selection
4. Plan Reimbursement
5. Contract Standard Compliance
6. Program Modification, Expansion, or Renewal
7. Program Evaluation
8. Regulatory Compliance/Federal Reporting
9. Health Services Research
10. Fraud and Abuse
11. Data Mining
12. ANOVA (Analysis of Variance)
13. State Medicaid Managed Care Quality Strategy
14. Do Not Use the Data Collected
15. Other

Text box

If “15” is selected, provide a text box with the instructions: “Please identify the other uses of collected data. Do not use abbreviations. Enter text in initial capital format. If more than one, click “Enter” after each entry.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
3. Must select one valid choice.
4. May select more than one valid choice.
5. If “14” is selected, may not select any other valid choice.
6. If “15” is selected, text box must be completed. Allow for entries of up to 80 characters each.

DATA ELEMENT: PAY for PERFORMANCE (P4P) PROGRAMS

Definition:

Pay-for-Performance Programs are designed to improve patients' quality of care by **assessing service delivery or patient behavior based on pre-defined standards, and adjusting compensation of benefits accordingly**. This element identifies whether the State has implemented P4P with any MCOs participating in the State's managed care program. Note that we are interested in P4P arrangements between the State and MCOs, NOT arrangements between MCOs and their providers.

Valid Choices:

1. The State has implemented a Pay-for-Performance program with the MCO.
2. The State HAS NOT implemented a Pay-for-Performance program with the MCO.
3. The State HAS NOT implemented a Pay-for-Performance program with the MCO, but *plans to implement* one in the future.

Edit Condition:

1. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
2. Must select one valid value.
3. May only select one valid value.
4. If "2" is selected, the State may skip all subsequent P4P elements.

DATA ELEMENT: P4P PROGRAM PAYERS

Definition:

P4P programs may involve one or more payers. This element identifies the payers for the P4P program the State and MCOs have implemented.

Valid Choices:

1. Medicaid is the only payer
2. Medicaid has collaborated with a public sector entity to support the P4P program
3. Medicaid has collaborated with a private sector entity to support the P4P program
4. Medicaid has collaborated with public and private sectors to support the P4P program
5. Other

Text box:

If “5” is selected, provide a text box with the statement “What other payer(s) has the State collaborated with to support the P4P program? Do not use abbreviations; enter the text in initial capital format. If more than one Other, click “Enter” between entries”.

Edit Condition:

1. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
2. Must select one valid value.
3. May not select more than one valid value.
4. If “5” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: P4P POPULATION CATEGORIES INCLUDED

Definition:

State P4P programs may cover all members of the MCO, or only a subset of MCO members. This element identifies the criteria used to define the P4P beneficiary populations.

Valid Choices:

1. The State's P4P program with the MCO covers all MCO members.
2. The State's P4P program with the MCO covers a subset of MCO members, defined by Medicaid beneficiary Maintenance Assistance Status and Basis of Eligibility
3. The State's P4P program with the MCO covers a subset of MCO members, defined by disease or medical condition
4. The State's P4P program with the MCO covers a subset of MCO members, defined by beneficiary age
5. Other

Text box:

If "5" is selected, provide a text box with the statement: "Please specify the criteria used to define the P4P population; do not use abbreviations; enter text in initial capital format. If more than one, click "Enter" after each population".

Edit Condition:

1. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
2. Must select one valid value.
3. May select more than one valid value.
4. If "5" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: P4P REWARD MODELS

Definition:

There is a wide range of P4P reward models implemented throughout the country, including both financial and non-financial incentives. This DATA ELEMENT identifies the components of the P4P reward models the State has implemented in its P4P program.

Valid Choices:

1. The State uses payment incentives/differentials to reward MCOs
2. The State uses preferential auto-enrollment to reward MCOs
3. The State uses public reporting to reward MCOs
4. The State uses member incentives in the MCO P4P program
5. The State uses withholds as an incentive
6. Other

Text box:

If “6” is selected, provide a text box with the statement “What other P4P incentive(s)/strategies does the P4P program use? Do not use abbreviations; enter the text in initial capital format. If more than one Other, click “Enter” between entries”.

Edit Condition:

1. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
2. Must select one valid value.
3. May select more than one valid value.
4. If “6” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: P4P MEMBER INCENTIVES

Definition:

Member incentives is one of the reward models that States include in their P4P programs. This element identifies the member incentives that State rewards their members.

Valid Choices:

Text box:

Provide a text box with the statement: "Please specify the member incentive(s) that State used to reward their members (Ex: Reduced/free medical products). Do not use abbreviations.

Enter text in initial capital format. If more than one, click "Enter" after each member incentive.

Allow up to 10 member incentives.

Edit Condition:

1. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
2. Skip if P4P REWARD MODELS is not "The State uses member incentives in the MCO P4P program".
3. Allow for entries of up to 80 characters each.

DATA ELEMENT: P4P PROGRAM CLINICAL CONDITIONS

Definition:

There is a wide variety of clinical conditions targeted in current P4P programs implemented throughout the country. This element identifies the clinical conditions targeted by the P4P program.

Valid Choices:

1. Diabetes
2. Cardiac Care
3. Well-child visits
4. Childhood immunizations
5. Perinatal Care
6. Asthma
7. Depression
8. Obesity
9. Other

Text box:

If "9" is selected, provide a text box with the statement "What other clinical conditions does the P4P program provide rewards? Do not use abbreviations; enter the text in initial capital format. If more than one Other, click "Enter" between entries".

Edit Condition:

1. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO" AND P4P POPULATION CATEGORIES INCLUDED is "3 - The State's P4P program with the MCO covers a subset of MCO members, defined by disease or medical condition".
2. Must select one valid value.
3. May select more than one valid value.
4. If "9" is selected, must complete text box entry. Allow for entries of up to 40 characters each.

DATA ELEMENT: P4P PROGRAM: MEASUREMENT OF IMPROVED PERFORMANCE

Definition:

In P4P initiatives, “performance” is measured in varying ways. This element identifies the measures used by the State to reward MCOs P4P program performance.

Valid Choices:

1. The State measures MCO achievement using clinically-based outcome measures (e.g., HEDIS, NQF, etc.)
2. The State measures MCO achievement by assessing levels of technology adoption
3. The State measures MCO achievement by assessing the adoption of systematic quality improvement processes
4. The State measures MCO achievement by assessing the timely submission of complete and accurate electronic encounter/claims data
5. The State measures MCO achievement by assessing patient satisfaction measures
6. The State measures MCO achievement by assessing improvements in, or reaching established standards in, administrative processes (e.g. timeliness of MCO response to grievances, improving customer service, etc.)
7. Other

Text box:

If “7” is selected, provide a text box with the statement “What other performance measurement techniques are used by the P4P program? Do not use abbreviations; enter the text in initial capital format. If more than one Other, click “Enter” between entries”.

Edit Condition:

1. Must complete if MANAGED CARE ENTITY is “MCO” or “HIO”.
2. Must select one valid value.
3. May select more than one valid value.
4. If “7” is selected, must complete text box entry. Allow for entries of up to 40 characters each.

DATA ELEMENT: P4P PROGRAM - INITIAL YEAR OF REWARDS

Definition:

This element identifies the first year of rewards distribution (i.e., differential payments, auto-assignment and/or public reporting).

Valid Choices:

Numeric Field

4-digit year in format YYYY

Edit Condition:

1. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
2. Enter 4-digit year for initial P4P program reward distribution YYYY.

DATA ELEMENT: P4P PROGRAM: EVALUATION COMPONENT

Definition:

Some P4P initiatives include a component to evaluate the effectiveness of the P4P program. This element identifies the existence of a P4P program evaluation component.

Valid Choices:

1. The State has conducted an evaluation of the effectiveness of its P4P program
2. The State HAS NOT conducted an evaluation of the effectiveness of its P4P program
3. The State HAS NOT conducted an evaluation of the effectiveness of its P4P program, but *plans to conduct an evaluation* in the future

Edit Condition:

1. Must complete if MANAGED CARE ENTITY is "MCO" or "HIO".
2. Must complete if the State has implemented a Pay-for-Performance program with the MCO.
3. Skip if the State HAS NOT implemented a Pay-for-Performance program with the MCO or plans to implement one in the future.
4. Must select one valid value.
5. May only select one valid value.

**XI. CATEGORY: QUALITY ACTIVITIES FOR PREPAID
INPATIENT HEALTH PLANS (PIHPs)**

DATA ELEMENT: STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES

Definition:

As a result of the Balanced Budget Act (BBA) of 1997, CMS requires that States implement strategies for quality assessment and performance improvement to ensure the delivery of quality care and services by their PIHPs contracted to the State Medicaid agency. States are required to include certain activities as part of their strategies. Other activities, though not required by the legislation may be performed by States at their option. This element asks for information on whether or not a State has performed the following activities relative to their PIHP.

- **Non-Duplication based on Accreditation**– Non-duplication based on Accreditation(i.e., if the PIHP is accredited by an organization as meeting a certain access, structure/operation, and/or quality improvement standards, and the State determines that the accrediting organization’s standards are at least as stringent as a State-specific standard required in 42 CFR 438 Subpart D, some States deem the PIHP to be in compliance with a state-specific standard in lieu of duplicating the State’s oversight.
- **Accreditation for Participation**– State requirement that plans must be accredited to participate in the Medicaid managed care program. Do not include “Non-Duplication” activities here.
- **Consumer Self-Report Data** – data collected through a survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a PIHP. The survey may be conducted by the State or a contractor to the State. Report all beneficiary surveys, regardless of whether the survey includes the entire Medicaid population enrolled in the PIHP or only a subpopulation such as individuals with special health care needs or disenrollees. Consumer focus groups should also be included.
- **Encounter Data** – detailed data about individual services provided to individual beneficiaries at the point of the beneficiary’s interaction with a PIHP institutional or practitioner provider. The level of detail about each reported service is similar to that of a standard claim form. Encounter data are also sometimes referred to as “shadow” or “pseudo” claims data. If PIHPs also report actual claims paid to their providers to the State, consider this to be PIHP encounter data.
- **Enrollee Hotlines** – toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their PIHP. 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 **period of time**. These projects are usually based on information extracted from medical records, or PIHP administrative data such as enrollment files and encounter or claims data. State staff, EQRO staff, PIHP staff or more than one of these entities may perform such studies at the discretion of the State.
- **PIHP Standards** – These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each PIHP must have in

order to participate in the Medicaid program.

- **Monitoring of PIHP**– activities related to the monitoring of standards that have been set for access, plan structure, operations, and quality measurement/improvement to determine that standards have been established, implemented, adhered to, etc.
- **Ombudsman** – Non-duplication based on Accreditation may apply when: (1) the PIHP is accredited by an organization as meeting a certain access, structure/operation, and/or quality improvement standards, determined by the State to be at least as stringent as State-specific standards required in 42 CFR 438 Subpart D; (2) the State deems the accrediting organization’s standards are consistent with the CMS Protocol for “Determining MCO/PIHP Compliance with Federal Medicaid Managed Care Regulations” (42 CFR 438.350(e)); and (3) the accrediting organization is not contracted as an External Quality Review Organization with the State. If all three conditions are met, some States deem the PIHP to be in compliance with one or more state-specific standards in lieu of duplicating the State’s oversight.
- **On-Site Reviews** – reviews performed on-site at the PIHP health care delivery sites to assess the physical resources and operational practices in place to deliver health care.
- **Performance Improvement Projects** – projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two **points in time** to ascertain if improvement has occurred based on one or more PIHP interventions or improvement strategies. These projects are required by the State and can be of the PIHP choosing or prescribed by the State
- **Performance Measures** – quantitative 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 PIHP.
- **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 survey may be conducted by the State or a contractor of the State.
- **Network Data** – data collected on numbers, types and/or location of providers or facilities contracted in relation to enrollees. Network data may include assessment of “open or closed panels”, or average enrollee assignment panel size for Primary Care Physicians.

Valid Choices:

1. Non-Duplication Based on Accreditation
2. Accreditation for Participation
3. Consumer Self-Report Data

4. Encounter Data
5. Enrollee Hotlines
6. Focused Studies
7. PIHP Standards
8. Monitoring PIHP Standards
9. Ombudsman
10. On-Site Reviews
11. Performance Improvement Projects
12. Performance Measures
13. Provider Data
14. Network Data
15. OTHER

Text box:

If “15” is selected, provide a text box with the question: “What other activity(s) does the State Medicaid agency or its agent perform as part of its State quality assessment and improvement strategy? Do not use abbreviations. Enter text in initial capital format. If more than one other activity is conducted, please click “Enter” after each type.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PIHP”.
3. Must select one valid choice.
4. May select more than one valid choice.
5. If “15” is selected, the text box must be completed. Allow for entries up to 80 characters each.
6. A text box entry that consists only of the term “HEDIS” or “Healthcare Effectiveness Data and Information Set” is not acceptable.

DATA ELEMENT: ENCOUNTER DATA COLLECTION: REQUIREMENTS

Definition:

This DATA ELEMENT asks what State requirements/specification are in place to ensure the submission of complete, accurate, and timely encounter data by the contracted PIHPs.

Valid Choices:

1. State DID NOT provide any requirements for encounter data collection
2. Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
3. Requirements for PIHPs to collect and maintain encounter data
4. Specifications for the submission of encounter data to the Medicaid agency
5. Standards for completeness, accuracy, and/or timeliness of encounter data submission
6. Incentives/sanctions to promote completeness, accuracy, and/or timeliness of encounter data submission
7. Requirements for data validation
8. OTHER

Text box:

If “8” is selected, provide a text box with the statement: “Please identify the other encounter data collection requirements. Do not use abbreviations. Enter text in initial capital format. If more than one, click “Enter” after each entry.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PIHP”.
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not “Encounter Data”.
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is “Encounter Data”.
5. If “1” selected, may not select “2” or “3” or “4” or “5” or “6” or “7” or “8”.
6. If “2” or “3” or “4” or “5” or “6” or “7” or “8” selected, may select more than one valid choice.
7. If “8” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: ENCOUNTER DATA COLLECTION: SUBMISSION SPECIFICATIONS

Definition:

This DATA ELEMENT asks what the State specifications are for the submission of encounter data by the contracted PIHPs.

Valid Choices:

1. Data submission requirements including documentation describing a set of encounter DATA ELEMENTs, definitions, sets of acceptable values, standards for data processing and editing
2. Use of Medicaid Identification Number for beneficiaries
3. Encounters to be submitted based upon national standardized forms (e.g., UB-04, NCPDP, ASC X12 837, ADA)
4. Use of “home grown” forms
5. Guidelines for frequency of encounter data submission
6. Guidelines for initial encounter data submission
7. Deadlines for regular/ongoing encounter data submission(s)
8. OTHER

Text box:

If “8” is selected, provide a text box with the statement: “Please identify the other encounter data submission specifications. Do not use abbreviations. Enter text in initial capital format. If more than one, click “Enter” after each entry.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PIHP”.
3. Skip if ENCOUNTER DATA COLLECTION: REQUIREMENTS is not “Specifications for the submission of encounter data to the Medicaid Agency”.
4. Must select one valid choice if ENCOUNTER DATA COLLECTION: REQUIREMENTS is “Specifications for the submission of encounter data to the Medicaid Agency”.
5. May select more than one valid choice.
6. If “8” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: ENCOUNTER DATA COLLECTION: STANDARDIZED FORMS

Definition:

Standardized forms are needed to ensure that DATA ELEMENTs are reported uniformly by all providers, and that reports from multiple sources are comparable and can be reliably merged. This element reflects what standardized forms the State requires their contracting PIHPs to use.

Valid Choices:

1. 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.
2. 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.
3. ANSI ASC X12 837 – transaction set format for transmitting health care claims data.
4. NCPDP – National Council for Prescription Drug Programs pharmacy claim form
5. ADA – American Dental Association dental claim form
6. OTHER

Text box:

If “6” is selected, provide a text box with the question: “What other standard formats does the State require? Do not use abbreviations. Enter text in initial capital format. If more than one other type of standard format is used, please click “Enter” after each type.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PIHP”.
3. Skip if ENCOUNTER DATA SUBMISSION SPECIFICATIONS is not “Encounters to be submitted based on national standardized forms”.
4. Must select one valid choice if ENCOUNTER DATA SUBMISSION SPECIFICATIONS is “Encounters to be submitted based on national standardized forms”.
5. May select more than one valid choice.
6. If “6” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: ENCOUNTER DATA VALIDATION: DATA ACCURACY CHECKS

Definition:

This element addresses how data accuracy is addressed, whether the State or its agent conducts the activity or whether the State requires contracting PIHPs to perform their own data accuracy assessments on their encounter data.

Data accuracy is defined as having information for the required encounter DATA ELEMENTs that validly represent care delivered. For example, encounters submitted could be checked to ensure that the beneficiary was eligible on the date of service, the encounter is not a duplicate of a previously reported encounter, or the provider type is appropriate for the procedure performed.

For each of the following Encounter DATA ELEMENTs, please enter a valid choice as indicated below:

(Note for programmer: the respondent must Enter a "1", "2" or "3" for each of the items listed below. It may be easier for the respondent to complete if the respondent is able to Enter the information off of one data entry screen rather than a screen for each element listed.)

- _____ Date of Service
- _____ Date of Processing
- _____ Date of Payment
- _____ Amount 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
- _____ OTHER

Text box:

If "OTHER" is selected, provide a text box with the question: "What other encounter DATA ELEMENT(s) is/are included in the State's Accuracy Checks?" Do not use abbreviations. Enter text in initial capital format. If more than one, click "Enter" after each measure.

Valid Choices:

1. DATA ELEMENT is not a required or optional element in the data content (data set).
2. State/PIHP DOES NOT conduct data accuracy check(s) on specified DATA ELEMENT
3. State/PIHP conducts accuracy check(s) on specified DATA ELEMENT

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Encounter Data".
4. Must select one valid choice for each of the Encounter DATA ELEMENTs listed if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Encounter Data".
5. May select only one valid choice for each of the Encounter DATA ELEMENTs listed.
6. If "OTHER" is selected, must complete text box entry. Allow for entries of up to 80 characters each.
7. If "OTHER" is selected, may select only one valid choice for each of the "Other" Encounter DATA ELEMENTs provided.

DATA ELEMENT: ENCOUNTER DATA VALIDATION: DATA COMPLETENESS ASSESSMENTS

Definition:

Data completeness is defined as having encounter data that reflects the complete set of services provided to every beneficiary who receives services from a PIHP. General data completeness assessments are attempts to assess the completeness of the entire encounter data submissions provided by a PIHP. This element asks if the State conducts general completeness assessments.

Valid Choices:

1. State conducts general data completeness assessments
2. State DOES NOT conduct general data completeness assessments

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENTACTIVITIES is not "Encounter Data".
4. Must select one valid choice for each of the Encounter DATA ELEMENTs listed if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Encounter Data".

DATA ELEMENT: ENCOUNTER DATA VALIDATION: METHODS

Definition:

This element identifies those methods used by a State or its agent when conducting encounter data validation activities:

Valid Choices:

1. Automated edits of key fields used for calculation (e.g. codes within an allowable range)
2. Automated analysis of encounter data submission to help determine data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
3. Medical record validation
4. Specification / source code review, such as a programming language used to create an encounter data file for submission
5. 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 or cost-ratios)
6. Per member per month analysis and comparisons across PIHPs
7. OTHER

Text box:

If "7" is selected, provide a text box with the question: "What other data validation method(s) does the State or its agent conduct? Do not use abbreviations. Enter text in initial capital format. If more than one other activity is conducted, please click "Enter" after each type."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP"
3. Skip if ENCOUNTER DATA: DATA ACCURACY CHECKS "2" for all choices and ENCOUNTER DATA: DATA COMPLETENESS ASSESSMENT "1"
4. Must select one valid choice if ENCOUNTER DATA: DATA ACCURACY CHECKS not "2" for all choices and ENCOUNTER DATA: DATA COMPLETENESS ASSESSMENT "1"
5. May select more than one valid choice
6. If "7" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: TYPES

Definition:

Performance measures (PM) are quantitative measurements of particular aspects of health care quality. They may be used in a quality improvement initiative, or collected separately.

Performance measures may be collected by the State, an agent of the State, or by the PIHP and submitted to the State, or they may be calculated by the State or its agent (i.e., using encounter data). This element identifies the types of PMs the State may calculate or require the PIHP to collect and/or submit.

- **Process** – measures that assess the actual provision of services for the prevention, diagnosis, and treatment of diseases (e.g., immunization rates, pap smear rates, and retinal examinations for persons with diabetes).
- **Health Status/Outcomes** – measures that assess the results of care provided, which may include, for example, changes in functional and/or health status and patient satisfaction with care.
- **Access/Availability of Care** – measures that assess the degree to which individuals and groups are able to receive needed services from the PIHP.
- **Use of Services/Utilization** – measures that provide information on the amount of services utilized by beneficiaries serviced by the PIHP.
- **Health Plan Stability/Financial/Cost of Care** – measures that provide information on the PIHPs financial stability or solvency (e.g., years in business, total revenue, net income, loss ratio, etc.). These measures can also provide information on cost of care such as trends of the cost of providing services.
- **Health Plan/Provider Characteristics** – measures that provide descriptive information about the number and characteristics of providers contracting with the PIHP to provide services to Medicaid beneficiaries. These measures also provide information on the structure and administrative practices of the PIHP and may include indicators such as the types of services and facilities available and the qualifications of practitioners.
- **Beneficiary Characteristics** – measures that provide descriptive information about the number and characteristics of beneficiaries served by the PIHP.
- **OTHER** measures that the PIHP calculates or collects that do not fall into any of the above categories.

Valid Choices:

1. Process
2. Health Status/Outcomes
3. Access/Availability of Care
4. Use of Services/Utilization
5. Health Plan Stability/Financial/Cost of Care
6. Health Plan/Provider Characteristics
7. Beneficiary Characteristics
8. OTHER

Text box:

If “8” is selected, provide a text box with the question: “What other type(s) of performance measure does the State collect? Please give examples. Do not use abbreviations. Enter text in initial capital format. If more than one other type of data is collected, please click “Enter” after each type.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PIHP”.
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not “Performance Measures”.
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is “Performance Measures”.
5. May select more than one valid choice.
6. If “8” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: PROCESS

Definition:

PROCESS measures are measures that assess the actual provision of services for the prevention, diagnosis, and treatment of diseases (e.g., immunization rates, pap smear rates, and retinal examinations for persons with diabetes). For each of the PROCESS performance measures listed below, select the ones that the State calculates, collects or requires its PIHP to submit.

Valid Choices:

PROCESS

1. Immunizations for two year olds
2. Adolescent immunization rate
3. Breast cancer screening rate
4. Cervical cancer screening rate
5. Influenza vaccination rate
6. Well-child care visit rates in first 15 months of life
7. Well-child care visit rates in 3, 4, 5, and 6 years of life
8. Adolescent well-care visit rates
9. Dental services
10. Lead screening rate
11. Pregnancy prevention
12. Initiation of prenatal care - timeliness of care
13. Frequency of on-going prenatal care
14. Check-ups after delivery
15. Asthma care - medication use
16. Follow-up after hospitalization for mental illness
17. Initiation or engagement of SUD treatment
18. Hearing services for individuals less than 21 years of age
19. Vision services for individuals less than 21 years of age
20. Smoking prevention or cessation
21. Cholesterol screening or management
22. Percentage of beneficiaries with at least one dental visit
23. HIV/AIDS care
24. Diabetes management/care
25. Depression medication management
26. Chlamydia screening in women
27. Controlling high blood pressure
28. Beta-blocker treatment after heart attack
29. Heart Attack care
30. Heart Failure care
31. Pneumonia care
32. Colorectal Cancer Screening
33. Antidepressant medication management
34. Influenza vaccination
35. Pneumonia vaccination

36. Screening for Human Immunodeficiency Virus
37. AntiD Immune Globulin
38. Appropriate treatment for Children with Upper Respiratory Infection (URI)
39. Appropriate Testing for Children with Pharyngitis
40. Ace Inhibitor/Angiotensin Receptor Blocker Therapy
41. Left Ventricular Function Assessment
42. OTHER

Text box:

If “32” is selected, provide a text box with the question: “What other Process measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PIHP”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Process”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Process”.
5. May select more than one valid choice.
6. If “32” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: HEALTH STATUS/OUTCOMES

Definition:

HEALTH STATUS/OUTCOMES measures are measures that assess the results of care provided, which may include, for example, changes in functional and/or health status and patient satisfaction with care. For each of the HEALTH STATUS/OUTCOMES performance measures listed below, select the ones that the State calculates, collects, or requires its PIHP to submit.

Valid Choices:

HEALTH STATUS/OUTCOMES

1. Number of children with diagnosis of rubella (measles) / 1,000 children
2. Percentage of low birth weight infants
3. Patient satisfaction with care delivered
4. Percentage of beneficiaries who are satisfied with their ability to access care
5. Mortality rates
6. OTHER

Text box:

If “5” is selected, provide a text box with the question: “What other Health Status/Outcomes measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PIHP”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Health Status/Outcomes”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Health Status/Outcomes”.
5. May select more than one valid choice.
6. If “5” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: ACCESS/AVAILABILITY OF CARE

Definition:

ACCESS/AVAILABILITY OF CARE measures are measures that assess the degree to which individuals and groups are able to receive needed services from the PIHP. For each of the ACCESS/AVAILABILITY OF CARE performance measures listed below, select the ones that the State calculates, collects or requires its PIHP to submit.

Valid Choices:

ACCESS/AVAILABILITY OF CARE

1. Ratio of PCPs to beneficiaries
2. Adult's access to preventive/ambulatory health services
3. Children's access to primary care practitioners
4. Average wait time for an appointment with PCP
5. Average distance to PCP
6. Ratio of mental health providers to number of beneficiaries
7. Ratio of dental providers to beneficiaries
8. Ratio of addiction professionals to number of beneficiaries
9. Percent of PCPs with "Open" or "Closed" Patient Assignment Panels
10. OTHER

Text box:

If "10" is selected, provide a text box with the question: "What other Access/Availability of Care measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if PERFORMANCE MEASURES: TYPES is not "Access/Availability of Care".
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is "Access/Availability of Care".
5. May select more than one valid choice.
6. If "10" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: USE OF SERVICES/UTILIZATION

Definition:

USE OF SERVICES/UTILIZATION measures are measures that provide information on the amount of services utilized by beneficiaries serviced by the PIHP. For each of the USE OF SERVICES/UTILIZATION performance measures listed below, select the ones that the State calculates, collects or requires its PIHPs to submit.

Valid Choices:

USE OF SERVICES/UTILIZATION

1. Number of PCP visits per beneficiary
2. Number of OB/GYN visits per adult female beneficiary
3. Number of specialist visits per beneficiary
4. Inpatient admissions / 1,000 beneficiaries
5. Emergency room visits / 1,000 beneficiaries
6. Number of days in ICF or SNF per beneficiary over 64 years
7. Drug Utilization
8. Percentage of beneficiaries with at least one dental visit
9. Number of home health visits per beneficiary
10. Inpatient admissions for MH/SUD conditions / 1,000 beneficiaries
11. Average number of visits to MH/SUD providers per beneficiary
12. Re-admission rates of MH/SUD
13. Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
14. OTHER

Text box:

If "14" is selected, provide a text box with the question: "What other Use of Services/Utilization measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if PERFORMANCE MEASURES: TYPES is not "Use of Services/Utilization".
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is "Use of Services/Utilization".
5. May select more than one valid choice.
6. If "14" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

**DATA ELEMENT: PERFORMANCE MEASURES: HEALTH PLAN
STABILITY/FINANCIAL/COST OF CARE**

Definition:

HEALTH PLAN STABILITY/FINANCIAL/COST OF CARE measures are measures that provide information on the PIHP's financial stability and the PIHP solvency (e.g., years in business, total revenue, net income, loss ratio, etc.). These measures can also provide information on cost of care such as information on trends of the cost of providing services. For each of the HEALTH PLAN STABILITY/FINANCIAL/COST OF CARE performance measures listed below, select the ones that the State calculates, collects or requires its PIHPs to submit.

Valid Choices:

HEALTH PLAN STABILITY/FINANCIAL/COST OF CARE

1. Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
2. Total revenue
3. Net income
4. Medical loss ratio
5. Actual reserves held by plan
6. State minimum reserve requirements
7. Days cash on hand
8. Days in unpaid claims / claims outstanding
9. Net worth
10. OTHER

Text box:

If "10" is selected, provide a text box with the question: "What other Health Plan Stability/Financial/Cost of Care measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if PERFORMANCE MEASURES: TYPES is not "Health Plan Stability/Financial/Cost of Care".
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is "Health Plan Stability/Financial/Cost of Care".
5. May select more than one valid choice.
6. If "10" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: HEALTH PLAN/PROVIDER CHARACTERISTICS

Definition:

HEALTH PLAN/PROVIDER CHARACTERISTICS measures are measures that provide descriptive information about the number and characteristics of providers contracting with the PIHP to provide services to Medicaid beneficiaries. These measures also provide information on the structure and administrative practices of the PIHP and may include indicators such as the types of services and facilities available and the qualifications of practitioners. For each of the HEALTH PLAN/PROVIDER CHARACTERISTICS performance measures listed below, select the ones that the State calculates, collects or requires its PIHPs to submit.

Valid Choices:

HEALTH PLAN/PROVIDER CHARACTERISTICS

1. Provider turnover
2. Board Certification
3. Languages spoken (other than English)
4. OTHER

Text box:

If “4” is selected, provide a text box with the question: “What other Health Plan/Provider Characteristics measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PIHP”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Health Plan/Provider Characteristics”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Health Plan/Provider Characteristics”.
5. May select more than one valid choice.
6. If “4” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: BENEFICIARY CHARACTERISTICS

Definition:

BENEFICIARY CHARACTERISTICS measures are measures that provide descriptive information about the number and characteristics of beneficiaries served by the PIHP. For each of the BENEFICIARY CHARACTERISTICS performance measures listed below, select the ones that the State calculates, collects or requires its PIHPs to submit.

Valid Choices:

BENEFICIARY CHARACTERISTICS

1. Percentage of beneficiaries who are auto-assigned to PIHPs
2. PIHP/PCP-specific disenrollment rate
3. Information of beneficiary ethnicity/race
4. Information on primary languages spoken by beneficiaries
5. Beneficiary need for interpreter
6. Weeks of pregnancy at time of enrollment in PIHP, for women giving birth during the reporting period
7. Percentage of beneficiaries auto-assigned to PCP
8. OTHER

Text box:

If “8” is selected, provide a text box with the question: “What other Beneficiary Characteristics measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PIHP”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Beneficiary Characteristics”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Beneficiary Characteristics”.
5. May select more than one valid choice.
6. If “8” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: USE OF HEDIS MEDICAID MEASURES

Definition:

The **Healthcare Effectiveness** Data and Information Set (HEDIS) is a collection of performance measures and their specifications are produced by the National Committee for Quality Assurance (NCQA). Some State Medicaid agencies have chosen to have their PIHPs report (or have a State contractor calculate and report) some or all of the HEDIS measures. In this element, a State is considered to use HEDIS measures if the measure was listed in HEDIS, even if the State modified the measure's specifications.

Valid Choices:

1. The State uses ALL of the HEDIS measures listed for Medicaid
2. The State uses SOME of the HEDIS measures listed for Medicaid
3. The State DOES NOT use any of the HEDIS measures

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Must select one valid choice.
4. May not select more than one valid choice.
5. May not select "1" or "2" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Encounter Data" or "Performance Measures" {2} In this case, provide the following instruction "If you use all the measures or some of the measures listed for Medicaid in HEDIS, you must be collecting encounter data or performance measures, but did not report doing so in STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES. Do you wish to change your previous answer?"

DATA ELEMENT: PERFORMANCE MEASURES: CALCULATION OF HEDIS MEASURES FROM ENCOUNTER DATA

Definition:

Some States have elected to generate HEDIS measures from encounter data as opposed to having the PIHP generate HEDIS measures.

Valid Choices:

1. The State DOES NOT generate from encounter data any of the HEDIS measures listed for Medicaid
2. The State generates from encounter data ALL of the HEDIS measures listed for Medicaid
3. The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
4. 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

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Encounter Data" and "Performance Measures".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Encounter Data" or "Performance Measures".
5. May not select more than one valid choice.

DATA ELEMENT: PERFORMANCE MEASURES: HEDIS MEASURE SPECIFICATIONS

Definition:

Some States use or require their contracting PIHPs to report some or all HEDIS measures specifications exactly as developed by NCQA. Some other States modify the HEDIS measures specifications. In this element, States that do not modify the HEDIS measures, other than to use only selected measures, should report that they use NCQA specifications.

Valid Choices:

1. State uses / requires PIHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects
2. 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
3. State modifies / requires PIHPs to modify some or all NCQA specifications in ways other than continuous enrollment

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if PERFORMANCE MEASURES: USE OF HEDIS MEDICAID MEASURES is "The State DOES NOT use any of the HEDIS measures".
4. Must select only one valid choice.
5. If 1 is selected, cannot select 2 or 3.
6. 2 and 3 can both be selected, if 1 not selected.

DATA ELEMENT: CONSUMER SELF-REPORT DATA

Definition:

Consumer self-report data is information collected through a survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a PIHP. The survey may be conducted by the State or a contractor to the State. Report all beneficiary surveys, regardless of whether the survey includes the entire Medicaid population enrolled in the PIHP or only a subpopulation such as individuals with special health care needs or disenrollees. Consumer focus groups should also be included. The State collects the following Consumer Assessment of Health Plans Survey (CAHPS) and/or "Other" types of Consumer Self-Report data:

Valid Choices:

1. CAHPS Adult Medicaid AFDC Questionnaire
2. CAHPS Child Medicaid AFDC Questionnaire
3. CAHPS Adult Medicaid SSI Questionnaire
4. CAHPS Child Medicaid SSI Questionnaire
5. CAHPS Adult with Special Needs Questionnaire
6. CAHPS Child with Special Needs Questionnaire
7. Consumer Oriented Mental Health Report Card
8. State-developed Survey
9. Disenrollment Survey
10. Consumer/Beneficiary Focus Groups
11. OTHER

Text box:

If "11" is selected, provide a text box with the question: "What other type(s) of consumer self-report data does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other type of data is collected, please click "Enter" after each type."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Consumer Self-Report Data".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Consumer Self-Report Data".
5. May select more than one valid choice.
6. If "11" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE IMPROVEMENT PROJECT REQUIREMENTS

Definition:

Performance improvement projects seek to improve the quality of care and services provided to Medicaid beneficiaries. PIHPs may be required to conduct quality assessment and performance improvement projects relating to topics selected by the State or projects of their own choosing. Please indicate the State's requirements for the conduct of performance improvement projects by its PIHPs.

Valid Choices:

1. PIHPs are required to conduct a project(s) of their own choosing
2. All PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency
3. Multiple, *but not all*, PIHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency. (For instance: regional projects).
4. Individual PIHPs are required to conduct a project prescribed by the State Medicaid agency

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Improvement Projects".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Performance Improvement Projects".
5. May select more than one valid choice.

DATA ELEMENT: PERFORMANCE IMPROVEMENT PROJECTS

Definition:

Performance improvement projects seek to improve the quality of care and services provided to Medicaid beneficiaries. Please indicate the types of common performance improvement project(s) that *some or all* of the PIHPs participating in the managed care program are required to conduct. The projects can be clinical, as well as non-clinical in focus.

- **Clinical Performance Improvement Projects** include projects focusing on Primary, Secondary, and/or Tertiary Prevention of Acute Conditions; Secondary, and/or Tertiary Prevention of Chronic Conditions; Care of Acute Conditions; Care of Chronic Conditions; High-Volume Services, High-Risk Services; and Continuity and Coordination of Care
- **Non-Clinical Performance Improvement Projects** include projects focusing on Availability, Accessibility, and Cultural Competency of Services; Interpersonal Aspects of Care; and Appeals, Grievances, and Other Complaints

Valid Choices:

1. Clinical Performance Improvement Projects
2. Non-Clinical Performance Improvement Projects

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES IS NOT "Performance Improvement Projects".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Performance Improvement Projects".
5. May select more than one valid choice.

DATA ELEMENT: CLINICAL PERFORMANCE IMPROVEMENT TOPICS

Definition:

For each clinical project required by the State, please provide the specific study topic area(s) to be addressed by the project.

Valid choices for Clinical Project Areas:

1. Well Child Care / EPSDT
2. Adolescent Well Care / EPSDT
3. Childhood Immunization
4. Adolescent Immunization
5. Child/Adolescent Hearing and Vision Screening and Services
6. Child/Adolescent Dental Screening and Services
7. Otitis Media management
8. Asthma management
9. Diabetes management
10. HIV Status/Screening
11. HIV/AIDS Prevention and/or Management
12. Smoking prevention and cessation
13. Adult hearing and vision screening
14. Cholesterol screening and management
15. Cervical cancer screening (Pap Test)
16. Cervical cancer treatment
17. Breast cancer screening (Mammography)
18. Breast cancer treatment
19. Pregnancy Prevention
20. Low birth-weight baby
21. Pre-natal Care
22. Inpatient maternity care and discharge planning
23. Post-natal Care
24. Newborn screening for heritable diseases
25. (Newborn) Failure to thrive
26. Emergency Room service utilization
27. Hospital Discharge Planning
28. Motor vehicle accidents
29. Domestic violence
30. Hip fractures
31. Prevention of Influenza
32. Medical problems of frail elderly
33. Treatment of myocardial infarction
34. Beta Blocker treatment after a heart attack
35. Coronary artery disease prevention
36. Coronary artery disease treatment
37. ETOH and other Substance Use Disorders screening and treatment
38. Substance Use Disorders treatment after detoxification service

39. Prescription drug abuse
40. Pharmacy Management
41. Depression management
42. Coordination of Primary and Behavioral Health care
43. Lead toxicity
44. Tuberculosis screening and treatment
45. Sickle cell anemia management
46. Hypertension management
47. Sexually transmitted disease screening
48. Sexually transmitted disease treatment
49. Hepatitis B screening and treatment
50. Hysterectomy
51. Coordination of care for persons with physical disabilities
52. OTHER

Text box:

If “52” is selected, provide a text box with the question: “What other common Clinical Performance Improvement Project Topics does the State address? Do not use abbreviations. Enter text in initial capital format. If more than one other topic is addressed, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PIHP”.
3. Skip if PERFORMANCE IMPROVEMENT PROJECTS is not “Clinical Performance Improvement Projects”.
4. Must select one valid choice if PERFORMANCE IMPROVEMENT PROJECTS is “Clinical Performance Improvement Projects”.
5. May select more than one valid choice.
6. If “52” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: NON-CLINICAL PERFORMANCE IMPROVEMENT TOPICS

Definition:

For each performance improvement project required by the State, please provide the specific study topic area(s) to be addressed by the project.

Valid Choices for Non-Clinical Project Area:

1. Availability of language interpretation services
2. Adults access to preventative/ambulatory health services
3. Children's access to primary care practitioners
4. Health information technology (e.g., state implementation of immunization and other registries, telemedicine initiatives or Regional Health Information Organization [RHIO] participation)
5. Reducing health care disparities via health literacy/education campaigns or other initiatives
6. OTHER

Text box:

If "6" is selected, provide a text box with the question: "What other common Non-Clinical Performance Improvement Topics does the State address? Do not use abbreviations. Enter text in initial capital format. If more than one other topic is addressed, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if PERFORMANCE IMPROVEMENT PROJECTS is not "Non-Clinical Performance Improvement Projects".
4. Must select one valid choice if PERFORMANCE IMPROVEMENT PROJECTS is "Non-Clinical Performance Improvement Projects".
5. May select more than one valid choice.
6. If "6" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PIHP STANDARDS

Definition:

Regulations implementing BBA provisions addressing State quality assessment and improvement strategies will address certain standards that States will need to require of the PIHPs. States may impart additional structural and operational requirements on their PIHP contractors. This element asks States to identify any additional quality standards that it requires its PIHPs to meet, in part or in whole.

Valid Choices:

1. CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
2. NAIC (National Association of Insurance Commissioners) Standards
3. NCQA (National Committee for Quality Assurance) Standards
4. JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
5. URAC Standards
6. State-Developed/Specified Standards
7. OTHER

Text box:

If "7" is selected, must complete text entry box. Allow for entries of up to 80 characters each.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "PIHP Standards".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "PIHP Standards".
5. May select more than one valid choice.
6. If "7" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: ACCREDITATION REQUIRED FOR PARTICIPATION

Definition:

Several private organizations accredit PIHPs. This DATA ELEMENT asks States to identify the organization(s) whose accreditation they require for the PIHPs participating in the managed care program.

Valid Choices:

1. NCQA (National Committee for Quality Assurance)
2. JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
3. AAAHC (Accreditation Association for Ambulatory Health Care)
4. URAC
5. OTHER

Text box:

If "5" is selected, provide a text box with the question: "What other agency's accreditation process is accepted by the State? Do not use abbreviations; Enter text in initial capital format. If more than one, click "Enter" after each agency."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Accreditation for Participation".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Accreditation for Participation".
5. May select more than one valid choice.
6. If "5" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: NON-DUPLICATION BASED ON ACCREDITATION

Definition:

Several organizations accredit managed care entities. This DATA ELEMENT asks States to identify the organization(s) with standards the State has determined are at least as stringent as the State-specific standard required in 42 CFR438 Subpart D, and whose accreditation the State uses, in part or in whole, to deem the PIHP to be in compliance in lieu of duplicating the State's oversight.

Valid Choices:

1. NCQA (National Committee for Quality Assurance)
2. JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
3. AAAHC (Accreditation Association for Ambulatory Health Care)
4. COA (Council on Accreditation of Families & Children)
5. URAC
6. OTHER

Text box:

If "6" is selected, provide a text box with the question: "What other agency's accreditation process is accepted by the State? Do not use abbreviations; Enter text in initial capital format. If more than one, click "Enter" after each agency."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Non-duplication based on Accreditation".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Non-duplication based on Accreditation"
5. May select more than one valid choice.
6. If "6 is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: EQRO ORGANIZATION

Definition:

Federal law requires States to provide for an external quality review of the access to, timeliness of, and quality outcomes of the services included in the PIHP contract. States can contract with entities that meet competency requirements and tests of independence from the State Medicaid agency and from the PIHP under review.

Valid Choices:

1. Quality Improvement Organization (QIO)
2. QIO-like entity
3. Private accreditation organization
4. State entity
5. Other

Text box:

If “5” is selected, provide a text box describing the other type of entity(ies) used for external quality review.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PIHP”.
3. Must select one valid choice.
4. May select more than one valid choice.
5. If “5” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: EQRO NAME

Definition:

Name(s) of the EQRO agency used by the State.

Valid Choices:

Text box:

Provide a text box with the statement: "Please specify the name(s) of the EQRO(s) used by your State. Do not use abbreviations. Enter text in initial capital format. If more than one, click "Enter" after each organization. Allow up to 5 organizations."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Allow for entries of up to 80 characters each.
4. Must make at least one entry.

DATA ELEMENT: MANDATORY EQRO ACTIVITIES

Definition:

Each State Medicaid agency that contracts with an PIHP must ensure that a qualified EQRO perform an annual external quality review for each contracting PIHP. The information used to carry out the review must be obtained from three mandatory EQRO-related activities. This DATA ELEMENT asks which mandatory activity(ies) are conducted by the EQRO.

Valid Choices:

1. Validation of performance improvement projects
2. Validation of performance measures
3. Review of PIHP compliance with structural and operational standards established by the State

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. Must select one valid choice.
4. May select more than one valid choice.
5. May not select "1" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Improvement Projects".
6. May not select "2" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Measures".

DATA ELEMENT: OPTIONAL EQRO ACTIVITIES

Definition:

Each State Medicaid agency that contracts with an PIHP must ensure that a qualified EQRO perform an annual external quality review for each contracting PIHP. In addition to the three mandatory activities, there are five *optional* activities. This DATA ELEMENT asks which of the following optional services will be conducted by the EQRO.

Valid choices:

1. Validation of encounter data
2. Administration or validation of consumer or provider surveys
3. Calculation of performance measures
4. Conduct of performance improvement projects
5. Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services (i.e. focused studies).
6. Technical assistance to PIHPs to assist them in conducting quality activities.
7. Assessment of PIHP Information System.
8. OTHER

Text box:

"If "8" is selected, provide a text box with the question: "What other "optional" external quality review activities does the State have their EQRO conduct? Do not use abbreviations. Enter text in initial capital format. If more than one, click "Enter" after each entry.

Edit Conditions:

1. Skip, if 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PIHP".
3. May select more than one valid choice.
4. May not select "1" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Encounter Data".
5. May not select "2" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Consumer Self-Report Data" or "Provider Survey Data".
6. May not select "3" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Measures".
7. May not select "4" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Improvement Projects".
8. May not select "5" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Focused Studies".
9. If "8" is selected, must complete text box entry. Allow for entries up to 40 characters.

DATA ELEMENT: USE OF COLLECTED DATA

Definition:

States can use data they collect from quality activities in a number of ways to improve or assure quality of care. This element asks States to identify how it uses collected data.

- **Track Health Service Provision (Access and Utilization)** – Utilization data can be used to track the provision of health services over time and/or compare trends between managed care entities participating in the Medicaid program or managed care and FFS.
- **Monitor Quality Improvement** – Process and outcome data can be used to monitor whether PIHPs improve the quality of care provided to Medicaid enrollees.
- **Beneficiary Plan Selection** – Quality and satisfaction data can be provided to beneficiaries to help them select a PIHP.
- **Plan Reimbursement** – States may use the information they collect to help set capitation rates. States may also use the information to determine incentives and/or penalties based on plan performance
- **Contract Standard Compliance** – States may use data they collect to monitor plan compliance with contract standards (e.g., waiting times for appointments).
- **Program Modification, Expansion, or Renewal** – States may use data they collect to make decisions about program modification, changes in coverage or benefits, or to support waiver renewal applications
- **Program Evaluation** – States may use data they collect to assess program results or to evaluate the effectiveness of the programs they have in place
- **Regulatory Compliance/Federal Reporting** – States may use data they collect to demonstrate compliance with regulations, for Federal reporting on waiver-related activities, or for general Federal reporting requirements
- **Health Services Research** – States may use data they collect to conduct health services research or they may provide data to external entities for the conduct of health services research
- **Fraud and Abuse** – States may use data they collect to identify potential instances of fraud and abuse by providers, managed care entities, etc.
- **Data Mining** – States may use data they collect to sort through data to identify and establish relationships. The key idea of the process is not hypothesis-driven, but attempts to identify unsuspected associations, clustering, forecasting, etc., that permits effective action to be taken in the absence of an explanation for the existence of the pattern.
- **ANOVA (Analysis of Variance)** – A mathematical process for separating the variability of a group of observations into assignable causes and setting up various significance tests.
- **Enhance/Revise State Managed Care Medicaid Quality Strategy** – States may use data they collect to revise State improvement initiatives, PIHP quality standards, or PIHP reporting specifications/requirements for performance measurement reporting or performance improvement projects
- **Do Not Use the Data Collected**

Valid Choices:

1. Track Health Service Provision
2. Monitor Quality Improvement
3. Beneficiary Plan Selection
4. Plan Reimbursement
5. Contract Standard Compliance
6. Program Modification, Expansion, or Renewal
7. Program Evaluation
8. Regulatory Compliance/Federal Reporting
9. Health Services Research
10. Fraud and Abuse
11. Data Mining
12. ANOVA (Analysis of Variance)
13. State Managed Care Medicaid Quality Strategy
14. Do Not Use the Data Collected
15. Other

Text box

If “15” is selected, provide a text box with the instructions: “Please identify the other uses of collected data. Do not use abbreviations. Enter text in initial capital format. If more than one, click “Enter” after each entry.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PIHP”.
3. Must select one valid choice.
4. May select more than one valid choice.
5. If “14” is selected, may not select any other valid choice.
6. If “15” is selected, text box must be completed. Allow for entries of up to 80 characters each.

**XII. CATEGORY: QUALITY ACTIVITIES FOR PREPAID
AMBULATORY HEALTH PLANS (PAHPs)**

DATA ELEMENT: STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES

Definition:

As a result of the Balanced Budget Act (BBA) of 1997, CMS requires that States implement strategies for quality assessment and performance improvement to ensure the delivery of quality care and services by their PAHPs contract to the State Medicaid agency. States are required to include certain activities as part of their strategies. Other activities, though not required by the legislation may be performed by States at their option. This element asks for information on whether or not a State has performed the following activities relative to PAHPs.

- **Consumer Self-Report Data** – data collected through a survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a PAHP. The survey may be conducted by the State or a contractor to the State. Report all beneficiary surveys, regardless of whether the survey includes the entire Medicaid population enrolled in the PAHP or only a subpopulation such as individuals with special health care needs or disenrollees. Consumer focus groups should also be included.
- **Encounter Data** – detailed data about individual services provided to individual beneficiaries at the point of the beneficiary’s interaction with a PAHP institutional or practitioner provider. The level of detail about each reported service is similar to that of a standard claim form. Encounter data are also sometimes referred to as “shadow” or “pseudo” claims data. If PAHPs also report actual claims paid to their providers to the State, consider this to be PAHP encounter data.
- **Enrollee Hotlines** – toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their 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 **period of time**. These projects are usually based on information extracted from medical records, or PAHP administrative data such as enrollment files and encounter or claims data. State staff, EQRO staff, PAHP staff or more than one of these entities may perform such studies at the discretion of the State.
- **PAHP Standards** – These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each PAHP must have in order to participate in the Medicaid program.
- **Monitoring of PAHP**– activities related to the monitoring of standards that have been set for access, plan structure, operations, and quality measurement/improvement 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 PAHP. An Ombudsman is a neutral party who works with the enrollee, the PAHP, and the provider (as appropriate) to resolve individual enrollee problems. Select this option only if the ombudsman program 1) is specifically identified by the State Medicaid agency to Medicaid beneficiaries for

their use; and 2) provides aggregated data on problems encountered by Medicaid beneficiaries back to the State Medicaid agency.

- **On-Site Reviews** – reviews performed on-site at the PAHP health care delivery sites to assess the physical resources and operational practices in place to deliver health care.
- **Performance Improvement Projects** – projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two **points in time** to ascertain if improvement has occurred based on one or more PAHP interventions or improvement strategies. These projects may be required by the State and may be of the PAHP choosing or prescribed by the State
- **Performance Measures** – quantitative 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 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 survey may be conducted by the State or a contractor of the State.
- **Network Data** – data collected on numbers, types and/or location of providers or facilities contracted in relation to enrollees. Network data may include assessment of “open or closed panels”, or average enrollee assignment panel size for Primary Care Physicians.

Valid Choices:

1. Consumer Self-Report Data
2. Encounter Data
3. Enrollee Hotlines
4. Focused Studies
5. PAHP Standards
6. Monitoring PAHP Standards
7. Ombudsman
8. On-Site Review
9. Performance Improvement Projects
10. Performance Measures
11. Provider Data
12. Network Data
13. Other

Text box:

If “13” is selected, provide a text box with the question: “What other activity(s) does the State Medicaid agency or its agent perform as part of its State quality assessment and improvement strategy? Do not use abbreviations. Enter text in initial capital format. If more than one other activity is conducted, please click “Enter” after each type.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete is MANAGED CARE ENTITY is “PAHP”.
3. Must select one valid choice.
4. May select more than one valid choice.
5. If “13” is selected, the text box must be completed. Allow for entries up to 80 characters each.
6. A text box entry that consists only of the term “HEDIS” or “Healthcare Effectiveness Data and Information Set” is not acceptable.

DATA ELEMENT: ENCOUNTER DATA COLLECTION: REQUIREMENTS

Definition:

This DATA ELEMENT asks what State requirements/specifications are in place to ensure the submission of complete, accurate, and timely encounter data by the contracted PAHPs.

Valid Choices:

1. State DID NOT provide any requirements for encounter data collection
2. Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
3. Requirements for PAHPs to collect and maintain encounter data
4. Specifications for the submission of encounter data to the Medicaid agency
5. Standards for completeness, accuracy, and/or timeliness of encounter data submission
6. Incentives/sanctions to promote completeness, accuracy, and/or timeliness of encounter data submission
7. Requirements for data validation
8. OTHER

Text box:

If “8” is selected, provide a text box with the statement: “Please identify the other encounter data collection requirements. Do not use abbreviations. Enter text in initial capital format. If more than one, click “Enter” after each entry.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PAHP”.
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not “Encounter Data”.
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is “Encounter Data”.
5. If “1” selected, may not select “2” or “3” or “4” or “5” or “6” or “7” or “8”.
6. If “2” or “3” or “4” or “5” or “6” or “7” or “8” selected, may select more than one valid choice.
7. If “8” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: ENCOUNTER DATA COLLECTION: SUBMISSION SPECIFICATIONS

Definition:

This DATA ELEMENT asks what the State specifications are for the submission of encounter data by the contracted PAHPs.

Valid Choices:

1. Data submission requirements including documentation describing a set of encounter DATA ELEMENTs, definitions, sets of acceptable values, standards for data processing and editing
2. Use of Medicaid Identification Number for beneficiaries
3. Encounters to be submitted based upon national standardized forms (e.g., UB-04, NCPDP, ASC X12 837, ADA)
4. Use of “home grown” forms
5. Guidelines for frequency of encounter data submission
6. Guidelines for initial encounter data submission
7. Deadlines for regular/ongoing encounter data submission(s)
8. OTHER

Text box:

If “8” is selected, provide a text box with the statement: “Please identify the other encounter data submission specifications. Do not use abbreviations. Enter text in initial capital format. If more than one, click “Enter” after each entry.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PAHP”.
3. Skip if ENCOUNTER DATA COLLECTION: REQUIREMENTS is not “Specifications for the submission of encounter data to the Medicaid agency”.
4. Must select one valid choice if ENCOUNTER DATA COLLECTION: REQUIREMENTS is “Specifications for the submission of encounter data to the Medicaid Agency”.
5. May select more than one valid choice.
6. If “8” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: ENCOUNTER DATA COLLECTION: STANDARDIZED FORMS

Definition:

Standardized forms are needed to ensure that DATA ELEMENTs are reported uniformly by all providers, and that reports from multiple sources are comparable and can be reliably merged. This element reflects what standardized forms the State requires their contracting PAHPs to use.

Valid Choices:

1. 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.
2. 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.
3. ANSI ASC X12 837 – transaction set format for transmitting health care claims data.
4. NCPDP – National Council for Prescription Drug Programs pharmacy claim form
5. ADA – American Dental Association dental claim form
6. OTHER

Text box:

If “6” is selected, provide a text box with the question: “What other standard formats does the State require? Do not use abbreviations. Enter text in initial capital format. If more than one other type of standard format is used, please click “Enter” after each type.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PAHP”.
3. Skip if ENCOUNTER DATA SUBMISSION SPECIFICATIONS is not “Encounters to be submitted based on national standardized forms”.
4. Must select one valid choice if ENCOUNTER DATA SUBMISSION SPECIFICATIONS is “Encounters to be submitted based on national standardized forms”.
5. May select more than one valid choice.
6. If “6” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: ENCOUNTER DATA VALIDATION: DATA ACCURACY CHECKS

Definition:

This element addresses how data accuracy is addressed, whether the State or its agent conducts the activity or whether the State requires contracting PAHPs to perform their own data accuracy assessments on their encounter data.

Data accuracy is defined as having information for the required encounter DATA ELEMENTs that validly represent care delivered. For example, encounters submitted could be checked to ensure that the beneficiary was eligible on the date of service, the encounter is not a duplicate of a previously reported encounter, or the provider type is appropriate for the procedure performed.

For each of the following Encounter DATA ELEMENTs, please enter a valid choice as indicated below:

(Note for programmer: the respondent must Enter a "1", "2" or "3" for each of the items listed below. It may be easier for the respondent to complete if the respondent is able to Enter the information off of one data entry screen rather than a screen for each element listed.)

- Date of Service
- Date of Processing
- Date of Payment
- Amount 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
- OTHER

Text box:

If "OTHER" is selected, provide a text box with the question: "What other encounter DATA ELEMENT(s) is/are included in the State's Accuracy Checks?" Do not use abbreviations. Enter text in initial capital format. If more than one, click "Enter" after each measure.

Valid Choices:

1. DATA ELEMENT is not a required or optional element in the data content (data set)
2. State/PAHP DOES NOT conduct data accuracy check(s) on specified DATA ELEMENT
3. State/PAHP conducts accuracy check(s) on specified DATA ELEMENT

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Encounter Data".
4. Must select one valid choice for each of the Encounter DATA ELEMENTs listed if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Encounter Data".
5. May select only one valid choice for each of the Encounter DATA ELEMENTs listed.
6. If "OTHER" is selected, must complete text box entry. Allow for entries of up to 80 characters each.
7. If "OTHER" is selected, may select only one valid choice for each of the "Other" Encounter DATA ELEMENTs provided.

DATA ELEMENT: ENCOUNTER DATA VALIDATION: DATA COMPLETENESS ASSESSMENTS

Definition:

Data completeness is defined as having encounter data that reflects the complete set of services provided to every beneficiary who receives services from a PAHP. General data completeness assessments are attempts to assess the completeness of the entire encounter data submissions provided by a PAHP. This element asks if the State conducts general completeness assessments.

Valid Choices:

1. State conducts general data completeness assessments
2. State DOES NOT conduct general data completeness assessments

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENTACTIVITIES is not "Encounter Data".
4. Must select one valid choice for each of the Encounter DATA ELEMENTs listed if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Encounter Data".

DATA ELEMENT: ENCOUNTER DATA VALIDATION: METHODS

Definition:

This element identifies those methods used by a State or its agent when conducting encounter data validation activities:

Valid Choices:

1. Automated edits of key fields used for calculation (e.g. codes within an allowable range)
2. Automated analysis of encounter data submission to help determine data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
3. Medical record validation
4. Specification / source code review, such as a programming language used to create an encounter data file for submission
5. Comparisons 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)
6. Per member per month analysis and comparisons across PAHPs
7. OTHER

Text box:

If "7" is selected, provide a text box with the question: "What other data validation method(s) does the State or its agent conduct? Do not use abbreviations. Enter text in initial capital format. If more than one other activity is conducted, please click "Enter" after each type."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if ENCOUNTER DATA: DATA ACCURACY CHECKS "2" for all choices and ENCOUNTER DATA: DATA COMPLETENESS ASSESSMENT "1".
4. Must select one valid choice if ENCOUNTER DATA: DATA ACCURACY CHECKS not "2" for all choices and ENCOUNTER DATA: DATA COMPLETENESS ASSESSMENT "1".
5. May select more than one valid choice.
6. If "7" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: TYPES

Definition:

Performance measures (PM) are quantitative measurements of particular aspects of health care quality. They may be used in a quality improvement initiative, or collected separately.

Performance measures may be collected by the State, an agent of the State, or by the PAHP and submitted to the State, or they may be calculated by the State or its agent (i.e., using encounter data). This element identifies the types of PMs the State may calculate or require the PAHP to collect and/or submit.

- **Process** – measures that assess the actual provision of services for the prevention, diagnosis, and treatment of diseases (e.g., immunization rates, pap smear rates, and retinal examinations for persons with diabetes).
- **Health Status/Outcomes** – measures that assess the results of care provided, which may include, for example, changes in functional and/or health status and patient satisfaction with care.
- **Access/Availability of Care** – measures that assess the degree to which individuals and groups are able to receive needed services from the PAHP.
- **Use of Services/Utilization** – measures that provide information on the amount of services utilized by beneficiaries serviced by the PAHP.
- **Health Plan Stability/Financial/Cost of Care** – measures that provide information on the PAHPs financial stability or solvency (e.g., years in business, total revenue, net income, loss ratio, etc.). These measures can also provide information on cost of care such as trends of the cost of providing services.
- **Health Plan/Provider Characteristics** – measures that provide descriptive information about the number and characteristics of providers contracting with the PAHP to provide services to Medicaid beneficiaries. These measures also provide information on the structure and administrative practices of the PAHP and may include indicators such as the types of services and facilities available and the qualifications of practitioners.
- **Beneficiary Characteristics** – measures that provide descriptive information about the number and characteristics of beneficiaries served by the PAHP.
- **OTHER** measures that the PAHP calculates or collects that do not fall into any of the above categories.

Valid Choices:

1. Process
2. Health Status/Outcomes
3. Access/Availability of Care
4. Use of Services/Utilization
5. Health Plan Stability/Financial/Cost of Care
6. Health Plan/Provider Characteristics
7. Beneficiary Characteristics
8. OTHER

Text box:

If “8” is selected, provide a text box with the question: “What other type(s) of performance measure does the State collect? Please give examples. Do not use abbreviations. Enter text in initial capital format. If more than one other type of data is collected, please click “Enter” after each type.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PAHP”.
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not “Performance Measures”.
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is “Performance Measures”.
5. May select more than one valid choice.
6. If “8” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: PROCESS

Definition:

PROCESS measures are measures that assess the actual provision of services for the prevention, diagnosis, and treatment of diseases (e.g., immunization rates, pap smear rates, and retinal examinations for persons with diabetes). For each of the PROCESS performance measures listed below, select the ones that the State calculates, collects or requires its PAHP to submit.

Valid Choices:

PROCESS

1. Immunizations for two year olds
2. Adolescent immunization rate
3. Breast cancer screening rate
4. Cervical cancer screening rate
5. Influenza vaccination rate
6. Well-child care visit rates in first 15 months of life
7. Well-child care visit rates in 3, 4, 5, and 6 years of life
8. Adolescent well-care visit rates
9. Dental services
10. Lead screening rate
11. Pregnancy prevention
12. Initiation of prenatal care - timeliness of care
13. Frequency of on-going prenatal care
14. Check-ups after delivery
15. Asthma care - medication use
16. Initiation or engagement of SUD treatment
17. Hearing services for individuals less than 21 years of age
18. Vision services for individuals less than 21 years of age
19. Smoking prevention
20. Cholesterol screening or management
21. Substance Use Disorders treatment after detoxification service
22. Percentage of beneficiaries with at least one dental visit
23. HIV/AIDS care
24. Diabetes management/care
25. Depression medication management
26. Chlamydia screening in women
27. Controlling high blood pressure
28. Beta-blocker treatment after heart attack
29. Heart attack care
30. Hearth failure care
31. Pneumonia care
32. OTHER

Text box:

If “32” is selected, provide a text box with the question: “What other Process measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PAHP”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Process”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Process”.
5. May select more than one valid choice.
6. If “32” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: HEALTH STATUS/OUTCOMES

Definition:

HEALTH STATUS/OUTCOMES measures are measures that assess the results of care provided, which may include, for example, changes in functional and/or health status and patient satisfaction with care. For each of the HEALTH STATUS/OUTCOMES performance measures listed below, select the ones that the State calculates, collects, or requires its PAHP to submit.

Valid Choices:

HEALTH STATUS/OUTCOMES

1. Patient satisfaction with care delivered
2. Percentage of beneficiaries satisfied with their ability to obtain care
3. OTHER

Text box:

If “3” is selected, provide a text box with the question: “What other Health Status/Outcomes measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PAHP”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Health Status/Outcomes”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Health Status/Outcomes”.
5. May select more than one valid choice.
6. If “3” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: ACCESS/AVAILABILITY OF CARE

Definition:

ACCESS/AVAILABILITY OF CARE measures are measures that assess the degree to which individuals and groups are able to receive needed services from the PAHP. For each of the ACCESS/AVAILABILITY OF CARE performance measures listed below, select the ones that the State calculates, collects or requires its PAHP to submit.

Valid Choices:

ACCESS/AVAILABILITY OF CARE

1. Adult's access to preventive/ambulatory health services
2. Ratio of addiction professionals to number of beneficiaries
3. Ratio of mental health providers to number of beneficiaries
4. Ratio of dental providers to beneficiaries
5. OTHER

Text box:

If "5" is selected, provide a text box with the question: "What other Access/Availability of Care measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if PERFORMANCE MEASURES: TYPES is not "Access/Availability of Care".
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is "Access/Availability of Care".
5. May select more than one valid choice.
6. If "5" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: USE OF SERVICES/UTILIZATION

Definition:

USE OF SERVICES/UTILIZATION measures are measures that provide information on the amount of services utilized by beneficiaries serviced by the PAHP. For each of the USE OF SERVICES/UTILIZATION performance measures listed below, select the ones that the State calculates, collects or requires its PAHPs to submit.

Valid Choices:

USE OF SERVICES/UTILIZATION

1. Emergency room visits / 1,000 beneficiaries
2. Drug Utilization
3. Percentage of beneficiaries with at least one dental visit
4. Average number of visits to MH/SUD providers per beneficiary
5. Re-admission rates of MH/SUD
6. Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
7. OTHER

Text box:

If "7" is selected, provide a text box with the question: "What other Use of Services/Utilization measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if PERFORMANCE MEASURES: TYPES is not "Use of Services/Utilization".
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is "Use of Services/Utilization".
5. May select more than one valid choice.
6. If "7" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

**DATA ELEMENT: PERFORMANCE MEASURES: HEALTH PLAN
STABILITY/FINANCIAL/COST OF CARE**

Definition:

HEALTH PLAN STABILITY/FINANCIAL/COST OF CARE measures are measures that provide information on the PAHP's financial stability and the PAHP solvency (e.g., years in business, total revenue, net income, loss ratio, etc.). These measures can also provide information on cost of care such as information on trends of the cost of providing services. For each of the HEALTH PLAN STABILITY/FINANCIAL/COST OF CARE performance measures listed below, select the ones that the State calculates, collects or requires its PAHPs to submit.

Valid Choices:

HEALTH PLAN STABILITY/FINANCIAL/COST OF CARE

1. Expenditures by medical category of service (i.e., ER, pharmacy, lab, x-ray, dental, vision, etc.)
2. Total revenue
3. Net income
4. Medical loss ratio
5. Actual reserves held by plan
6. State minimum reserve requirements
7. Days cash on hand
8. Days in unpaid claims / claims outstanding
9. Net worth
10. OTHER

Text box:

If "10" is selected, provide a text box with the question: "What other Health Plan Stability/Financial/Cost of Care measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if PERFORMANCE MEASURES: TYPES is not "Health Plan Stability/Financial/Cost of Care".
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is "Health Plan Stability/Financial/Cost of Care".
5. May select more than one valid choice.
6. If "10" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: HEALTH PLAN/PROVIDER CHARACTERISTICS

Definition:

HEALTH PLAN/PROVIDER CHARACTERISTICS measures are measures that provide descriptive information about the number and characteristics of providers contracting with the PAHP to provide services to Medicaid beneficiaries. These measures also provide information on the structure and administrative practices of the PAHP and may include indicators such as the types of services and facilities available and the qualifications of practitioners. For each of the HEALTH PLAN/PROVIDER CHARACTERISTICS performance measures listed below, select the ones that the State calculates, collects or requires its PAHPs to submit.

Valid Choices:

HEALTH PLAN/PROVIDER CHARACTERISTICS

1. Provider turnover
2. Board Certification
3. Languages spoken (other than English)
4. OTHER

Text box:

If “4” is selected, provide a text box with the question: “What other Health Plan/Provider Characteristics measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PAHP”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Health Plan/Provider Characteristics”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Health Plan/Provider Characteristics”.
5. May select more than one valid choice.
6. If “4” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: BENEFICIARY CHARACTERISTICS

Definition:

BENEFICIARY CHARACTERISTICS measures are measures that provide descriptive information about the number and characteristics of beneficiaries served by the PAHP. For each of the BENEFICIARY CHARACTERISTICS performance measures listed below, select the ones that the State calculates, collects or requires its PAHPs to submit.

Valid Choices:

BENEFICIARY CHARACTERISTICS

1. Percentage of beneficiaries who are auto-assigned to PAHPs
2. PAHP/PCP-specific disenrollment rate
3. Information of beneficiary ethnicity/race
4. Information on primary languages spoken by beneficiaries
5. Beneficiary need for interpreter
6. Percentage of beneficiaries auto-assigned to PCP
7. OTHER

Text box:

If “7” is selected, provide a text box with the question: “What other Beneficiary Characteristics measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PAHP”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Beneficiary Characteristics”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Beneficiary Characteristics”.
5. May select more than one valid choice.
6. If “7” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: USE OF HEDIS MEDICAID MEASURES

Definition:

The **Healthcare Effectiveness** Data and Information Set (HEDIS) is a collection of performance measures and their specifications are produced by the National Committee for Quality Assurance (NCQA). Some State Medicaid agencies have chosen to have their PAHPs report (or have a State contractor calculate and report) some or all of the HEDIS measures. In this element, a State is considered to use HEDIS measures if the measure was listed in HEDIS, even if the State modified the measure's specifications.

Valid Choices:

1. The State uses ALL of the HEDIS measures listed for Medicaid
2. The State uses SOME of the HEDIS measures listed for Medicaid
3. The State DOES NOT use any of the HEDIS measures

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Must select one valid choice.
4. May not select more than one valid choice.
5. May not select "1" or "2" if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Encounter Data" or "Performance Measures". In this case, provide the following instruction "If you use all the measures or some of the measures listed for Medicaid in HEDIS, you must be collecting encounter data or performance measures, but did not report doing so in STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES. Do you wish to change your previous answer?"

DATA ELEMENT: PERFORMANCE MEASURES: CALCULATION OF HEDIS MEASURES FROM ENCOUNTER DATA

Definition:

Some States have elected to generate HEDIS measures from encounter data as opposed to having the PAHP generate HEDIS measures.

Valid Choices:

1. The State DOES NOT generate from encounter data any of the HEDIS measures listed for Medicaid
2. The State generates from encounter data ALL of the HEDIS measures listed for Medicaid
3. The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
4. 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

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Encounter Data" and "Performance Measures".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Encounter Data" and "Performance Measures".
5. May not select more than one valid choice.

DATA ELEMENT: PERFORMANCE MEASURES: HEDIS MEASURE SPECIFICATIONS

Definition:

Some States use or require their contracting PAHPs to report some or all HEDIS measures specifications exactly as developed by NCQA. Some other States modify the HEDIS measures specifications. In this element, States that do not modify the HEDIS measures, other than to use only selected measures, should report that they use NCQA specifications.

Valid Choices:

1. State uses / requires PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects
2. 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
3. State modifies / requires PAHPs to modify some or all NCQA specifications in ways other than continuous enrollment

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if PERFORMANCE MEASURES: USE OF HEDIS MEDICAID MEASURES is "The State DOES NOT use any of the HEDIS measures".
4. Must select only one valid choice.
5. If select 1, cannot select 2 or 3.
6. 2 and 3 can both be selected, if 1 not selected.

DATA ELEMENT: CONSUMER SELF-REPORT DATA

Definition:

Consumer self-report data is information collected through a survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a PAHP. The survey may be conducted by the State or a contractor to the State. Report all beneficiary surveys, regardless of whether the survey includes the entire Medicaid population enrolled in the PAHP or only a subpopulation such as individuals with special health care needs or disenrollees. Consumer focus groups should also be included. The State collects the following Consumer Assessment of Health Plans Survey (CAHPS) and/or "Other" types of Consumer Self-Report data:

Valid Choices:

1. CAHPS Adult Medicaid AFDC Questionnaire
2. CAHPS Child Medicaid AFDC Questionnaire
3. CAHPS Adult Medicaid SSI Questionnaire
4. CAHPS Child Medicaid SSI Questionnaire
5. CAHPS Adult with Special Needs Questionnaire
6. CAHPS Child with Special Needs Questionnaire
7. Consumer Oriented Mental Health Report Card
8. State-developed Survey
9. Disenrollment Survey
10. Consumer/Beneficiary Focus Groups
11. OTHER

Text box:

If "11" is selected, provide a text box with the question: "What other type(s) of consumer self-report data does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other type of data is collected, please click "Enter" after each type."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Consumer Self-Report Data".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Consumer Self-Report Data".
5. May select more than one valid choice.
6. If "11" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE IMPROVEMENT PROJECT REQUIREMENTS

Definition:

Performance improvement projects seek to improve the quality of care and services provided to Medicaid beneficiaries. PAHPs may be required to conduct quality assessment and performance improvement projects relating to topics selected by the State or projects of their own choosing. Please indicate the State's requirements for the conduct of performance improvement projects by its PAHPs.

Valid Choices:

1. PAHPs are required to conduct a project(s) of their own choosing
2. All PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency
3. Multiple, *but not all*, PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency. (For instance: regional projects).
4. Individual PAHPs are required to conduct a project prescribed by the State Medicaid agency

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Improvement Projects".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Performance Improvement Projects".
5. May select more than one valid choice.

DATA ELEMENT: PERFORMANCE IMPROVEMENT PROJECTS

Definition:

Performance improvement projects seek to improve the quality of care and services provided to Medicaid beneficiaries. Please indicate the types of common performance improvement project(s) that *some or all* of the PAHPs participating in the managed care program are required to conduct. The projects can be clinical, as well as non-clinical in focus.

- **Clinical Performance Improvement Projects** include projects focusing on Primary, Secondary, and/or Tertiary Prevention of Acute Conditions; Secondary, and/or Tertiary Prevention of Chronic Conditions; Care of Acute Conditions; Care of Chronic Conditions; High-Volume Services, High-Risk Services; and Continuity and Coordination of Care
- **Non-Clinical Performance Improvement Projects** include projects focusing on Availability, Accessibility, and Cultural Competency of Services; Interpersonal Aspects of Care; and Appeals, Grievances, and Other Complaints

Valid Choices:

1. Clinical Performance Improvement Projects
2. Non-Clinical Performance Improvement Projects

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "Performance Improvement Projects".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "Performance Improvement Projects".
5. May select more than one valid choice.

DATA ELEMENT: CLINICAL PERFORMANCE IMPROVEMENT TOPICS

Definition:

For each clinical project required by the State, please provide the specific study topic area(s) to be addressed by the project.

Valid choices for Clinical Project Areas:

1. Well Child Care/EPSTD
2. Adolescent Well Care/EPSTD
3. Childhood Immunization
4. Adolescent Immunization
5. Child/Adolescent Hearing and Vision Screening and Services
6. Child/Adolescent Dental Screening and Services
7. Otitis media management
8. Asthma management
9. Diabetes management
10. HIV Status/Screening
11. HIV/AIDS Prevention and/or Management
12. Smoking prevention and cessation
13. Adult hearing and vision screening
14. Cholesterol screening and management
15. Cervical cancer screening (mammography)
16. Cervical cancer treatment
17. Pregnancy prevention
18. Low birth-weight baby
19. Pre-natal care
20. Post-natal care
21. Newborn screening for heritable diseases
22. (Newborn) failure to thrive
23. Emergency Room service utilization
24. Coronary artery disease prevention
25. Coronary artery disease treatment
26. Motor vehicle accidents
27. Domestic violence
28. Hip fractures
29. Prevention of influenza
30. Medical problems of frail elderly
31. Treatment of myocardial infarction
32. Beta blocker treatment after heart attack
33. ETOH and other Substance Use Disorders screening and treatment
34. Substance Use Disorders treatment after detoxification service
35. Prescription drug abuse
36. Pharmacy Management
37. Depression management
38. Coordination of Primary and Behavioral Health care
39. Hypertension management

40. Coordination of primary and behavioral health care
41. Lead toxicity
42. Tuberculosis screening and treatment
43. Sickle cell anemia management
44. Hypertension management
45. Sexually transmitted disease screening
46. Sexually transmitted disease treatment
47. Hepatitis B screening and treatment
48. Hysterectomy
49. Coordination of care for persons with physical disabilities
50. OTHER

Text box:

If “50” is selected, provide a text box with the question: “What other common Clinical Performance Improvement Project Topics does the State address? Do not use abbreviations. Enter text in initial capital format. If more than one other topic is addressed, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PAHP”.
3. Skip if PERFORMANCE IMPROVEMENT PROJECTS is not “Clinical Performance Improvement Projects”.
4. Must select one valid choice if PERFORMANCE IMPROVEMENT PROJECTS is “Clinical Performance Improvement Projects”.
5. May select more than one valid choice.
6. If “50” is selected, must complete text box. Allow for entries of up to 80 characters.

DATA ELEMENT: NON-CLINICAL PERFORMANCE IMPROVEMENT TOPICS

Definition:

For each performance improvement project required by the State, please provide the specific study topic area(s) to be addressed by the project.

Valid Choices for Non-Clinical Project Area:

1. Availability of language interpretation services
2. Adults access to preventative/ambulatory health services
3. Children's access to primary care practitioners
4. Health information technology (e.g., state implementation of immunization and other registries, telemedicine initiatives or Regional Health Information Organization [RHIO] participation)
5. Reducing health care disparities via health literacy/education campaigns or other initiatives
6. OTHER

Text box:

If "6" is selected, provide a text box with the question: "What other common Non-Clinical Performance Improvement Topics does the State address? Do not use abbreviations. Enter text in initial capital format. If more than one other topic is addressed, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if PERFORMANCE IMPROVEMENT PROJECTS is not "Non-Clinical Performance Improvement Projects".
4. Must select one valid choice if PERFORMANCE IMPROVEMENT PROJECTS is "Non-Clinical Performance Improvement Projects".
5. May select more than one valid choice.
6. If "6" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PAHP STANDARDS

Definition:

Regulations implementing BBA provisions addressing State quality assessment and improvement strategies will address certain standards that States will need to require of the PAHPs. States may impart additional structural and operational requirements on their PAHP contractors. This element asks States to identify any additional quality standards that it requires its PAHPs to meet, in part or in whole.

Valid Choices:

1. Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
2. NAIC (National Association of Insurance Commissioners) Standards
3. NCQA (National Committee for Quality Assurance) Standards
4. JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
5. URAC Standards
6. State-Developed/Specified Standards
7. OTHER

Text box:

If "7" is selected, must complete text entry box. Allow for entries of up to 80 characters each.

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PAHP".
3. Skip if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is not "PAHP Standards".
4. Must select one valid choice if STATE QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES is "PAHP Standards".
5. May select more than one valid choice.
6. If "7" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: USE OF COLLECTED DATA

Definition:

States can use data they collect from quality activities in a number of ways to improve or assure quality of care. This element asks States to identify how it uses collected data.

- **Track Health Service Provision (Access and Utilization)** – Utilization data can be used to track the provision of health services over time and/or compare trends between managed care entities participating in the Medicaid program or managed care and FFS.
- **Monitor Quality Improvement** – Process and outcome data can be used to monitor whether PAHPs improve the quality of care provided to Medicaid enrollees.
- **Beneficiary Plan Selection** – Quality and satisfaction data can be provided to beneficiaries to help them select a PAHP.
- **Plan Reimbursement** – States may use the information they collect to help set capitation rates. States may also use the information to determine incentives and/or penalties based on plan performance
- **Contract Standard Compliance** – States may use data they collect to monitor plan compliance with contract standards (e.g., waiting times for appointments).
- **Program Modification, Expansion, or Renewal** – States may use data they collect to make decisions about program modification, changes in coverage or benefits, or to support waiver renewal applications
- **Program Evaluation** – States may use data they collect to assess program results or to evaluate the effectiveness of the programs they have in place
- **Regulatory Compliance/Federal Reporting** – States may use data they collect to demonstrate compliance with regulations, for Federal reporting on waiver-related activities, or for general Federal reporting requirements
- **Health Services Research** – States may use data they collect to conduct health services research or they may provide data to external entities for the conduct of health services research
- **Fraud and Abuse** – States may use data they collect to identify potential instances of fraud and abuse by providers, managed care entities, etc.
- **Data Mining** – States may use data they collect to sort through data to identify and establish relationships. The key idea of the process is not hypothesis-driven, but attempts to identify unsuspected associations, clustering, forecasting, etc., that permits effective action to be taken in the absence of an explanation for the existence of the pattern.
- **ANOVA (Analysis of Variance)** – A mathematical process for separating the variability of a group of observations into assignable causes and setting up various significance test.
- **Enhance/Revise State Managed Care Medicaid Quality Strategy** – States may use data they collect to revise State improvement initiatives, PIHP quality standards, or PIHP reporting specifications/requirements for performance measurement reporting or performance improvement projects
- **Do Not Use the Data Collected**

Valid Choices:

1. Track Health Service Provision
2. Monitor Quality Improvement
3. Beneficiary Plan Selection
4. Plan Reimbursement
5. Contract Standard Compliance
6. Program Modification, Expansion, or Renewal
7. Program Evaluation
8. Regulatory Compliance/Federal Reporting
9. Health Services Research
10. Fraud and Abuse
11. Data Mining
12. ANOVA (Analysis of Variance)
13. State Medicaid Managed Care Quality Strategy
14. Do Not Use the Data Collected
15. OTHER

Text box

If “15” is selected, provide a text box with the instructions: “Please identify the other uses of collected data. Do not use abbreviations. Enter text in initial capital format. If more than one, click “Enter” after each entry.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PAHP”.
3. Must select one valid choice.
4. May select more than one valid choice.
5. If “14” is selected, may not select any other valid choice.
6. If “15” is selected, text box must be completed. Allow for entries of up to 80 characters each.

**XIII. CATEGORY: QUALITY ACTIVITIES FOR PRIMARY
CARE CASE MANAGEMENT (PCCM) PROGRAMS**

DATA ELEMENT: QUALITY OVERSIGHT ACTIVITIES FOR PRIMARY CARE CASE MANAGEMENT (PCCM) PROGRAMS

Definition:

States may use a number of mechanisms to assess and improve the quality of care provided by PCCM programs that receive fee-for-service reimbursement (Note: PCCM providers may also receive a small case management fee or enhanced fees for specified services). This element asks for information on whether or not a State has performed the following activities:

- **Consumer Self-Report Data** – data collected through a survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled with a primary care case manager. The survey may be conducted by the State or a contractor to the State. Report all beneficiary surveys, regardless of whether a survey includes the entire Medicaid population enrolled in the PCCM program or only a subpopulation such as individuals with special health care needs or disenrollees. Consumer focus groups should also be included.
- **Enrollee Hotlines** – toll-free telephone lines, usually staffed by the State or a contractor of the State, that beneficiaries might call when they encounter a problem with their PCCM Program/Provider. The people who staff this telephone line 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 **period of time**. These projects are usually based on information extracted from appropriate medical records or administrative data such as enrollment files and claims data. State staff or a contractor of the State may perform these studies.
- **Ombudsman** – An ombudsman is an individual who assists enrollees in resolving problems they may have with their primary care case manager. An Ombudsman is a neutral party who works with the enrollee and the provider (as appropriate) to resolve individual enrollee problems. Select this option only if the ombudsman program 1) is specifically identified by the State Medicaid agency to Medicaid beneficiaries for their use; and 2) provides aggregate data on problems encountered by Medicaid beneficiaries back to the State Medicaid agency.
- **On Site Reviews** – reviews performed on-site at the primary care case manager’s office to assess the physical resources and operational practices in place to deliver health care.
- **Performance Improvement Projects** – projects conducted by the State or its contractor on the PCCM program that examine and achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals

processes, etc. They measure performance at two **points in** time to ascertain if improvement has occurred based on one or more intervention or improvement strategies.

- **Performance Measures** – quantitative 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 program’s performance such as access and availability of care, utilization of care, beneficiary characteristics, and other structural and operational aspects of health care services.
- **Provider Data** are data collected through a survey or focus group of providers who participate in the Medicaid PCCM program and have provided services to enrolled Medicaid beneficiaries. The survey may be conducted by the State or a State contractor.
- **Network Data** – data collected on numbers, types and/or location of providers or facilities contracted in relation to enrollees. Network data may include assessment of “open or closed panels,” or average enrollee assignment panel size for Primary Care Physicians.

Valid Choices:

1. Consumer Self-Report Data
2. Enrollee Hotlines
3. Focused Studies
4. Ombudsman
5. On-Site Reviews
6. Performance Improvement Projects
7. Performance Measures
8. Provider Data
9. Network Data
10. OTHER
11. Does not perform any of the Quality Activities for the PCCM Program

Text box:

If “10” is selected, provide a text box with the question: “What other activity(s) does the State conduct? Do not use abbreviations. Enter text in initial capital format. If more than one other activity is conducted, please click “Enter” after each type.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PCCM”.
3. Must select one valid choice.
4. May select more than one valid choice.
5. If “10” is selected, the text box must be completed. Allow for entries of up to 80 characters each.

6. A text box entry that consists only of the term "HEDIS" or "Healthcare Effectiveness Data and Information Set" is not acceptable.
7. If "11" is selected, may not select any other choices.

DATA ELEMENT: PERFORMANCE MEASURES: TYPES

Definition:

Performance measures are quantitative or qualitative measurements of particular aspects of health care quality. Performance measures are often used to assess PCCM program performance and may be used in conjunction with quality improvement initiatives, or may be collected separately. Performance measures may be collected by the State or a contractor of the State. This element asks the State to identify the types of performance measures it collects for its PCCM program.

- **Process** – measures that assess the actual provision of services for the prevention, diagnosis, and treatment of diseases (e.g., immunization rates, pap smear rates, and retinal examinations for persons with diabetes).
- **Health Status/Outcomes** – measures that assess the results of care provided, which may include, for example, changes in functional and/or health status and patient satisfaction with care.
- **Access/Availability of Care** – measures that assess the degree to which individuals and groups are able to receive needed services from providers.
- **Use of Services/Utilization** – measures that provide information on the amount of services utilized by beneficiaries serviced by providers.
- **Provider Characteristics** – measures that provide descriptive information about the number and characteristics of individual providers who provide services to Medicaid beneficiaries. These measures also provide information on the structure and administrative practices of the providers and may include indicators such as the types of services and facilities available and the qualifications of practitioners.
- **Beneficiary Characteristics** – measures that provide descriptive information about the number and characteristics of beneficiaries served by the providers.
- **OTHER** measures that are calculated or collected that do not fall into any of the above categories

Valid Choices:

1. Process
2. Health Status/Outcomes
3. Access/Availability of Care
4. Use of Services/Utilization
5. Provider Characteristics
6. Beneficiary Characteristics
7. OTHER

Text box:

If “7” is selected, provide a text box with the question: “What other type(s) of performance measure does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other type of data is collected, please click “Enter” after each type.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PCCM".
3. Skip if QUALITY OVERSIGHT ACTIVITIES FOR PCCM PROGRAMS is not "Performance Measures".
4. Must select one valid choice if QUALITY OVERSIGHT ACTIVITIES FOR PCCM PROGRAMS is "Performance Measures".
5. May select more than one valid choice.
6. If "7" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: PROCESS

Definition:

PROCESS measures are measures that assess the actual provision of services for the prevention, diagnosis, and treatment of diseases (e.g., immunization rates, pap smear rates, and retinal examinations for persons with diabetes). For each of the PROCESS QUALITY performance measures listed below, select the ones that the State or its contractor collects.

Valid Choices:

PROCESS

1. Immunization rates for two year olds
2. Adolescent immunization rates
3. Breast cancer screening rate
4. Cervical cancer screening rate
5. Influenza vaccination rate
6. Well-child care visit rates in first 15 months of life
7. Well-child care visit rates in 3,4,5, and 6 years of life
8. Adolescent well-care visit rates
9. Dental services
10. Lead screening rates
11. Pregnancy prevention
12. Initiation of prenatal care - timeliness of
13. Frequency of on-going prenatal care
14. Check-ups after delivery
15. Asthma care - medication use
16. Follow-up after hospitalization for mental illness
17. Initiation or engagement of SUD treatment
18. Identification of Substance Use Disorders
19. Hearing services for individuals less than 21 years of age
20. Vision services for individuals less than 21 years of age
21. Smoking prevention or cessation
22. Cholesterol screening or management
23. Percentage of beneficiaries with at least one dental visit
24. HIV/AIDS care
25. Diabetes management/care
26. Depression medication management
27. Chlamydia screening in women
28. Controlling high blood pressure
29. Beta-blocker treatment after heart attack
30. Heart Attack care
31. Heart Failure care
32. Pneumonia care
33. OTHER

Text box:

If “33” is selected, provide a text box with the question: “What other Process Quality measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PCCM”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Process”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Process”.
5. May select more than one valid choice.
6. If “33” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: HEALTH STATUS/OUTCOMES

Definition:

HEALTH STATUS/OUTCOMES measures are measures that assess the results of care provided, which may include, for example, changes in functional and/or health status and patient satisfaction with care. For each of the HEALTH STATUS/OUTCOMES performance measures listed below, select the ones that the State or its contractor collects.

Valid Choices:

HEALTH STATUS/OUTCOMES

1. Number of children with diagnosis of rubella (measles) / 1,000 children
2. Percentage of low birth weight infants
3. Patient satisfaction with care delivered
4. Percentage of beneficiaries satisfied with their ability to obtain care
5. OTHER

Text box:

If "5" is selected, provide a text box with the question: "What other Health Status/Outcomes measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PCCM".
3. Skip if PERFORMANCE MEASURES: TYPES is not "Health Status/Outcomes".
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is "Health Status/Outcomes".
5. May select more than one valid choice.
6. If "5" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: ACCESS/AVAILABILITY OF CARE

Definition:

ACCESS/AVAILABILITY OF CARE measures are measures that assess the degree to which individuals and groups are able to receive needed services from providers. For each of the ACCESS/AVAILABILITY OF CARE performance measures listed below, select the ones that the State or its contractor collects.

Valid Choices:

ACCESS/AVAILABILITY OF CARE

1. Ratio of primary care case managers to beneficiaries
2. Adult access to preventive/ambulatory health services
3. Children's access to primary care practitioners
4. Average wait time for an appointment with primary care case manager
5. Average distance to primary care case manager
6. Ratio of mental health providers to number of beneficiaries
7. Ratio of dental providers to beneficiaries
8. Ratio of addiction professionals to number of beneficiaries
9. Percent of PCPs with "Open" or "Closed" Patient Assignment Panels
10. OTHER

Text box:

If "10" is selected, provide a text box with the question: "What other Access/Availability of Care measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PCCM".
3. Skip if PERFORMANCE MEASURES: TYPES is not "Access/Availability of Care".
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is "Access/Availability of Care".
5. May select more than one valid choice.
6. If "10" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: USE OF SERVICES/UTILIZATION

Definition:

USE OF SERVICES/UTILIZATION measures are measures that provide information on the amount of services utilized by beneficiaries serviced by providers. For each of the USE OF SERVICES/UTILIZATION performance measures listed below, select the ones that the State or its contractor collects.

Valid Choices:

USE OF SERVICES/UTILIZATION

1. Number of primary care case manager visits per beneficiary
2. Number of OB/GYN visits per adult female beneficiary
3. Number of specialist visits per beneficiary
4. Inpatient admissions / 1,000 beneficiaries
5. Emergency room visits / 1,000 beneficiaries
6. Number of days in ICF or SNF per beneficiary over 64 years
7. Drug utilization
8. Percentage of beneficiaries with at least one dental visit
9. Number of home health visits per beneficiary
10. Inpatient admissions for MH/SUD conditions / 1,000 beneficiaries
11. Average number of visits to MH/SUD providers per beneficiary
12. Re-admission rates of MH/SUD
13. Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
14. OTHER

Text box:

If "14" is selected, provide a text box with the question: "What other Use of Services/Utilization measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PCCM".
3. Skip if PERFORMANCE MEASURES: TYPES is not "Use of Services/Utilization".
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is "Use of Services/Utilization".
5. May select more than one valid choice.
6. If "14" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: PROVIDER CHARACTERISTICS

Definition:

PROVIDER CHARACTERISTICS measures are measures that provide descriptive information about the number and characteristics of individual providers who provide services to Medicaid beneficiaries. These measures also provide information on the structure and administrative practices of the providers and may include indicators such as the types of services and facilities available and the qualifications of practitioners. For each of the PROVIDER CHARACTERISTICS performance measures listed below, select the ones that the State or its contractor collects.

Valid Choices:

PROVIDER CHARACTERISTICS

1. Provider turnover
2. Board Certification
3. Languages spoken (other than English)
4. OTHER

Text box:

If “4” is selected, provide a text box with the question: “What other Provider Characteristics measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PCCM”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Provider Characteristics”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Provider Characteristics”.
5. May select more than one valid choice.
6. If “4” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: PERFORMANCE MEASURES: BENEFICIARY CHARACTERISTICS

Definition:

BENEFICIARY CHARACTERISTICS measures are measures that provide descriptive information about the number and characteristics of beneficiaries served by the providers. For each of the BENEFICIARY CHARACTERISTICS performance measures listed below, select the ones that the State or its contractor collects.

Valid Choices:

BENEFICIARY CHARACTERISTICS

1. Percentage of beneficiaries who are auto-assigned to a PCCM
2. Disenrollment rate
3. Information on beneficiary ethnicity/race
4. Information on primary languages spoken by beneficiaries
5. Beneficiary need for interpreter
6. Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period
7. Percentage of beneficiaries auto-assigned to PCP
8. OTHER

Text box:

If “8” is selected, provide a text box with the question: “What other Beneficiary Characteristics measure(s) does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other measure is collected, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PCCM”.
3. Skip if PERFORMANCE MEASURES: TYPES is not “Beneficiary Characteristics”.
4. Must select one valid choice if PERFORMANCE MEASURES: TYPES is “Beneficiary Characteristics”.
5. May select more than one valid choice.
6. If “8” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: CONSUMER SELF-REPORT DATA

Definition:

Consumer self-report data may include information collected through a survey or a focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled with a primary care case manager. The survey may be conducted by the State or a contractor to the State. Report all beneficiary surveys, regardless of whether the survey includes the entire Medicaid population enrolled in the PCCM program or only a subpopulation such as individuals with special health care needs or disenrollees. Consumer focus groups should also be included. The State collects the following Consumer Assessment of Health Plans Survey (CAHPS) and/or Other types of Consumer self-report data:

Valid Choices:

1. CAHPS Adult Medicaid AFDC Questionnaire
2. CAHPS Child Medicaid AFDC Questionnaire
3. CAHPS Adult Medicaid SSI Questionnaire
4. CAHPS Child Medicaid SSI Questionnaire
5. CAHPS Adult with Special Needs Questionnaire
6. CAHPS Child with Special Needs Questionnaire
7. Consumer Oriented Mental Health Report Card
8. State-developed Survey
9. Disenrollment Survey
10. Consumer/Beneficiary Focus Groups
11. OTHER

Text box:

If "11" is selected, provide a text box with the question: "What other type(s) of consumer self-report data does the State collect? Do not use abbreviations. Enter text in initial capital format. If more than one other type of data is collected, please click "Enter" after each type."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PCCM".
3. Skip if QUALITY OVERSIGHT ACTIVITIES FOR PCCM PROGRAMS is not "Consumer Self-Report Data".
4. Must select one valid choice if QUALITY OVERSIGHT ACTIVITIES FOR PCCM PROGRAMS is "Consumer Self-Report Data".
5. May select more than one valid choice.
6. If "11" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

Element Name: PERFORMANCE IMPROVEMENT PROJECTS

Definition:

Performance improvement projects seek to improve the quality of care and services provided to Medicaid beneficiaries. The State or its contractor may conduct quality assessment and performance improvement projects on the PCCM program in clinical, as well as non-clinical areas.

- **Clinical Performance Improvement Projects** include projects focusing on Primary, Secondary, and/or Tertiary Prevention of Acute Conditions; Secondary, and/or Tertiary Prevention of Chronic Conditions; Care of Acute Conditions; Care of Chronic Conditions; High-Volume Services, High-Risk Services; and Continuity and Coordination of Care
- **Non-Clinical Performance Improvement Projects** include projects focusing on Availability, Accessibility, and Cultural Competency of Services; Interpersonal Aspects of Care; and Appeals, Grievances, and Other Complaints

Valid Choices:

1. Clinical Performance Improvement Projects
2. Non-Clinical Performance Improvement Projects

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PCCM".
3. Skip if QUALITY OVERSIGHT ACTIVITIES FOR PCCM PROGRAMS is not "Performance Improvement Projects".
4. Must select one valid choice if QUALITY OVERSIGHT ACTIVITIES FOR PCCM PROGRAMS is "Performance Improvement Projects".
5. May select more than one valid choice.

DATA ELEMENT: CLINICAL PERFORMANCE IMPROVEMENT TOPICS

Definition:

For each PCCM program clinical performance improvement project conducted, please provide the specific study topic area(s) to be addressed by the project.

1. Well Child Care / EPSDT
2. Adolescent Well Care / EPSDT
3. Childhood Immunization
4. Adolescent Immunization
5. Child/Adolescent Hearing and Vision Screening and Services
6. Child/Adolescent Dental Screening and Services
7. Otitis Media management
8. Asthma management
9. Diabetes management
10. HIV Status/Screening
11. HIV/AIDS Prevention and/or Management
12. Smoking prevention and cessation
13. Adult hearing and vision screening
14. Cholesterol screening and management
15. Cervical cancer screening (Pap Test)
16. Cervical cancer treatment
17. Breast cancer screening (Mammography)
18. Breast cancer treatment
19. Pregnancy Prevention
20. Low birth-weight baby
21. Pre-natal Care
22. Inpatient maternity care and discharge planning
23. Post-natal Care
24. Newborn screening for heritable diseases
25. (Newborn) Failure to thrive
26. Emergency Room service utilization
27. Hospital Discharge Planning
28. Motor vehicle accidents
29. Domestic violence
30. Hip fractures
31. Prevention of Influenza
32. Medical problems of frail elderly
33. Treatment of myocardial infarction
34. Beta Blocker treatment after a heart attack
35. Coronary artery disease prevention
36. Coronary artery disease treatment
37. ETOH and other Substance Use Disorders screening and treatment
38. Substance Use Disorders treatment after detoxification service
39. Prescription drug abuse
40. Pharmacy Management

41. Depression management
42. Coordination of Primary and Behavioral Health care
43. Lead toxicity
44. Tuberculosis screening and treatment
45. Sickle cell anemia management
46. Hypertension management
47. Sexually transmitted disease screening
48. Sexually transmitted disease treatment
49. Hepatitis B screening and treatment
50. Hysterectomy
51. Coordination of care for persons with physical disabilities
52. OTHER

Text box:

If “52” is selected, provide a text box with the question: “What other Clinical Performance Improvement Project Topics does the State conduct on its PCCM program? Do not use abbreviations. Enter text in initial capital format. If more than one other topic is addressed, please click “Enter” after each measure.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PCCM”.
3. Skip if PERFORMANCE IMPROVEMENT PROJECTS is not “Clinical Performance Improvement Projects”.
4. Must select one valid choice if PERFORMANCE IMPROVEMENT PROJECTS is “Clinical Performance Improvement Projects”.
5. May select more than one valid choice.
6. If “52” is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: NON-CLINICAL PERFORMANCE IMPROVEMENT TOPICS

Definition:

For each PCCM program non-clinical performance improvement project conducted, please provide the specific study topic area(s) to be addressed by the project.

1. Availability of language interpretation services
2. Adults access to preventative/ambulatory health services
3. Children's access to primary care practitioners
4. Health information technology (e.g., state implementation of immunization and other registries, telemedicine initiatives or Regional Health Information Organization [RHIO] participation)
5. Reducing health care disparities via health literacy/education campaigns or other initiatives
6. OTHER

Text box:

If "6" is selected, provide a text box with the question: "What other Non-Clinical Performance Improvement Topics does the State conduct on its PCCM program? Do not use abbreviations. Enter text in initial capital format. If more than one other topic is addressed, please click "Enter" after each measure."

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is "PCCM".
3. Skip if PERFORMANCE IMPROVEMENT PROJECTS is not "Non-Clinical Performance Improvement Projects".
4. Must select one valid choice if PERFORMANCE IMPROVEMENT PROJECTS is "Non-Clinical Performance Improvement Projects".
5. May select more than one valid choice.
6. If "6" is selected, must complete text box entry. Allow for entries of up to 80 characters each.

DATA ELEMENT: USE OF COLLECTED DATA

Definition:

States can use data they collect in a number of ways to improve or assure quality of care. This DATA ELEMENT asks States to identify how it uses collected data.

- **Track Health Service Provision (Access and Utilization)** – Utilization data can be used to track the provision of health services over time and/or to compare trends between managed care entities participating in the Medicaid program or FFS and managed care.
- **Monitor Quality Improvement** – Process and outcome data can be used to monitor whether the PCCM program or its primary care case managers improve the quality of care provided to Medicaid enrollees.
- **Beneficiary Provider Selection** – Quality and satisfaction data can be provided to beneficiaries to help them select a primary care case manager.
- **Contract Standard Compliance** – States may use data they collect to monitor provider compliance with contract standards (e.g., waiting times for appointments).
- **Program Modification, Expansion, or Renewal** – States may use data they collect to make decisions about program modification, expansion of coverage or benefits, or to support waiver renewal applications
- **Program Evaluation** – States may use data they collect to assess program results or to evaluate the effectiveness of the PCCM program they have in place
- **Regulatory Compliance/Federal Reporting** – States may use data they collect to demonstrate compliance with regulations, for Federal reporting on waiver-related activities, or for general Federal reporting requirements
- **Health Services Research** – States may use data they collect to conduct health services research or they may provide data to external entities for the conduct of health services research
- **Provider Profiling** – Data can be analyzed at the level of individual providers to assist in quality improvement.
- **Fraud and Abuse** – States may use data they collect to identify potential instances of fraud and abuse by providers, managed care entities, etc.
- **Data Mining** – States may use data they collect to sort through data to identify and establish relationships. The key idea of the process is not hypothesis-driven, but attempts to identify unsuspected associations, clustering, forecasting, etc., that permits effective action to be taken in the absence of an explanation for the existence of the pattern.
- **ANOVA (Analysis of Variance)** – A mathematical process for separating the variability of a group of observations into assignable causes and setting up various significance test.
- **Enhance/Revise State Managed Care Medicaid Quality Strategy** – States may use data they collect to revise State improvement initiatives, PIHP quality standards, or PIHP reporting specifications/requirements for performance measurement reporting or performance improvement projects.
- **Do Not Use the Data Collected**

● Other

Valid Choices:

1. Track Health Service Provision
2. Monitor Quality Improvement
3. Beneficiary Provider Selection
4. Contract Standard Compliance
5. Program Modification, Expansion, or Renewal
6. Program Evaluation
7. Regulatory Compliance/Federal Reporting
8. Health Services Research
9. Provider Profiling
10. Fraud and Abuse
11. Data Mining
12. ANOVA (Analysis of Variance)
13. State Medicaid Managed Care Quality Strategy
14. Do Not Use the Data Collected
15. OTHER

Text box

If “15” is selected, provide a text box with the instructions: “Please identify the other uses of collected data. Do not use abbreviations. Enter text in initial capital format. If more than one, click “Enter” after each entry.”

Edit Conditions:

1. Skip, if uses 1915(b)(4) authority solely for fee-for-service reimbursement arrangement.
2. Must complete if MANAGED CARE ENTITY is “PCCM”.
3. Must select one valid choice.
4. May select more than one valid choice.
5. If “14” is selected, may not select any other valid choice.
6. If “15” is selected, text box must be completed. Allow for entries of up to 80 characters each.