Managed Care Quality Strategy

2018

Executive Summary

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The Mississippi Division of Medicaid's (DOM) coordinated care program, MississippiCAN, is now seven years old and continues to grow and develop.

MississippiCAN was authorized by the state Legislature in 2009 and implemented in January of 2011. The program was developed with the specific goals of improving access to needed medical services, improving the quality of care, and improving cost predictability.

Since its inception, MississippiCAN has continually evolved and expanded over six years. In the beginning, the program only applied to a few categories of eligibility (or populations of beneficiaries), such as disabled children at home and the working disabled. With legislative approval, additional eligible populations were added or "rolled into" the program in the following years. In 2015, MississippiCAN was affected by two substantial impacts – the inclusion of all categories of children on Medicaid and inpatient hospital services. Today, approximately 70 percent of Medicaid beneficiaries in Mississippi are served through coordinated care.

MississippiCAN has been in a continuous state of evolution. We are currently undergoing a complex process of analyzing data to evaluate outcomes and understand trends that are emerging. As we continue to work closely with our coordinated care organizations we are seeing positive improvements.

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Section I: Introduction

Managed Care Goals, Objectives and Overview

Overview of the Mississippi Coordinated Access Network Program:
As part of the Social Security Amendments of 1965, Medicaid was created to provide health coverage for certain eligible, low-income populations. In 1969, Mississippi Medicaid was authorized by the State Legislature. The Division of Medicaid in the Office of the Governor (DOM) is the sole agency responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP).

The mission of DOM is to responsibly provide access to quality health coverage for vulnerable Mississippians, and doing so with the stated values of accountability, consistency and respect.

DOM implemented the Mississippi Coordinated Access Network (MississippiCAN) Program for selected high-risk beneficiaries on Jan. 1, 2011, as authorized by the State Legislature. MississippiCAN is a statewide coordinated care program designed to meet the following managed-care goals:

- **Improve access to necessary medical services** by connecting beneficiaries with a medical home, increasing access to health-care providers and improving beneficiaries' use of primary and preventive care services.
- **Improve quality of care and population health** by providing systems and supportive services, including care coordination, care management and other programs that allow beneficiaries to take increased responsibility for their health care.
- **Improve efficiencies and cost effectiveness** by contracting with entities on a full-risk prepaid capitated basis to provide comprehensive services through an efficient, cost-effective system of care.

Beneficiaries were enrolled into one of two coordinated care organizations (CCO) — Magnolia Health and UnitedHealthcare Community Plan — which provided specialized services and access to care. Prior to 2011, Mississippi Medicaid beneficiaries received care through a fee-for-service (FFS) program model. Following the initial implementation phase of the MississippiCAN program, DOM was authorized to enroll up to 45 percent of Medicaid beneficiaries into MississippiCAN during the 2012 legislative session, increasing the program to include additional populations and services. In 2014 and 2015, DOM received legislative approval to further grow the program to include previously excluded inpatient hospital services for eligible beneficiaries and to enroll all Medicaid-eligible children up to age 19.

MississippiCAN was reprocured in 2017, and beginning in October 2018, the 1915(i) Intellectual/Developmental Disabilities Community Support Program (IDD CSP), Psychiatric Residential Treatment Facilities (PRTF) and Mississippi Youth Programs Around the Clock (MYPAC) program will also be included in MississippiCAN. Effective with the 2017 procurement, beneficiaries have the choice to enroll in three CCOs: Magnolia Health, Molina Health Plan and UnitedHealthcare Community Plan. The CCOs reimburse

Managed Care Goals, Objectives and Overview (continued)

all network providers at a rate no less than the amount that DOM reimburses fee-for-service providers.

As of 2018, beneficiaries not eligible to participate in the MississippiCAN program include: nursing home residents or residents of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); beneficiaries institutionalized in a facility that is not a Psychiatric Residential Treatment Facility; beneficiaries enrolled in a waiver program; Medicare-eligible beneficiaries; and beneficiaries with hemophilia.

As of 2018, state law requires mandatory beneficiary participation in MississippiCAN, except for those individuals excluded by federal law from mandatory participation. Individuals eligible for Medicaid in the following coverage groups are mandated to participate:

- Supplemental Security Income (SSI) (ages 19-65)
- Working Disabled (ages 19-65)
- Breast/Cervical Cancer Group (ages 19-65)
- Parents and Caretakers (Temporary Assistance for Needy Families (TANF)) (ages 19-65)
- Pregnant women (ages 8-65)
- Newborns (ages 0-1)
- Children (TANF) (ages 1-19)
- Children up to age 19; 100 percent of the federal poverty level (FPL) (ages 6-19)
- Quasi-CHIP (ages 6-19)
- Children (Beginning CY 2015) ages 1-19

Individuals eligible for Medicaid in the following coverage groups have optional participation:

- SSI (ages 0-19)
- Disabled Child Living at Home (ages 0-19)
- Foster Care Children IV-E and CWS
- Foster Care Children with Adoption Assistance (ages 0-19)

Approximately 68 percent of Mississippi Medicaid beneficiaries are enrolled in managed care. See **Appendix A** for 2018 enrollment data.

DOM's goal is to ensure that the contracted CCOs not only perform the administrative function of a typical insurer, but also be adept at addressing the unique challenges and needs of low-income populations.

Managed Care Goals, Objectives and Overview (continued)

Overview of the Mississippi Children's Health Insurance Program:
Effective Jan. 1, 2013, the MississippiCHIP program administration and management was transferred from the State and School Employees Health Insurance Management Board to DOM. Since 2015, Magnolia Health and UnitedHealthcare Community Plan have managed CHIP. DOM will re-procure for two CCOs to manage the program in 2018. At the time of the 2018 procurement, the benefit coverage benchmark will change from the State and School Employees' Health Insurance Plan benefit to the DOM benefit.

Managed care oversight has become an agency-wide function as the MississippiCAN program has expanded:

DOM also utilizes the MississippiCAN Quality Task Force (QTF) to accomplish oversight responsibilities and solicit input for improvements. Members of the QTF include representatives from DOM, the CCOs, beneficiaries and the External Quality Review Organization (EQRO). The QTF meetings are the central forum for communication and collaboration for quality strategies, plans and activities, and opportunities to develop systematic and integrated approaches to quality activities.

DOM receives input from the Mississippi Medical Care Advisory Committee, composed of members who are either a health-care provider or consumers of health-care services appointed by the Governor, Lieutenant Governor and the Speaker of the House of Representatives.

Development and Review of Quality Strategy

The Managed Care Quality Strategy serves as a road map to monitor and implement quality improvement and allows for necessary revisions to strengthen the effectiveness and reporting of the program. It provides a framework to communicate the state's vision, objectives and monitoring strategies addressing issues of health-care costs, quality and accessibility for the state's most vulnerable citizens.

The Managed Care Quality Strategy details the standards and mechanisms for holding the CCOs accountable for desired outcomes. It also articulates compliance requirements from the Centers for Medicare & Medicaid Services (CMS) federal Medicaid managed care rule, 42 C.F.R. § 438.340(a) requirements.

During this process, DOM is seeking input from internal and external stakeholders, including the DOM medical director, CCOs, health-care and beneficiary advocacy groups, the Drug Utilization Review Board, and the Medical Care Advisory Committee consistent with the standards set forth in 42 C.F.R. § 438.340(c).

Development and Review of Quality Strategy (continued)

DOM also relies upon the annual EQRO technical report for detailed information regarding the regulatory and contractual compliance of the CCOs and results of performance improvement projects (PIPs) and performance measures. Results from this report include information regarding the effectiveness of the CCO program, strengths and weaknesses identified, and potential opportunities for improvement. The information is incorporated into the Managed Care Quality Strategy and used for initiating and developing quality improvement projects. Feedback from Medicaid beneficiaries that is used in the development of the Managed Care Quality Strategy is garnered through several methods including the QTF, member satisfaction surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and member grievance and appeals reporting.

Timeline for Managed Care Quality Strategy Assessment

The Managed Care Quality Strategy is reviewed internally by DOM and shared with the EQRO and CCOs for review. The Mississippi Band of Choctaw Indians (MBCI) is consulted in accordance with the state's Tribal consultation policy. See **Appendix B** for tribal policy.

Public comment is garnered through DOM's website and public stakeholder meetings prior to submitting the Strategy to CMS for review. See **Appendix C** for public comment and CMS submission timeline.

Development and Review of Quality Strategy (continued)

The Managed Care Quality Strategy is assessed annually for effectiveness and must be updated to reflect state and federal mandates related to managed care as significant changes occur, or no less than every three years. Updates to the Strategy will be made available on the DOM website upon CMS approval. Significant changes are defined as changes that impact quality activities or threaten the effectiveness of the strategy. The Managed Care Quality Strategy has evolved over time as a result of programmatic changes, the health needs of beneficiaries, clinical practice guidelines, federal and state laws, project outcomes and best practices.

The Managed Care Quality Strategy is developed based upon a structure and processes that support and encourage achievement of sustainable improvements in the quality of care and services provided to all Medicaid beneficiaries. DOM continues to utilize data collection and reporting for ongoing quality initiatives, to identify areas for improvement and to responsibly provide oversight of MississippiCAN and MississippiCHIP CCOs.

Section II: Assessment

Quality and Appropriateness of Care

DOM has ongoing quality assessment and performance improvement strategies to ensure the delivery of quality health care to MississippiCAN and MississippiCHIP beneficiaries. The CCOs are contractually required to maintain an administrative and organizational structure that supports effective and efficient delivery of services to beneficiaries.

DOM strives to assess and improve the accuracy of data to clearly reflect the performance of the CCOs in managing the delivery of health care to their beneficiaries. Currently, DOM requires a number of quality assessment and performance improvement results to be reported on a monthly, quarterly and annual basis. The measures are submitted by the CCO in a state-mandated Reporting Manual, formatted using state-specific definitions, and have required time frames by which to calculate and report. Any deviances are to be noted as variances by the CCO, and actions taken for improvement are to be described. DOM may use corrective actions when a CCO fails to provide the requested services or otherwise fails to meet contractual responsibilities related to quality. The metrics that are mandated for each CCO to self-report are submitted electronically using an approved template and uploaded to a secure ShareFile site. See **Appendix D** for the MississippiCAN and MississippiCHIP Reporting Manual.

Performance Measures

DOM has adopted the majority of the National Adult and Child Health Care Quality Measures, along with state-specific performance measures and focused topics for required Performance Improvement Projects (PIPs). These state-mandated measures and projects address a range of priority issues for the Mississippi Medicaid populations. The measures have been identified through a process of data analysis and evaluation of trends within these populations. Performance goals are based on improvement to or maintenance of the following benchmarks: Healthcare Effectiveness Data and Information Set (HEDIS) 25th, 50th and 75th percentiles, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Quality Compass national benchmarks. See **Appendix E** for the Adult and Child Health Quality Measures.

Final selection and approval of PIPs and performance measures is the responsibility of the Office of Health Services and DOM leadership. State-specific performance measures are reported by the CCOs, and results are reviewed quarterly by DOM, with final HEDIS results reviewed annually. Validation of the PIPs results are reviewed by DOM annually in conjunction with the EQRO compliance report results.

DOM and the CCOs maintain an ongoing collaborative process on the development, addition and modification of performance measures to identify opportunities for improving health outcomes. DOM imposes appropriate remedies to align performance with contractual requirements.

Performance Measures (continued)

As necessary, DOM and the EQRO provide technical assistance to each CCO to refine, correct and maintain the reporting templates to reflect the most current program changes, include evidence-based best practices and ensure continued standardization of the reporting process.

External Quality Review Organization

DOM has contracted with Carolina Centers for Medical Excellence (CCME) to undertake external quality review activities for MississippiCAN and MississippiCHIP programs. The EQRO analyzes and evaluates aggregated information on the CCO quality, timeliness and access to covered health-care services.

The EQRO current scope of work includes:

- Validating performance measures
- Validating performance improvement projects
- Validating consumer and provider surveys
- Determine CCO compliance with state standards for access to care, structure and operations, and quality measurement and improvement for the MississippiCAN program review, within the previous three-year period.

The CCOs provide annual audited HEDIS data for review. The EQRO must address the following activities while validating performance measures: Review the data management processes of the CCO and, for those performance measures based on HEDIS, evaluate algorithmic compliance (the translation of captured data into actual statistics) with HEDIS Technical Specifications. For other performance measures, DOM provides specifications for data collection and verifies performance measures to confirm that the reported results are based on accurate source information.

The EQRO undertakes the following steps in validating focused studies/PIPs:

- Assess the CCO methodology for conducting the focused study/PIP
- Verify actual focused study/PIP study findings
- Evaluate the overall validity and reliability of study results to comply with requirements set forth in 42 C.F.R 438.240(b)(2)

The EQRO reviews the CCO compliance with the state's standards for access to care, structure and operations, and quality measurement and improvement.

External Quality Review Organization (continued)

The EQRO follows CMS' most current Monitoring Medicaid Managed Care Organization (MCOs) and Prepaid Inpatient Health Plans (PIHPs) protocol. This validation occurs annually and contains seven activities:

- Planning for compliance monitoring activities
- Obtaining background information from DOM
- Documenting review
- Conducting interviews
- Collecting any other accessory information (e.g., from site visits)
- Analyzing and compiling findings
- Reporting results to DOM

The EQRO is contractually required to participate in the Quality Task Force meetings and, upon request, must prepare and present information and consult with this committee.

An additional responsibility of the EQRO is to validate consumer and provider surveys on quality of care. This is attained by following CMS' most current Administering or Validating Surveys protocol, which undertakes the following activities to assess the methodological soundness of the surveys:

- Reviews survey purpose(s) and objective(s)
- Reviews intended survey audience(s)
- Assesses the reliability and validity of the survey instrument
- Assesses the adequacy of the response rate
- Reviews survey data analysis and findings/conclusions
- Documents evaluation of survey

In addition to the federal- and state-required activities, the EQRO suggests activities that DOM may consider to enhance the external quality review process and to support DOM in achieving its objective to improve quality based on the analysis and evaluation of the CCOs' quality, timeliness and access to health-care services. Non-duplication of EQRO activities does not apply as defined in 42 C.F.R. § 438.360(c).

Section III: State Standards

Access Standards

Network adequacy standards are an important tool for ensuring that beneficiaries have access to providers and care. The CCOs must recruit and maintain a provider network, using provider contracts as approved by DOM. They must comply with federal regulations regarding provider network adequacy as stated in 42 C.F.R. § 438.68, 438.206, 438.207; and they must comply with state regulations regarding reconsideration of inclusion per Miss. Code Ann. § 83-41-409 (e).

The CCOs utilize a universal application, credentialing and contracting process for MississippiCAN providers established by DOM and conduct provider credentialing simultaneously with provider contracting to ensure timely processing. However, the credentialing process must be completed before final execution of the contract with the provider. The CCOs are solely responsible for providing a network of physicians, pharmacies, facilities and other health-care providers through which the CCO provides coverage and services included in covered services. In establishing its provider network, the CCOs must contract with as many Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as necessary to allow beneficiary access to participating FQHCs and RHCs without requiring beneficiaries to travel a significantly greater distance from the location of a non-participating FQHC or RHC. If the CCO cannot satisfy this standard for FQHC and RHC access at any time, they must allow their beneficiary to seek care from non-contracting FQHCs and RHCs and must reimburse these providers at Medicaid fee schedule rates.

In the case of specialty pharmacies, the CCOs may not deny a pharmacy or pharmacist the right to participate as a contract provider if the pharmacy or pharmacist agrees to provide pharmacy services, including but not limited to prescription drugs, that meet the terms and requirements set forth by the CCO and agrees to the terms of reimbursement set forth by the CCO in accordance with Miss. Code Ann. § 83-9-6.

The CCO must ensure that its network of providers is adequate to ensure access to all covered services and that all providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the covered services. The CCO may not close their provider network for any provider type without prior approval from DOM.

In addition to maintaining a sufficient number of providers in its network to provide all services to its beneficiaries, the CCO shall meet the geographic access standards for all beneficiaries set forth in the following table:

Access Standards (continued)

Provider Type	Urban	Rural
PCPs – Adult and Pediatric	Two within 15 miles	Two within 30 miles
Hospitals	One within 30 minutes or 30 miles	One within 60 minutes or 60 miles
Specialists – Adult and Pediatric	One within 30 minutes or 30 miles	One within 60 minutes or 60 miles
General Dental Providers – Adult and Pediatric	One within 30 minutes or thirty 30 miles	One within 60 minutes or 60 miles
Dental Subspecialty Providers	One within 30 minutes or 30 miles	One within 60 minutes or 60 miles
Emergency Care Providers	One within 30 minutes or 30 miles	One within 30 minutes or 30 miles
Urgent Care Providers	One within 30 minutes or 30 miles	Not Applicable
OB/GYN	One within 30 minutes or 30 miles	One within 60 minutes or 60 miles
Behavioral Health (Mental Health and Substance Use Disorder) Providers – Adult and Pediatric	One within 30 minutes or 30 miles	One within 60 minutes or 60 miles
Durable Medical Equipment Providers	One within 30 minutes or 30 miles	One with 60 minutes or 60 miles
Pharmacies	One open 24 hours a day, seven days a week within 30 minutes or 30 miles	One open twenty-four 24 hours a day (or has an afterhours emergency phone number and pharmacist on call), seven days a week within 60 minutes or 60 miles
Dialysis Providers	One within 60 minutes or 60 miles	One within 90 minutes or 90 miles

DOM specifies the urban and rural designation of counties within Mississippi. All travel times are maximums for the amount of time it takes a beneficiary, using traditional means of travel in a direct route, to travel from their home to the provider. DOM recognizes that Non-Emergency Transportation (NET) providers may not always follow direct routes due to multiple passengers.

If the CCO is unable to identify a sufficient number of providers located within an area to meet the geographic access standards or is unable to identify a sufficient number of providers within a provider

Access Standards (continued)

type or specialty, the CCO must submit documentation to DOM verifying the lack of providers. DOM may approve exceptions to the geographic access standards in such cases. DOM may impose liquidated damages per contract allowances if the CCO fails to meet provider network access standards.

The CCOs must pay for covered services on an out-of- network basis for the beneficiary if the CCO's provider network is unable to provide such services within the geographic access standards. Services must be provided and paid for in an adequate and timely manner and for as long as the CCO is unable to provide them.

The CCOs submit a Network Geographic Access Assessment (GeoAccess) Report on a quarterly basis to DOM demonstrating compliance with these requirements.

The CCOs must have in its network the capacity to ensure that the appointment scheduling does not exceed the following time frames:

Type	Appointment Scheduling Timeframes
PCP (Well Care Visit)	Not to exceed 30 calendar days
PCP (Routine Sick visit)	Not to exceed seven calendar days
PCP (Urgent Care visit)	Not to exceed 24 hours
Specialists	Not to exceed 45 calendar days
Dental Providers (routine visits)	Not to exceed 45 calendar days
Dental Providers (Urgent Care)	Not to exceed 48 hours
Behavioral Health/Substance Use Disorder Providers (routine visit)	Not to exceed 21 calendar days
Behavioral Health/Substance Use Disorder Providers (urgent visit)	Not to exceed 24 hours
Behavioral Health/Substance Use Disorder Providers (post- discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven calendar days
Urgent Care Providers	Not to exceed 24 hours
Emergency Providers	Immediately (24 hours a day, seven days a week) and without Prior Authorization

Each network physician shall maintain hospital admitting privileges with a network hospital as required for the performance of his or her practice or have a written agreement with a network physician who has hospital admitting privileges. All network providers must be accessible to beneficiaries and must maintain a reasonable schedule of operating hours. At least annually, the CCOs must conduct a review of the accessibility and availability of primary care providers and must follow up with those providers who do not meet the accessibility and availability standards set forth by DOM. The CCOs must submit the findings

Access Standards (continued)

from this review in writing to DOM.

DOM reserves the right to periodically review the adequacy of service locations and hours of operation and require corrective action to improve beneficiary access to services.
The CCOs must also demonstrate that there is sufficient Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) providers in the network to ensure timely access to services for Indian beneficiaries who are eligible to receive services from such providers.

The CCOs must provide female beneficiaries with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health-care services. This is in addition to the beneficiary's designated source of primary care if that source is not a women's health specialist.

Upon request, the CCOs must provide for a second opinion from a network provider or arrange for the beneficiary to obtain one outside the network from an out-of-network provider, at no cost to the beneficiary.

The CCOs encourage the development of National Committee for Quality Assurance (NCQA)-recognized Patient-Centered Medical Homes and coordinate with any DOM initiatives related to the development and NCQA recognition of Patient-Centered Medical Homes, as defined by DOM. Based on the collaboration with DOM, DOM defines specific reporting requirements which may change as the initiative is implemented. DOM notifies the CCOs of the reporting requirements in writing at least 60 days before the report containing the required information is due.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) wellness services shall be administered in accordance with Mississippi Administrative Code Title 23, State Plan and written communication from DOM to the CCOs. For CMS-mandatory reporting purposes including, but not limited to, CMS 416 reporting, EPSDT wellness services must be provided by enrolled Medicaid providers. Those providers include, but are not limited to, the Mississippi State Department of Health (MSDH), other public and private agencies, private physicians, RHCs, comprehensive health clinics, public schools and/or public school districts certified by the Mississippi Department of Education and similar agencies which provide various components of the EPSDT services, that have signed an EPSDT-specific provider agreement with DOM. DOM provides the CCOs with a list of qualified EPSDT providers on a monthly basis.

Access Standards (continued)

The CCOs must demonstrate that their networks include sufficient family planning providers to ensure timely access to covered services.

The CCOs must ensure that network providers provide physical access, reasonable accommodations and accessible equipment for Medicaid beneficiaries with physical or mental disabilities.

The CCO provider network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency. They must also consider the expected utilization of services given the characteristics and health-care needs of the population. Additionally, the CCOs must not prohibit, or otherwise restrict, a health-care professional acting within the lawful scope of practice, from advising or advocating on behalf of the beneficiary who is his or her patient for the following:

- Beneficiary's health status, medical care or treatment options, including any alternative treatment that may be self-administered
- Any information the beneficiary needs in order to decide among all relevant treatment options
- Risks, benefits and consequences of treatment or non-treatment
- Beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions
- Beneficiary's responsibility for non-covered items and/or services only if the provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the beneficiary that an item or service rendered is a non-covered item and/or service and that the beneficiary is financially responsible for the item and/or service

The CCOs must have written policies and procedures, approved by DOM, for the prior authorization of services, which must comply with the CCO contract and Mississippi Administrative Code. DOM must receive prior authorization criteria and associated policies and procedures for advanced written approval 45 calendar days prior to implementation of the criteria, process or procedure.

The CCOs shall have procedures for processing requests for initial and continuing authorizations of services. Decisions to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested must be made by a physician pursuant to Miss. Code Ann. § 41-83-31.

The CCOs shall use a mechanism to ensure consistent application of review criteria for authorization decisions that includes consultation with the requesting provider when appropriate. The CCOs shall determine the medical necessity for non-inpatient hospital medical services authorizations, retroactive eligibility reviews and retrospective reviews to eligible Mississippi Medicaid beneficiaries using DOM's

Access Standards (continued)

approved criteria and policies.

The CCOs may not structure compensation to individuals or utilization management entities so as to provide inappropriate incentives for the individual or entity to deny, limit or discontinue medically necessary services to any beneficiary.

The CCOs shall comply with 42 C.F.R. § 438.210 (b)(3), which requires that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the beneficiary's medical, behavioral health or long-term services and supports needs.

Transition of Care Policy

DOM and each CCO maintains a transition of care policy consistent with requirements of 42 C.F.R. § 438.62. The CCOs must make the transition of care policy publicly available and provide instructions to beneficiaries and potential enrollees on how to access continued services upon transition. The transition of care policy must be explained to beneficiaries in the materials to members and potential enrollees in accordance with § 438.10.

In the event a beneficiary entering the CCO, either as a new beneficiary or transferring from another CCO, is receiving medically necessary services in addition to or other prenatal services the day before enrollment, the CCO is responsible for the costs of continuation of such medically necessary services, without any form of prior authorization and without regard to whether such services are being provided by a network provider or non-contract providers.

For medically necessary covered services, the CCO must provide the continuation of such services for up to 90 calendar days or until the beneficiary may be reasonably transferred without disruption to a network provider, whichever is less. The CCO may require prior authorization for continuation of services beyond 30 calendar days; however, the CCO is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

For medically necessary covered services being provided by a network provider, the CCO shall provide continuation of such services from that provider. Beneficiaries who are transitioning to another provider when a provider currently treating their chronic or acute medical or behavioral health condition, or currently providing prenatal services, has terminated participation with the CCO, the beneficiary must receive continuation of coverage for such provider for up to 90 calendar days or until he/she may be reasonably transferred to another provider without disruption of care, whichever is less.

Transition of Care Policy (continued)

For beneficiaries in their second or third trimester of pregnancy, the CCO shall allow continued access to the beneficiary's prenatal care provider and any provider currently treating the beneficiary's chronic, acute medical or behavioral health/substance use disorder through the postpartum period.

Structure and Operations Standard

Mississippi Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid-covered services. The CCOs must prepare, submit to DOM for approval, and follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the CCO, in accordance with 42 C.F.R. § 438.214 and Mississippi Department of Insurance Regulation 98-1. The CCOs maintain a Credentialing Committee, and the CCOs' medical directors shall have overall responsibility for the Committee's activities. The CCOs utilize a universal application, credentialing and contracting process for MississippiCAN providers as established by DOM. The CCOs must conduct provider credentialing simultaneously with provider contracting to ensure timely processing; however, credentialing must be completed before final execution of the contract with the provider.

The CCOs credentialing and recredentialing policies and procedures must meet the requirements within 42 C.F.R.§ 438.12 and must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The CCOs may not employ or contract with providers excluded from participation in federal health-care programs under either section 1128 or section 1128A of the Act.

The CCOs use credentialing and recredentialing standards set forth by the NCQA and EQRO recommendations. The CCOs follow the most current version of the credentialing organization's credentialing requirements from year to year.

The CCOs are required to verify and certify to DOM that all network providers and any out-of-network providers to whom beneficiaries may be referred are properly licensed in accordance with all applicable state law and regulations, are eligible to participate in the Medicaid program, and have in effect appropriate policies of malpractice insurance as may be required by the CCO and DOM. The CCOs must ensure that all network providers are enrolled with the state as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. part 455, subparts B and E.

The CCOs may be subject to sanctions if they offer or give something of value to a beneficiary that the CCO knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid.

Structure and Operations Standard (continued)

The CCOs must abide by the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, including EDI, code sets, identifiers, security, and privacy provisions as may be applicable to the services under the CCO contract.

To the extent that the CCOs use one or more subcontractors or agents to provide services, and such subcontractors or agents receive or have access to protected health information (PHI), each such subcontractor or agent shall sign an agreement with the CCO that complies with HIPAA.

The CCO shall ensure that all agents and subcontractors to whom it provides PHI received from DOM (or created or received by the CCO on behalf of DOM) agree in writing to the same restrictions, terms and conditions relating to PHI that apply to the CCO in the contract. DOM has the option to review and approve all such written agreements between the CCOs and its agents and subcontractors prior to their effective date.

The CCOs must draft and disseminate to beneficiaries, providers and subcontractors a system and procedure with the prior written approval of DOM for the receipt and adjudication of complaints, grievances and appeals or requests for a State Fair Hearing by beneficiaries. The complaint, grievance and appeal policies and procedures shall be in accordance with 42 C.F.R. Part 438, Subpart F and DOM's Managed Care Quality Strategy.

The contractor shall review the complaint, grievance and appeal procedure at reasonable intervals, but no less than annually, for amending as needed, with the prior written approval of DOM in order to improve that system and procedure.

DOM has the right to intercede on a beneficiary's behalf at any time during the CCO's complaint, grievance and/or appeal process whenever there is an indication from the beneficiary, or where applicable, authorized person, that a serious quality of care issue is not being addressed timely or appropriately. Additionally, the beneficiary may be accompanied by a representative of the beneficiary's choice to any proceedings.

The CCOs shall provide beneficiaries as a part of the Member handbook, information on how they or their representatives can submit a complaint or file a grievance or an appeal, and the resolution process. The Member information shall also advise beneficiaries of their right to file a request for a State Fair Hearing with DOM, upon notification of a CCO ABN, subsequent to an appeal of the CCO.

Structure and Operations Standard (continued)

The CCO has the right to subcontract to provide services specified under the CCO contract subject to DOM's approval. The CCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with DOM. Any subcontract into which the CCO enters with respect to performance under the contract shall in no way relieve the CCO of the legal responsibility to carry out the terms of its contract. DOM considers the CCO to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from its contract. The CCO is solely responsible for the fulfillment of its contract terms with DOM and for the performance of any subcontractor under such subcontract approved by DOM.

Measurement and Improvement Standards

The CCOs develop clinical practice guidelines, and make them available to providers. Those clinical practice guidelines are consistent with national standards for disease and chronic illness management of beneficiaries. The clinical practice guidelines must be based on reasonable scientific evidence, reasonable medical evidence, reviewed annually by network providers who can recommend adoption of clinical practice guidelines to the CCO, and communicated to those whose performance is measured against them. Clinical guidelines are provided by the CCOs to physicians and other network providers as appropriate. The CCOs review the guidelines at least every two years and update them as appropriate.

On an annual basis, the CCOs measure provider performance against at least two of the clinical guidelines and provide DOM the results of the study and a summary of any corrective actions taken to ensure compliance with the guidelines.

The CCOs operate an internal quality management (QM) system and quality improvement (QI) program in compliance with 42 C.F.R. § 438.330 which:

- Provides for review by appropriate health professionals of the process followed in providing covered services to beneficiaries;
- Provides for systematic data collection of performance and beneficiary outcomes;
- Provides for interpretation and dissemination of performance and outcome data to network providers and out-of-network providers approved for referrals for primary and specialty;
- Provides for the prompt implementation of modifications to the CCO's policies, procedures and/or processes for the delivery of covered services as may be indicated by the foregoing;
- Provides for the maintenance of member encounter data to identify each practitioner providing services to beneficiaries, specifically including the unique physician identifier for each physician; and

Measurement and Improvement Standards (continued)

- Complies with Miss. Code Ann. § 83-41-313 et seq. (1972, as amended), of the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plan Protection Act and Miss. Code Ann. § 83-41-409 (1972, as amended) of the Patient Protection Act of 1995.

The CCOs have a written description of the QM program that focuses on health outcomes and includes the following:

1) A written program description including an Annual QM Program Work Plan; detailed objectives, accountabilities and time frames; definition of the scope of the QM program, and an Annual Program Evaluation.
2) A work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all QM activities, consistent with the clinical Performance Measures and targets put forth by DOM, including, but not limited to:
    a) Data collection and analysis;
    b) Evaluation and reporting of findings;
    c) Implementation of improvement actions where applicable; and
    d) Individual accountability for each activity.
3) Composition of the QM committee including a physical and behavioral health provider.
4) Procedures for remedial action when deficiencies are identified.
5) Specific types of problems requiring corrective action.
6) Provisions for monitoring and evaluating corrective action to ensure that actions for improvement have been effective.
7) Procedures for provider review and feedback on results.
8) Annual performance evaluation of the QM program as part of the Internal Audit that includes:
    a) Description of completed and ongoing QM activities including Care Management effectiveness evaluation;
    b) Identified issues, including tracking of issues over time;
    c) Trending of measures to assess performance in quality of clinical care and quality of service to beneficiaries; and
    d) An analysis of whether there have been demonstrated improvements in beneficiaries' health outcomes, the quality of clinical care and quality of service to beneficiaries; and overall effectiveness of the QM program (e.g., improved HEDIS scores).
9) The CCOs must have in effect mechanisms to assess the quality and appropriateness of care furnished to beneficiaries with special health-care needs. The assessment mechanism must use appropriate health-care professionals.

Measurement and Improvement Standards (continued)

10) The CCOs must address health-care disparities.

PIPs are required by CMS as an essential component of the CCO's quality program and are used to assess and improve processes, thereby improving outcomes of health care. DOM mandates that each CCO conduct a minimum of four clinical or non-clinical PIPs on topics prevalent and significant to the population served. PIPs must be pre-approved by DOM, meet all relevant CMS requirements and be designed to achieve significant improvement sustained over time in health outcomes and beneficiary satisfaction. Currently, DOM requires one mandated clinical topic - obesity - due to the critical importance of this area to the Mississippi Medicaid population. The chart noted below reflects PIPs identified by CCO for 2018.

Magnolia Health Plan		UnitedHealthcare	
MSCAN	**MSCHIP**	**MSCAN**	**MSCHIP**
Asthma	Asthma	Member Satisfaction	Adolescent Care
CHF	Obesity	ACE Inhibitors	Member Satisfaction
Diabetes	ADHD	Diabetes	Obesity
Obesity	EPSDT	Obesity	FUH*

**Follow-up after Hospitalization for Mental Illness (FUH)*

The CCOs must maintain a health information system that collects, analyzes, integrates and reports data. The system must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. The CCOs must collect data on beneficiary and provider characteristics (i.e., trimester of enrollment, tracking of appointments kept and not kept, place of service, provider type), and make all collected data available to DOM, to CMS, to the Mississippi Department of Insurance, and to any other oversight agency of DOM.

Section IV: Improvement and Interventions

Monitoring and Planning

DOM's Managed Care Quality Strategy for 2018 focuses on preventive health for all programs. Additionally there is a keen focus on maternal and child health. Described throughout this Managed Care Quality Strategy are requirements, standards and protocols built to ensure DOM, the CCOs, the EQRO and other key stakeholders remain engaged in ongoing, active quality improvement efforts. Ongoing monitoring provides DOM with quality-related data for future monitoring and planning.

Sanctions

In the event DOM finds the CCOs to be non-compliant with program standards, performance standards or the applicable statutes or rules governing Medicaid prepaid health plans, DOM issues a written notice of deficiency, requests a corrective action plan, and/or specifies the manner and time frame in which the deficiency is to be cured. If the CCOs fail to cure the deficiency as ordered to the satisfaction of DOM, DOM has the right to exercise administrative sanction options in addition to any other rights and remedies that may be available to DOM such as:

- Suspension of further enrollment after notification by DOM of a determination of a contract violation. Whenever DOM determines that the CCO is out of compliance with contractual obligations, DOM may suspend enrollment of new beneficiaries into the CCO. When exercising this option, DOM must notify the CCO in writing of its intent to suspend new enrollment at least seven business days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by DOM, or may be indefinite. DOM may also notify existing beneficiaries of the CCO's non-compliance and provide an opportunity to disenroll from the CCO and/or to re-enroll with another CCO.
- Suspension or recoupment of the capitation rate paid for:
  - Any month for any beneficiary denied the full extent of covered services meeting the standards set by the CCO or who received or is receiving substandard services after notification by DOM of a determination of a contract violation. Whenever DOM determines that the CCO has failed to provide to a beneficiary any medically necessary items and/or covered services required under contractual obligations, DOM may impose a fine of up to $25,000. The CCO is given at least 15 calendar days from the date of the written notice prior to the withholding of any capitation payment
  - Months in which reports are not submitted as required after notification by DOM of a determination of a violation. Whenever DOM determines that the CCO has failed to submit any data or reports required pursuant to contractual obligations accurately, in satisfactory form, and within the specified time frame, DOM has the right to withhold 1 percent of the next

Sanctions (continued)

monthly capitation payment and thereafter until the data or report is received by and to the satisfaction of DOM

- Beneficiaries enrolled after the effective date of any sanctions imposed and until CMS or DOM is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur

- Civil monetary penalties of up to $100,000 for acts of discrimination against individuals on the basis of their health status or need for health-care services, or providers, or misrepresentation or falsification of information furnished to CMS or DOM
- Civil monetary penalties of up to $25,000 for misrepresentation or falsification of information furnished to individuals or providers, or for failure to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. §§ 422.208 and 422.210, or DOM determines that the CCO has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by DOM or that contain false or materially misleading information
- Civil monetary penalties of up to $25,000, or double the amount of excess charges, whichever is greater, for premiums or charges in excess of the amounts permitted under the Medicaid program
- Temporary management upon a finding by DOM that the CCO has repeatedly failed to meet substantive requirements of contractual requirements, there is continued egregious behavior by the CCO, there is substantial risk to the health of beneficiaries, or it is necessary to ensure the health of the beneficiaries, in accordance with § 1932 of the Social Security Act
- Termination of the CCO contract
- In the case of inappropriate marketing activities, referral may also be made to the Department of Insurance for review and appropriate enforcement action
- Require special training or retraining of marketing representatives including, but not limited to, business ethics, marketing policies, effective sales practices, and DOM marketing policies and regulations, at the CCO's expense
- In the event the CCO becomes financially impaired to the point of threatening the ability of DOM to obtain the services provided for under contractual obligations, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or its assets, DOM may, at its option, immediately terminate the contract effective the close of business on the date specified
- Refuse to consider for future contracting a CCO that fails to submit member encounter data on a timely and accurate basis
- Refer any matter to the applicable federal agencies for civil money penalties
- Exclude the CCO from participation in the Medicaid program
- Refer any matter to the state or federal agencies responsible for investigating or addressing consumer affairs matters, where applicable
- Impose any other sanctions as provided by 42 C.F.R. § 438.700 et seq.

Sanctions (continued)

DOM must provide the CCO written notice 15 calendar days before sanctions as specified above are imposed, which must include the basis and nature of the sanction. The type of action taken shall be in relation to the nature and severity of the deficiency. The basis for imposition of sanctions includes, but is not limited to:

- DOM determines the contractor acts or fails to act as follows:
  - Fails substantially to provide medically necessary services that the CCO is required to provide, under law or under contract, to a beneficiary covered under the contract
  - Imposes on beneficiaries premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program
  - Acts to discriminate among beneficiaries on the basis of their health status or need for health-care services. This includes termination of enrollment or refusal to re-enroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services
  - Misrepresents or falsifies information that it furnishes to CMS or to DOM
  - Misrepresents or falsifies information that it furnishes to a beneficiary, potential beneficiary or health-care provider
  - Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. §§ 422.208 and 422.210
- DOM determines that the CCO has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by DOM or that contain false or materially misleading information
- DOM determines that the CCO has violated any of the requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations

DOM retains authority to impose additional sanctions under state statutes or state regulations that address areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance.

DOM gives CMS written notice whenever it imposes or lifts a sanction for one of the violations listed in 42 C.F.R. § 438.700 et seq. The notice is given no later than 30 days after DOM imposes or lifts the sanction, and specifies the type of sanction, and the reason DOM has decided to impose or lift the sanction.

Section IV: Improvement and Interventions

Health Information Technology

The CCOs must make all data collected in accordance with 42 C.F.R. § 438.242 available to DOM. The CCOs must provide to DOM all clinical data that is captured by providers and transmitted to the CCOs. Clinical data, includes but is not limited to diagnoses, procedures, medications, immunizations, allergies, smoking status, body mass index, vitals, visit notes, radiology orders, tests ordered and results received for general labs and pathology labs. Clinical data shall be provided to DOM using the clinical data exchange standards of Consolidated-Clinical Document Architecture (C-CDA) and/or Health Level-7 (HL7) 2.5. Transmission of clinical data must occur through either direct transmission to DOM's interoperability platform or through the statewide Health Information Exchange (HIE) known as Mississippi Health Information Network (MS-HIN).

Conclusion

The goals and objectives of DOM to ensure beneficiaries have access to health care and can achieve positive health outcomes can be realized through a quality improvement program. Through adequate capacity and services, coordination and continuity of care, appropriate and objective health risk assessments, timely authorization of services, and continual improvements utilizing best practices, DOM can support its beneficiaries and providers. Engagement and feedback are critical to the success of this Managed Care Quality Strategy, to DOM's quality efforts moving forward, and to Mississippi Medicaid's transformation efforts broadly.

DOM's quality strategy seeks to ensure continuous quality improvement in clinical quality matters. Additionally, reporting, analyzing data, monitoring adherence to contract requirement and to federal and state regulations, continual review of applicable standards and national/regional trends, as well as providing feedback to the CCOs mitigates fragmentation of services and improves care without reduction of services and promotes better utilization of precious resources. The Managed Care Quality Strategy is intended to focus on measuring service utilization and outcomes, reporting and effectively communicating findings, and improving coordination of care across settings, providers and specified domains.

Managed Care Quality Strategy

Appendices

Appendix A: Medicaid Enrollment Reports

2018 Medicaid Enrollment

Month Year	Children	Aged	Disabled & Blind	Adults	Other	TOTAL	CHIP	Total Medicaid & CHIP
	(includes all children except those who qualify based on disability)			Parents, caretakers, pregnant women, and adult refugees	Family planning waiver	For all populations	Children's Health Insurance Program	For Medicaid & CHIP
Jan-18	366,136	70,442	174,026	65,166	24,250	700,020	47,117	747,137
Feb-18	363,461	70,288	173,985	64,759	24,192	696,685	47,162	743,847
Mar-18	360,239	71,281	172,925	64,242	23,376	692,063	47,019	739,082
Apr-18	358,571	72,337	172,018	63,963	23,291	690,180	46,958	737,138
May-18	356,607	71,282	173,089	64,066	22,862	687,906	46,585	734,491
Jun-18	353,148	71,266	173,045	63,530	22,588	683,577	46,152	729,729
Jul-18								
Aug-18								
Sep-18								
Oct-18								
Nov-18								
Dec-18								

2018 MississippiCAN Enrollment

Month Year	Magnolia Health	Unitedhealthcare Community Plan	Total MississippiCAN
Jan-18	246,038	224,557	470,595
Feb-18	243,323	221,694	465,017
Mar-18	240,056	217,847	457,903
Apr-18	238,443	216,052	454,495
May-18	237,516	214,415	451,931
Jun-18	234,992	212,271	447,263
Jul-18	232,443	209,339	441,782
Aug-18			0
Sep-18			0
Oct-18			0
Nov-18			0
Dec-18			0

State of Mississippi

1.4 **State of Mississippi Medical Care Advisory Committee**

There is an advisory committee to the Mississippi Division of Medicaid on health and medical care services established in accordance with and meeting all the requirements of 42 C.F.R § 431.12.

Tribal Consultation Requirements

The Mississippi Division of Medicaid complies with Section 1902(a)(73) and Section 2107(e)(I) of the Social Security Act by seeking advice on a regular, ongoing basis from a designee of the Indian health programs concerning Medicaid and Children's Health Insurance Program (CHIP) matters having a direct impact on Indian health programs and urban Indian organizations. Mississippi has only one federally recognized Tribe and that is the Mississippi Band of Choctaw Indians (MBCI).

The Mississippi Division of Medicaid consults with the MBCI by notifying the MBCI's designee in writing with a description of the proposed change and direct impact, at least thirty (30) days prior to each submission by the State of any Medicaid State Plan Amendment (SPA), and at least sixty (60) days prior to each submission of any waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects likely to have a direct impact on Indian health programs, Tribal organizations, or urban Indian organizations (I/T/U) by email. Direct impact is defined as any Medicaid or CHIP program changes that are more restrictive for eligibility determinations, changes that reduce payment rates or payment methodologies to I/T/U providers, reductions in covered services, changes in consultation policies, and proposals for demonstrations or waivers that may impact I/T/U providers. If no response is received from the MBCI within the notification time-frames listed above, the Division of Medicaid will proceed with the submission to the Centers for Medicare and Medicaid Services (CMS).

MBCI designees are the Choctaw Health Center's Deputy Health Director and Director of Financial Services.

If the Mississippi Division of Medicaid is not able to consult with the Tribe within the notification time-frames prior to a submission the Division of Medicaid must e-mail a copy of the proposed submission along with the reason for the urgency to the MBCI designee. The Tribe may waive this notification time-frame requirement in writing via e-mail. If requested, a conference call with the MBCI designee and/or other Tribal representatives will be held to review the submission and its impact on the Tribe. In the event of a conference call, the Division of Medicaid will then confirm the discussion via email and request a response from the designee to ensure agreement on the submission. This documentation will be provided as part of the submission information to CMS.

If the tribe does not respond to the request or responds that they do not agree to the expedited process, the Division of Medicaid will follow the normal consultation timeframes articulated in the preceding paragraph.

Appendix C: Quality Strategy Activity

Date	Quality Strategy Activity
June 22, 2018	Tribal Consultation Notice
June 22, 2018	Post Draft Quality Strategy for Public Comment
July 23, 2018	Submit Final Draft Quality Strategy to CMS
Upon CMS Approval	Post Approved Quality Strategy (Post CMS Approval)
July 1, 2019	Review Quality Strategy
July 1, 2020	Review Quality Strategy
April 1, 2021	Evaluation of Quality Strategy Effectiveness
July 1, 2021	Review and Update Quality Strategy

MississippiCAN Reporting Manual

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
1.	1	Monthly	1-A-1	Unduplicated Number of Newly Enrolled Members in Care Management Program	8-A	Care Management Responsibilities
2.	1	Monthly	1-A-2	Unduplicated Number of Disenrolled Care Management Members	8-A	Care Management Responsibilities
3.	1	Monthly	1-A-3	Unduplicated Number of Members Contacted for Purposes of Care Management	8-A	Care Management Responsibilities
4.	1	Monthly	1-A-4	Number of Successful Care Management Contacts	8-A	Care Management Responsibilities
5.	1	Monthly	1-A-5	Health Risk Assessment (HRA)	8-A-1	Assignment of Risk Levels
6.	1	Monthly	1-A-6	Adult Physical Exams	8-A	Care Management Responsibilities
7.	1	Monthly	1-B-1	Unduplicated Number of Newly Enrolled Members in Medical Care Management Program	8-A	Care Management Responsibilities
8.	1	Monthly	1-B-2	Unduplicated Number of Disenrolled Medical Care Management Members	8-A	Care Management Responsibilities
9.	1	Monthly	1-B-3	Unduplicated Number of Members Enrolled in the Medical Care Management Program and Contacted for Purposes of Care Management	8-A	Care Management Responsibilities
10.	1	Monthly	1-B-4	Number of Successful Care Management Contacts to Members Enrolled in the Medical Care Management Program	8-A	Care Management Responsibilities
11.	1	Quarterly	1-B-5	Identification and Monitoring of Over- and Under-Utilization of Services for Members Enrolled in the Medical Care Management Program	8-A	Care Management Responsibilities

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
12.	1	Monthly	1-B-6	Care Management Staffing Ratios for Members Enrolled in the Medical Care Management Program	8-A	Care Management Responsibilities
13.	1	Monthly	1-B-7	Medical Home Linkage for Members Enrolled in the Medical Care Management Program	4-B; 8-A	Choice of a Network Provider; Care Management Responsibilities
14.	1	Monthly	1-C-1	Unduplicated Number of Newly Enrolled Members in Behavioral Health Care Management Program	8-A	Care Management Responsibilities
15.	1	Monthly	1-C-2	Unduplicated Number of Disenrolled Behavioral Health Care Management Members	8-A	Care Management Responsibilities
16.	1	Monthly	1-C-3	Unduplicated Number of Members Enrolled in the Behavioral Health Care Management Program and Contacted for the Purposes of Care Management	8-A	Care Management Responsibilities
17.	1	Monthly	1-C-4	Number of Successful Care Management Contacts to Members Enrolled in the Behavioral Health Care Management Program	8-A	Care Management Responsibilities
18.	1	Quarterly	1-C-5	Identification and Monitoring of Over- and Under-Utilization of Services for Members Enrolled in the Behavioral Health Care Management Program	8-A	Care Management Responsibilities
19.	1	Monthly	1-C-6	Care Management Staffing Ratios for Members Enrolled in the Behavioral Health Care Management Program	8-A	Care Management Responsibilities
20.	1	Monthly	1-C-7	Medical Home Linkage for Members Enrolled in the Behavioral Health Care Management Program	4-B; 8-A	Choice of a Network Provider; Care Management Responsibilities

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
21.	1	Monthly	1-D-1	Unduplicated Number of Newly Enrolled Members in Maternal Health Care Management Program	8-A	Care Management Responsibilities
22.	1	Monthly	1-D-10	Very Low Birth Weight Babies	9-E; Exhibit F	Performance Measures; Performance Measures
23.	1	Monthly	1-D-2	Unduplicated Number of Disenrolled Maternal Health Care Management Members	8-A	Care Management Responsibilities
24.	1	Monthly	1-D-3	Unduplicated Number of Members Enrolled in the Maternal Health Care Management Program and Contacted for Purposes of Care Management	8-A	Care Management Responsibilities
25.	1	Monthly	1-D-4	Number of Successful Care Management Contacts to Members Enrolled in the Maternal Care Management Program	8-A	Care Management Responsibilities
26.	1	Quarterly	1-D-5	Identification and Monitoring of Over- and Under-Utilization of Services for Members Enrolled in the Maternal Health Care Management Program	8-A	Care Management Responsibilities
27.	1	Monthly	1-D-6	Care Management Staffing Ratios for Members Enrolled in the Maternal Health Care Management Program	8-A	Care Management Responsibilities
28.	1	Monthly	1-D-7	Medical Home Linkage for Members Enrolled in the Maternal Health Care Management Program	4-B; 8-A	Choice of a Network Provider; Care Management Responsibilities
29.	1	Monthly	1-D-8	Number of Pre-Term Deliveries for Members Enrolled in the Maternal Health Care Management	8-A	Care Management Responsibilities

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
				Program		
30.	1	Monthly	1-D-9	Type of Delivery for High-Risk Pregnant Members Enrolled in the Maternal Health Care Management Program	8-A	Care Management Responsibilities
31.	1	Monthly	1-E-1	Unduplicated Number of Newly Enrolled Members in the Care Management Program for Foster Care Members	8-A	Care Management Responsibilities
32.	1	Quarterly	1-E-10	Utilization of Medications Categorized by Antidepressant, Antipsychotic, Attention Deficit Hyperactivity Disorder (ADHD), and Psychotropic	8-A	Care Management Responsibilities
33.	1	Monthly	1-E-2	Unduplicated Number of Disenrolled Foster Care Members in Care Management	8-A	Care Management Responsibilities
34.	1	Monthly	1-E-3	Unduplicated Number of Foster Care Members Enrolled in the Care Management Program and Contacted for Purposes of Care Management	8-A	Care Management Responsibilities
35.	1	Monthly	1-E-4	Number of Successful Care Management Contacts to Foster Care Members Enrolled in the Care Management Program	8-A	Care Management Responsibilities
36.	1	Quarterly	1-E-5	Identification and Monitoring of Over- and Under-Utilization of Services for Foster Care Members Enrolled in the Care Management Program	8-A	Care Management Responsibilities

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
37.	1	Monthly	1-E-6	Care Management Staffing Ratios for Foster Care Members Enrolled in Care Management Program	8-A	Care Management Responsibilities
38.	1	Monthly	1-E-7	Medical Home Linkage for Foster Care Members Enrolled in the Care Management Program	4-B; 8-A	Choice of a Network Provider; Care Management Responsibilities
39.	1	Quarterly	1-E-8	Screenings and Assessments Completed within Timeframe Identified in Settlement Agreement	8-A	Care Management Responsibilities
40.	1	Quarterly	1-E-9	Utilization of Ongoing Assessments and Examinations	8-A	Care Management Responsibilities
41.	2	Monthly	2-A-1	Member Enrollment Statistics and Trends	4-K	Member Listing Report
42.	2	Monthly	2-A-2	Description of Any Member Enrollment Trends	4-K	Member Listing Report
43.	2	Monthly	2-B-1	Medical Utilization Statistics and Trends (excludes behavioral health)	9-N	Utilization Review
44.	2	Monthly	2-B-10	Rebated Drug Volume	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
45.	2	Monthly	2-B-11	Top 50 Members	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
46.	2	Monthly	2-B-12	Advanced Imaging Services Utilized	5-F; 9-N	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review
47.	2	Monthly	2-B-1-2	Behavioral Health Utilization Statistics and Trends – Injectable Anti-Psychotics	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
48.	2	Monthly	2-B-1-3	Description of Behavioral Health Utilization Trends	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
49.	2	Monthly	2-B-2	Description of Any Utilization Trends (excludes behavioral health)	9-N	Utilization Review
50.	2	Monthly	2-B-3	Pharmaceutical Statistics	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
51.	2	Monthly	2-B-4	Top 100 Drugs by Utilization	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
52.	2	Monthly	2-B-5	Top 100 Drugs by Amount Paid	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
53.	2	Monthly	2-B-6	Validation Preferred Drug List Use	5-F	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices
54.	2	Monthly	2-B-7	Pharmacy Prior Authorization Report	5-J	Prior Authorizations
55.	2	Monthly	2-B-8	Physician Administered Drugs and Implantable Drug System Devices	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
56.	2	Monthly	2-B-9	Exception Report Clinical Trials and/or Investigative or Experimental Drugs	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
57.	2	Monthly	2-C-1	Claims Processing Statistics	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
58.	2	Monthly	2-C-1-1	Behavioral Health Claims	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
						Retrieval Systems
59.	2	AdHoc	2-C-1-1-AH	Pended/Suspended Behavioral Health Claims	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
60.	2	Monthly	2-C-1-2	Behavioral Health Claims Denial Reason	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
61.	2	AdHoc	2-C-1-AH	Pended/Suspended Claims (excludes behavioral health)	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
62.	2	Monthly	2-C-2	Physician Administered Drugs (PAD), Number Administered (includes behavioral health)	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
63.	2	Monthly	2-C-2-AH	Physician Administered Drug Claims, Denied Claims – Other	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
64.	2	Monthly	2-C-3	Medical Claims Denial Reason (excludes behavioral health)	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
65.	2	Monthly	2-C-4	Claims Processing Statistics – Pharmacy	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
66.	2	Monthly	2-C-5	Pharmacy Claims Denial Reason	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
67.	2	Monthly	2-D-1	Call Center Statistics – All CCO Calls (excludes behavioral health)	6-A; 7-H-1	Member Services Call Center; Provider Services Call Center
68.	2	Monthly	2-D-1-1	Call Center Statistics – All CCO Calls (Behavioral Health Only)	6-A	Member Services Call Center
69.	2	Monthly	2-D-1-2	Call Center Statistics – Member Hotline Calls (Behavioral Health Only)	6-A; 15-E	Member Services Call Center; Liquidated Damages
70.	2	Monthly	2-D-1-3	Member Hotline – Types of Calls (Behavioral Health Only)	6-A	Member Services Call Center
71.	2	Monthly	2-D-1-4	Call Center Statistics – Provider Hotline Calls (Behavioral Health Only)	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
72.	2	Monthly	2-D-1-5	Provider Hotline –Types of Calls (Behavioral Health Only)	7-H-1	Provider Services Call Center
73.	2	Monthly	2-D-1-6	Call Center Statistics – Behavioral Health Clinical Line Calls	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
74.	2	Monthly	2-D-1-7	Member Nurse Line – Types of Behavioral Health Clinical Line Calls (behavioral health only)	6-A	Member Services Call Center
75.	2	Monthly	2-D-2	Call Center Statistics – Member Hotline Calls (excludes behavioral health)	6-A; 15-E	Member Services Call Center; Liquidated Damages

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
76.	2	Monthly	2-D-3	Member Hotline – Types of Calls (excludes behavioral health)	6-A	Member Services Call Center
77.	2	Monthly	2-D-4	Call Center Statistics – Provider Hotline Calls (excludes behavioral health)	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
78.	2	Monthly	2-D-5	D-5. Provider Hotline – Types of Calls (excludes behavioral health)	7-H-1	Provider Services Call Center
79.	2	Monthly	2-D-6	Call Center Statistics – Member Nurse Line Calls (excludes behavioral health)	6-A; 15-E	Member Services Call Center; Liquidated Damages
80.	2	Monthly	2-D-7	Member Nurse Line – Types of Nurse Line Calls (includes behavioral health)	6-A	Member Services Call Center
81.	2	Monthly	2-E-1	Medical Provider Network (excludes behavioral health)	Section 7	Provider Network
82.	2	Monthly	2-E-1-AH	Terminated Provider Report	7-D	Provider Terminations
83.	2	Monthly	2-E-1-AH	Terminated Provider Report	7-D	Provider Terminations
84.	2	Monthly	2-E-2	Behavioral Health Provider Network	Section 7	Provider Network
85.	2	AdHoc	2-E-2-AH	Terminated Provider Report	7-D	Provider Terminations
86.	2	Annually	2-E-3	Provider Directory Delivery Report	6.E	Member Services
87.	2	Monthly	2-F-1	Overall Prior Authorization Requests Received (includes behavioral health)	5-J	Prior Authorizations
88.	2	AdHoc	2-F-1-AH	Prior Authorization Ad-Hoc Report	5-J	Prior Authorizations
89.	2	Monthly	2-F-2	Prior Authorization Turn Around Time Report	5-J	Prior Authorizations
90.	2	AdHoc	2-F-2-AH	Prior Authorization Turn Around Time Ad-Hoc Report	5-J	Prior Authorizations
91.	2	Monthly	2-F-3	Pharmacy Prior Authorizations	5-J	Prior Authorizations

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
92.	2	Monthly	2-F-3-AH	Pharmacy Prior Authorization Ad-Hoc	5-J	Prior Authorizations
93.	2	Monthly	2-F-4	Authorized Delivery Report	9-O	Reporting Maternity Admissions for Delivery
94.	2	Quarterly	2-F-4	Authorized Delivery Report	9-O	Reporting Maternity Admissions for Delivery
95.	2	Monthly	2-F-5	Resubmission of Authorized Maternity Delivery Report	9.O	Quality Management
96.	2	Monthly	2-G-1	Encounter Data Acceptance Rate	10-R	Member Encounter Data
97.	2	Monthly	2-G-2	Description of Encounter Data Acceptance Rate Trends	10-R	Member Encounter Data
98.	2	Monthly	2-H-1	Medical Member Complaints Summary (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
99.	2	Monthly	2-H-10	Behavioral Health Member Grievance Detail	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
100.	2	Monthly	2-H-11	Behavioral Health Member Appeals Summary	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
101.	2	Monthly	2-H-12	Behavioral Health Member Appeals Detail	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
102.	2	Monthly	2-H-2	Medical Member Complaints Detail (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
103.	2	Monthly	2-H-3	Medical Member Grievances Summary (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
104.	2	Monthly	2-H-4	Medical Member Grievances Detail (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
105.	2	Monthly	2-H-5	Medical Member Appeals Summary (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
106.	2	Monthly	2-H-6	Medical Member Appeals Detail (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
107.	2	Monthly	2-H-7	Behavioral Health Member Complaint Summary	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
108.	2	Monthly	2-H-8	Behavioral Health Member Complaint Detail	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
109.	2	Monthly	2-H-9	Behavioral Health Member Grievance Summary	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
110.	2	Monthly	2-I-1	Provider Complaint Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
111.	2	Monthly	2-I-2	Provider Complaint Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
112.	2	Monthly	2-I-3	Provider Grievances Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
113.	2	Monthly	2-I-7	Behavioral Health Provider Complaints Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
						Hearing Process
114.	2	Monthly	2-I-8	Behavioral Health Provider Complaints Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
115.	2	Monthly	2-I-9	Behavioral Health Provider Grievances Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
116.	2	Monthly	2-I-11	Behavioral Health Provider Appeals Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
117.	2	Monthly	2-I-10	Behavioral Health Provider Grievances Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
118.	2	Monthly	2-I-12	Behavioral Health Provider Appeals Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
119.	2	Monthly	2-I-5	Provider Appeals Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
120.	2	Monthly	2-I-4	Provider Grievances Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
121.	2	Monthly	2-I-6	Provider Appeals Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
122.	2	Monthly	2-J-1	Provider State Issues/MIG Summary	1-J	Responsiveness to Division Requests
123.	2	Monthly	2-J-2	Provider State Issues/MIG Detail	1-J	Responsiveness to Division Requests
124.	2	Monthly	2-J-3	Member State Issues/MIG Summary	1-J	Responsiveness to Division Requests
125.	2	Monthly	2-J-4	Member State Issues/MIG Detail	1-J	Responsiveness to Division Requests
126.	3	Annually	3-A-1	Appointment Availability – PCPs	7-B	Provider Network Requirements
127.	3	Quarterly	3-A-1	Appointment Availability – PCPs	7-B	Provider Network Requirements
128.	3	Annually	3-A-2	Appointment Availability – Behavioral Health Providers	7-B	Provider Network Requirements
129.	3	Quarterly	3-A-2	Appointment Availability – Behavioral Health Providers	7-B	Provider Network Requirements
130.	3	Annually	3-A-3	Appointment Availability – OB/GYN Providers	7-B	Provider Network Requirements
131.	3	Quarterly	3-A-3	Appointment Availability – OB/GYN Providers	7-B	Provider Network Requirements
132.	3	Quarterly	3-A-4	Contracted Hospitals	7-B	Provider Network Requirements
133.	3	Quarterly	3-A-5	GeoAccess Reporting Requirements	7-B	Provider Network Requirements
134.	3	Quarterly	3-A-6	Insure Kids Now Provider Data	7-B	Provider Network Requirements
135.	3	Quarterly	3-B-1	Provider Call Center Audit	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
136.	3	AdHoc	3-B-1-AH	Provider Call Center Issues	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
137.	3	Quarterly	3-B-2	CCO Member Call Center Audit	6-A; 15-E	Member Services Call Center; Liquidated Damages
138.	3	AdHoc	3-B-2-AH	CCO Member Call Center Issues	6-A; 15-E	Member Services Call Center; Liquidated Damages
139.	3	Quarterly	3-B-3	CCO Provider Services Call Center Training Report	7-H-1	Provider Services Call Center

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
140.	3	Quarterly	3-B-4	CCO Member Services Call Center Training Report	6-A-4	Staff Training
141.	3	Quarterly	3-B-5	CCO Nurse Line Call Center Training Report	6-A-4	Staff Training
142.	3	Annually	3-C-1-A	Marketing Work Plan-Annual	6-I	Marketing
143.	3	Quarterly	3-C-1-Q	Marketing Work Plan Updates-Quarterly	6-I	Marketing
144.	3	Quarterly	3-C-2	Marketing Activities Log	6-I	Marketing
145.	3	Quarterly	3-C-3	Marketing Complaints Tracking Log	6-I	Marketing
146.	3	Monthly	3-D-1	New Member Card Report	6-I	Marketing
147.	3	Monthly	3-D-2	Returned Card Report	6-C	Member Identification Card
148.	3	Quarterly	3-E-1	Provider Credentialing	7-E	Provider Credentialing and Qualifications
149.	3	Quarterly	3-E-2	List of Providers Credentialed Over 90 Days	7-E	Provider Credentialing and Qualifications
150.	3	Annually	3-F-1	Health Education and Prevention Work Plan-Annual	6-B	Member Education
151.	3	Quarterly	3-F-2	Health Education and Prevention Work Plan Updates-Quarterly	6-B	Member Education
152.	3	Quarterly	3-F-2	Health Education and Prevention Work Plan Updates	6-B	Member Education
153.	3	Annually	3-G-1	EPSDT Report	5-D; 7-C; 9-R	EPSDT Services; PCP Responsibilities; EPSDT Audit
154.	3	Quarterly	3-G-1	EPSDT Report	5-D; 7-C; 9-R	EPSDT Services; PCP Responsibilities; EPSDT Audit
155.	3	Quarterly	3-G-2	PHRMS/ISS Report	8-A-3	Perinatal High Risk Management/Infant Services System
156.	3	Monthly	3-H-1	Pharmacy Lock-In Program Report	10-F	Pharmacy Lock-In Program
157.	4	Semi-Annually	4-A-1	Provider Incentive Plan	7-K	Physician Incentive

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
						Plans
158.	4	AdHoc	4-A-2	Patient-Centered Medical Home	7-B-5	Patient-Centered Medical Homes
159.	4	Annually	4-B-1	HEDIS® Compliance Audit	9-E; Exhibit F	Performance Measures; Performance Measures
160.	4	Annually	4-B-2	CAHPS® Survey Report	9-F; Exhibit F	CAHPS® Member Satisfaction Survey; Performance Measures
161.	4	Annually	4-B-3	Performance Measure Results	9-E; Exhibit F	Performance Measures; Performance Measures
162.	4	Quarterly	4-B-3	Performance Measure Updates	9-E; Exhibit F	Performance Measures; Performance Measures
163.	4	Annually	4-C-1	Quality Management Program Description (Medical)	9-K; Exhibit G	Quality Management Committee; Quality Management
164.	4	Annually	4-C-1-1	Quality Management Program Description (Behavioral Health)	9-K; Exhibit G	Quality Management Committee; Quality Management
165.	4	Annually	4-C-1-2	Quality Management Work Plan (Behavioral Health)	9-K; Exhibit G	Quality Management Committee; Quality Management
166.	4	Quarterly	4-C-1-2	Quality Management Work Plan Updates (Behavioral Health)	9-K; Exhibit G	Quality Management Committee; Quality Management
167.	4	Quarterly	4-C-1-2	Quality Management Work Plan Updates (Behavioral Health)	9-K; Exhibit G	Quality Management Committee; Quality Management
168.	4	Annually	4-C-1-3	Quality Management Program Evaluation (Behavioral)	9-K; Exhibit G	Quality Management Committee; Quality

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
						Management
169.	4	Annually	4-C-2	Quality Management Work Plan (Medical)	9-K; Exhibit G	Quality Management Committee; Quality Management
170.	4	Quarterly	4-C-2	Quality Management Work Plan Updates (Medical)	9-K; Exhibit G	Quality Management Committee; Quality Management
171.	4	Annually	4-C-3	Quality Management Program Evaluation (Medical)	9-K; Exhibit G	Quality Management Committee; Quality Management
172.	4	Quarterly	4-C-4	Performance Improvement Project Updates	9-I	Performance Improvement Projects
173.	4	Annually	4-C-5	Performance Improvement Project Results	9-I	Performance Improvement Projects
174.	4	Annually	4-D-1	Utilization Management Program Description	9-N	Utilization Review
175.	4	Annually	4-E-1	Provider Satisfaction Survey Questions and Methodology	9-G	Provider Satisfaction Survey
176.	4	Annually	4-E-2	Provider Satisfaction Survey Results	9-G	Provider Satisfaction Survey
177.	4	Monthly	4-E-3	Provider Services Representative Visit Log	7-H; 7-I	Provider Services; Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
178.	5	Monthly	5-A-1	Cash Disbursement Journal	10-R-6	Accuracy of Data
179.	5	Annually	5-A-2	Encounter Data Completeness Plan	10-R-5	Data Completeness
180.	5	Quarterly	5-A-3	Provider Preventable Conditions	7-J-2	Payments for Provider-Preventable Conditions
181.	5	Quarterly	5-B-1	New Provider Investigations/Complaints	10-U; Section 11	Fraud and Abuse Reporting; Program

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
						Integrity
182.	5	Weekly	5-B-1	New Provider Investigations/Complaints	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
183.	5	Quarterly	5-B-10	Internal Contractor Reporting	10-V	Internal Contractor Reporting
184.	5	Monthly	5-B-11	Third Party Casualty	11-L; 11-M; Section 13	Third Party Liability Audit; Third Party Liability Reporting; Third Party Liability
185.	5	Monthly	5-B-12	Third Party Leads	11-L; 11-M; Section 13	Third Party Liability Audit; Third Party Liability Reporting; Third Party Liability
186.	5	Monthly	5-B-13	Cost Avoidance & TPL Recoveries	11-L; 11-M; Section 13	Third Party Liability Audit; Third Party Liability Reporting; Third Party Liability
187.	5	Quarterly	5-B-2	New Member Investigations/Complaints	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
188.	5	Weekly	5-B-2	New Member Investigations/Complaints	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
189.	5	Annually	5-B-3	Annual Provider Report of New Investigations/Complaints	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
190.	5	Annually	5-B-4	Annual Member Report of New Investigations/Complaints	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
191.	5	Semi-Annually	5-B-5	Semi-Annual Provider New Investigations/Complaints Activity Report	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
192.	5	Semi-Annually	5-B-6	Semi-Annual Member New Investigations/Complaints Activity Report	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
193.	5	Quarterly	5-B-7	Credible Allegation of Fraud Referrals	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
194.	5	Annually	5-B-8	Fraud and Abuse Compliance Plan	11-B	Fraud and Abuse Compliance Plan

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
195.	5	Quarterly	5-B-9	Prepayment Review	5-J; 10-U	Prior Authorizations; Fraud and Abuse Reporting
196.	5	Weekly	5-B-9	Prepayment Review	5-J; 10-U	Prior Authorizations; Fraud and Abuse Reporting
197.	5	Annually	5-C-1	Medical Loss Ratio Rebate Calculation - MSCAN	Exhibit C	Medical Loss Ratio (MLR) Requirements
198.	5	Quarterly	5-C-1	Medical Loss Ratio Rebate Calculation - MSCAN	Exhibit C	Medical Loss Ratio (MLR) Requirements
199.	5	Annually	5-D-1	Disenrollment Survey	9-J	Disenrollment Survey
200.	5	Quarterly	5-D-2	Disenrollment Survey Results	9-J	Disenrollment Survey
201.	5	Annually	5-E-1	Department of Insurance (DOI) Filings	10-I	Financial Reports
202.	5	Quarterly	5-E-1	Department of Insurance (DOI) Filings	10-I	Financial Reports
203.	5	Annually	5-E-2	Contractor Licensures	1-F	Contractor Representations
204.	5	Annually	5-E-3	Small and Minority Business Reporting	10-Y	Small and Minority Business Reporting
205.	5	Monthly	5-E-4	Fee Schedule Validation	12-A	Capitation Payments
206.	5	Monthly	5-E-5	Systems Updates of PDL Indicators	5-F; 12-A	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Capitation Payments
207.	5	Quarterly	5-E-6	Provider Licensure Information	7-E	Provider Credentialing and Qualifications
208.	5	Quarterly	5-E-7	NCCI Savings Report	Section 11	Program Integrity
209.	5	Monthly	5-F-1	MHAP Distribution Report	12-B	Mississippi Hospital Access Program

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
210.	5	Annually	5-F-2	Annual MHAP Distributions Report	12-B	Mississippi Hospital Access Program
211.	5	AdHoc	5-G-1	Inpatient Provider Statistical and Summary Report	10-K	Provider Statistical and Summary Report
212.	5	Annually	5-G-1	Inpatient Provider Statistical and Summary Report	10-K	Provider Statistical and Summary Report
213.	5	AdHoc	5-G-2	Outpatient Provider Statistical and Summary Report	10-K	Provider Statistical and Summary Report
214.	5	Annually	5-G-2	Outpatient Provider Statistical and Summary Report	10-K	Provider Statistical and Summary Report
215.	5	Monthly	5-H-1	Claims Denial Report	10-J; 10-Q; 17-A; 17-B	Claims Denial Report; Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
216.	6	Monthly	6-A-1	NET Operations Summary	Exhibit E	Non-Emergency Transportation (NET) Requirements
217.	6	Monthly	6-A-10	From Trips Drop Off Timeliness	Exhibit E	Non-Emergency Transportation (NET) Requirements
218.	6	Monthly	6-A-11	Daily Vendor Late/No-Shows	Exhibit E	Non-Emergency Transportation (NET) Requirements
219.	6	Monthly	6-A-12	Appointment Timeliness Detail	Exhibit E	Non-Emergency Transportation (NET) Requirements
220.	6	Monthly	6-A-13	Monthly Vendor Timeliness Detail	Exhibit E	Non-Emergency Transportation (NET) Requirements
221.	6	Monthly	6-A-14	Trip Processing Time Report	Exhibit E	Non-Emergency Transportation (NET) Requirements
222.	6	Monthly	6-A-15	Trip Processing Time Report Summary	Exhibit E	Non-Emergency Transportation (NET) Requirements

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
223.	6	Monthly	6-A-2	Denials	Exhibit E	Non-Emergency Transportation (NET) Requirements
224.	6	Monthly	6-A-3	Top Five Denial Reasons	Exhibit E	Non-Emergency Transportation (NET) Requirements
225.	6	Monthly	6-A-4	NET Call Center Statistics	Exhibit E	Non-Emergency Transportation (NET) Requirements
226.	6	Monthly	6-A-5	Subcontractor Oversight Report	Exhibit E	Non-Emergency Transportation (NET) Requirements
227.	6	Monthly	6-A-6	Overall Vendor Timeliness	Exhibit E	Non-Emergency Transportation (NET) Requirements
228.	6	Monthly	6-A-7	Hospital Discharge Timeliness	Exhibit E	Non-Emergency Transportation (NET) Requirements
229.	6	Monthly	6-A-8	Will Call Timeliness	Exhibit E	Non-Emergency Transportation (NET) Requirements
230.	6	Monthly	6-A-9	To Trips Pickup Timeliness	Exhibit E	Non-Emergency Transportation (NET) Requirements
231.	6	Quarterly	6-B-1	Pre/Post Fixed/Non Fixed Verification Report	Exhibit E	Non-Emergency Transportation (NET) Requirements
232.	6	Quarterly	6-C-1	NET Vehicle Inspections and Validation Check Report	Exhibit E	Non-Emergency Transportation (NET) Requirements
233.	6	Quarterly	6-C-2	NET Driver Report	Exhibit E	Non-Emergency Transportation (NET) Requirements
234.	7	Monthly	7-A-1	Summary of Allowed Amount by Medicaid Category	10-R	Member Encounter Data
235.	7	Monthly	7-A-10	Allowed Amount by Provider by Mental Health DRGs, Pediatric	10-R	Member Encounter Data
236.	7	Monthly	7-A-10-A	Allowed Amount by Provider by Mental Health DRGs, Adult	10-R	Member Encounter Data

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
237.	7	Monthly	7-A-2	Summary of Allowed Amount by APR-DRG, Top 50 DRGs by Stays	10-R	Member Encounter Data
238.	7	Monthly	7-A-3	Summary of Allowed Amount by APR-DRG, Top 50 DRGs by Allowed Amount	10-R	Member Encounter Data
239.	7	Monthly	7-A-4	Summary of Allowed Amount by Peer Group- Top 8 Providers	10-R	Member Encounter Data
240.	7	Monthly	7-A-4-A	Summary of Allowed Amount by All Hospitals sorted by Peer Group	10-R	Member Encounter Data
241.	7	Monthly	7-A-5	Highest Paying Claims- Top 100 Claims by Allowed Amount	10-R	Member Encounter Data
242.	7	Monthly	7-A-6	DRG Cost Outlier Allowed Amount- Top 25	10-R	Member Encounter Data
243.	7	Monthly	7-A-7	Allowed Amount by Patient Discharge Status	10-R	Member Encounter Data
244.	7	Monthly	7-A-8	Long Stays, Top 50 by Length of Stay	10-R	Member Encounter Data
245.	7	Monthly	7-A-9	Short Stays, Days < National ALOS * 10%	10-R	Member Encounter Data
246.	2	Monthly	2-J-4	Member State Issues/MIG Detail	1-J	Responsiveness to Division Requests
247.	2	Monthly	2-K-1	Provider Network - X08 Providers		
248.	2	Quarterly	2-K-2	0359T Behavior Identification Assessments		
249.	2	Monthly	2-K-3	ASD Claims		
250.	2	Monthly	2-K-4	Care Management		
251.	2	Monthly	2-K-5	Beneficiary Appeals		
252.	2	Monthly	2-K-6	Provider Appeals		

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	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
1.	1	Monthly	1-A-1	Unduplicated Number of Newly Enrolled Members in Care Management Program	8-A	Care Management Responsibilities
2.	1	Monthly	1-A-2	Unduplicated Number of Disenrolled Care Management Members	8-A	Care Management Responsibilities
3.	1	Monthly	1-A-3	Unduplicated Number of Members Contacted for Purposes of Care Management	8-A	Care Management Responsibilities
4.	1	Monthly	1-A-4	Number of Successful Care Management Contacts	8-A	Care Management Responsibilities
5.	1	Monthly	1-A-5	Health Risk Assessment (HRA)	8-A-1	Assignment of Risk Levels
6.	1	Monthly	1-A-6	Adult Physical Exams	8-A	Care Management Responsibilities
7.	1	Monthly	1-B-1	Unduplicated Number of Newly Enrolled Members in Medical Care Management Program	8-A	Care Management Responsibilities
8.	1	Monthly	1-B-2	Unduplicated Number of Disenrolled Medical Care Management Members	8-A	Care Management Responsibilities
9.	1	Monthly	1-B-3	Unduplicated Number of Members Enrolled in the Medical Care Management Program and Contacted for Purposes of Care Management	8-A	Care Management Responsibilities
10.	1	Monthly	1-B-4	Number of Successful Care Management Contacts to Members Enrolled in the Medical Care Management Program	8-A	Care Management Responsibilities
11.	1	Quarterly	1-B-5	Identification and Monitoring of Over- and Under-Utilization of Services for Members Enrolled in the Medical Care Management Program	8-A	Care Management Responsibilities

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
12.	1	Monthly	1-B-6	Care Management Staffing Ratios for Members Enrolled in the Medical Care Management Program	8-A	Care Management Responsibilities
13.	1	Monthly	1-B-7	Medical Home Linkage for Members Enrolled in the Medical Care Management Program	4-B; 8-A	Choice of a Network Provider; Care Management Responsibilities
14.	1	Monthly	1-C-1	Unduplicated Number of Newly Enrolled Members in Behavioral Health Care Management Program	8-A	Care Management Responsibilities
15.	1	Monthly	1-C-2	Unduplicated Number of Disenrolled Behavioral Health Care Management Members	8-A	Care Management Responsibilities
16.	1	Monthly	1-C-3	Unduplicated Number of Members Enrolled in the Behavioral Health Care Management Program and Contacted for the Purposes of Care Management	8-A	Care Management Responsibilities
17.	1	Monthly	1-C-4	Number of Successful Care Management Contacts to Members Enrolled in the Behavioral Health Care Management Program	8-A	Care Management Responsibilities
18.	1	Quarterly	1-C-5	Identification and Monitoring of Over- and Under-Utilization of Services for Members Enrolled in the Behavioral Health Care Management Program	8-A	Care Management Responsibilities
19.	1	Monthly	1-C-6	Care Management Staffing Ratios for Members Enrolled in the Behavioral Health Care Management Program	8-A	Care Management Responsibilities
20.	1	Monthly	1-C-7	Medical Home Linkage for Members Enrolled in the Behavioral Health Care Management Program	4-B; 8-A	Choice of a Network Provider; Care Management Responsibilities

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
21.	1	Monthly	1-E-1	Unduplicated Number of Newly Enrolled Members in the Care Management Program for Foster Care Members	8-A	Care Management Responsibilities
22.	1	Quarterly	1-E-10	Utilization of Medications Categorized by Antidepressant, Antipsychotic, Attention Deficit Hyperactivity Disorder (ADHD), and Psychotropic	8-A	Care Management Responsibilities
23.	1	Monthly	1-E-2	Unduplicated Number of Disenrolled Foster Care Members in Care Management	8-A	Care Management Responsibilities
24.	1	Monthly	1-E-3	Unduplicated Number of Foster Care Members Enrolled in the Care Management Program and Contacted for Purposes of Care Management	8-A	Care Management Responsibilities
25.	1	Monthly	1-E-4	Number of Successful Care Management Contacts to Foster Care Members Enrolled in the Care Management Program	8-A	Care Management Responsibilities
26.	1	Quarterly	1-E-5	Identification and Monitoring of Over- and Under-Utilization of Services for Foster Care Members Enrolled in the Care Management Program	8-A	Care Management Responsibilities
27.	1	Monthly	1-E-6	Care Management Staffing Ratios for Foster Care Members Enrolled in Care Management Program	8-A	Care Management Responsibilities
28.	1	Monthly	1-E-7	Medical Home Linkage for Foster Care Members Enrolled in the Care Management Program	4-B; 8-A	Choice of a Network Provider; Care Management Responsibilities

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
29.	1	Quarterly	1-E-8	Screenings and Assessments Completed within Timeframe Identified in Settlement Agreement	8-A	Care Management Responsibilities
30.	1	Quarterly	1-E-9	Utilization of Ongoing Assessments and Examinations	8-A	Care Management Responsibilities
31.	2	Monthly	2-A-1	Member Enrollment Statistics and Trends	4-K	Member Listing Report
32.	2	Monthly	2-A-2	Description of Any Member Enrollment Trends	4-K	Member Listing Report
33.	2	Monthly	2-B-1	Medical Utilization Statistics and Trends (excludes behavioral health)	9-N	Utilization Review
34.	2	Monthly	2-B-10	Rebated Drug Volume	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
35.	2	Monthly	2-B-11	Top 50 Members	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
36.	2	Monthly	2-B-1-1	Behavioral Health Utilization Statistics and Trends	5-E; 9-N	Behavioral Health/Substance Use Disorder; Utilization Review
37.	2	Monthly	2-B-12	Advanced Imaging Services Utilized	5-F; 9-N	Prescription Drugs, Physician-Administered Drugs

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
						and Implantable Drug System Devices; Utilization Review
38.	2	Monthly	2-B-1-2	Behavioral Health Utilization Statistics and Trends – Injectable Anti-Psychotics	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
39.	2	Monthly	2-B-1-3	Description of Behavioral Health Utilization Trends	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
40.	2	Monthly	2-B-2	Description of Any Utilization Trends (excludes behavioral health)	9-N	Utilization Review
41.	2	Monthly	2-B-3	Pharmaceutical Statistics	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
42.	2	Monthly	2-B-4	Top 100 Drugs by Utilization	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
43.	2	Monthly	2-B-5	Top 100 Drugs by Amount Paid	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
						Drug System Devices; Utilization Review; Drug Utilization Data
44.	2	Monthly	2-B-6	Validation Preferred Drug List Use	5-F	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices
45.	2	Monthly	2-B-7	Pharmacy Prior Authorization Report	5-J	Prior Authorizations
46.	2	Monthly	2-B-8	Physician Administered Drugs and Implantable Drug System Devices	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
47.	2	Monthly	2-B-9	Exception Report Clinical Trials and/or Investigative or Experimental Drugs	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
48.	2	Monthly	2-C-1	Claims Processing Statistics	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
49.	2	Monthly	2-C-1-1	Behavioral Health Claims	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
50.	2	AdHoc	2-C-1-1-AH	Pended/Suspended Behavioral Health Claims	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
51.	2	Monthly	2-C-1-2	Behavioral Health Claims Denial Reason	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
52.	2	AdHoc	2-C-1-AH	Pended/Suspended Claims (excludes behavioral health)	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
53.	2	Monthly	2-C-2	Physician Administered Drugs (PAD), Number Administered (includes behavioral health)	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
54.	2	Monthly	2-C-2-AH	Physician Administered Drug Claims, Denied Claims – Other	5-F; 9-N; 10-S	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Utilization Review; Drug Utilization Data
55.	2	Monthly	2-C-3	Medical Claims Denial Reason (excludes behavioral health)	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
56.	2	Monthly	2-C-4	Claims Processing Statistics – Pharmacy	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
57.	2	Monthly	2-C-5	Pharmacy Claims Denial Reason	10-Q; 17-A; 17-B	Health Information System; Claims Payment; Claims Processing and Information Retrieval Systems
58.	2	Monthly	2-D-1	Call Center Statistics – All CCO Calls (excludes behavioral health)	6-A; 7-H-1	Member Services Call Center; Provider Services Call Center
59.	2	Monthly	2-D-1-1	Call Center Statistics – All CCO Calls (Behavioral Health Only)	6-A	Member Services Call Center
60.	2	Monthly	2-D-1-2	Call Center Statistics – Member Hotline Calls (Behavioral Health Only)	6-A; 15-E	Member Services Call Center; Liquidated Damages
61.	2	Monthly	2-D-1-3	Member Hotline – Types of Calls (Behavioral Health Only)	6-A	Member Services Call Center
62.	2	Monthly	2-D-1-4	Call Center Statistics – Provider Hotline Calls (Behavioral Health Only)	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
63.	2	Monthly	2-D-1-5	Provider Hotline –Types of Calls (Behavioral Health Only)	7-H-1	Provider Services Call Center
64.	2	Monthly	2-D-1-6	Call Center Statistics – Behavioral Health Clinical Line Calls	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
65.	2	Monthly	2-D-1-7	Member Nurse Line – Types of Behavioral Health Clinical Line Calls (behavioral health only)	6-A	Member Services Call Center

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
66.	2	Monthly	2-D-2	Call Center Statistics – Member Hotline Calls (excludes behavioral health)	6-A; 15-E	Member Services Call Center; Liquidated Damages
67.	2	Monthly	2-D-3	Member Hotline – Types of Calls (excludes behavioral health)	6-A	Member Services Call Center
68.	2	Monthly	2-D-4	Call Center Statistics – Provider Hotline Calls (excludes behavioral health)	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
69.	2	Monthly	2-D-5	D-5. Provider Hotline – Types of Calls (excludes behavioral health)	7-H-1	Provider Services Call Center
70.	2	Monthly	2-D-6	Call Center Statistics – Member Nurse Line Calls (excludes behavioral health)	6-A; 15-E	Member Services Call Center; Liquidated Damages
71.	2	Monthly	2-D-7	Member Nurse Line – Types of Nurse Line Calls (includes behavioral health)	6-A	Member Services Call Center
72.	2	Monthly	2-E-1	Medical Provider Network (excludes behavioral health)	Section 7	Provider Network
73.	2	Monthly	2-E-1-AH	Terminated Provider Report	7-D	Provider Terminations
74.	2	Monthly	2-E-2	Behavioral Health Provider Network	Section 7	Provider Network
75.	2	AdHoc	2-E-2-AH	Terminated Provider Report	7-D	Provider Terminations
76.	2	Monthly	2-F-1	Overall Prior Authorization Requests Received (includes behavioral health)	5-J	Prior Authorizations
77.	2	AdHoc	2-F-1-AH	Prior Authorization Ad-Hoc Report	5-J	Prior Authorizations
78.	2	Monthly	2-F-2	Prior Authorization Turn Around Time Report	5-J	Prior Authorizations
79.	2	AdHoc	2-F-2-AH	Prior Authorization Turn Around Time Ad-Hoc Report	5-J	Prior Authorizations

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
80.	2	Monthly	2-F-3	Pharmacy Prior Authorizations	5-J	Prior Authorizations
81.	2	Monthly	2-F-3-AH	Pharmacy Prior Authorization Ad-Hoc	5-J	Prior Authorizations
82.	2	Monthly	2-F-4	Authorized Delivery Report	9-O	Reporting Maternity Admissions for Delivery
83.	2	Monthly	2-G-1	Encounter Data Acceptance Rate	10-R	Member Encounter Data
84.	2	Monthly	2-G-2	Description of Encounter Data Acceptance Rate Trends	10-R	Member Encounter Data
85.	2	Monthly	2-H-1	Medical Member Complaints Summary (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
86.	2	Monthly	2-H-7	Behavioral Health Member Complaint Summary	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
87.	2	Monthly	2-H-8	Behavioral Health Member Complaint Detail	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
88.	2	Monthly	2-H-9	Behavioral Health Member Grievance Summary	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
89.	2	Monthly	2-H-10	Behavioral Health Member Grievance Detail	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
90.	2	Monthly	2-H-2	Medical Member Complaints Detail (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
91.	2	Monthly	2-H-3	Medical Member Grievances Summary (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
92.	2	Monthly	2-H-4	Medical Member Grievances Detail (excludes	6-K	Member Complaint, Grievance, Appeal

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
				behavioral health)		and State Fair Hearing Process
93.	2	Monthly	2-I-1	Provider Complaint Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
94.	2	Monthly	2-I-7	Behavioral Health Provider Complaints Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
95.	2	Monthly	2-I-8	Behavioral Health Provider Complaints Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
96.	2	Monthly	2-I-9	Behavioral Health Provider Grievances Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
97.	2	Monthly	2-I-10	Behavioral Health Provider Grievances Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
98.	2	Monthly	2-I-2	Provider Complaint Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
99.	2	Monthly	2-I-3	Provider Grievances Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
100.	2	Monthly	2-I-4	Provider Grievances Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
101.	2	Monthly	2-J-1	Provider State Issues/MIG Summary	1-J	Responsiveness to Division Requests
102.	2	Monthly	2-J-2	Provider State Issues/MIG Detail	1-J	Responsiveness to Division Requests
103.	2	Monthly	2-J-3	Member State Issues/MIG Summary	1-J	Responsiveness to Division Requests
104.	2	Monthly	2-J-4	Member State Issues/MIG Detail	1-J	Responsiveness to Division Requests
105.	2	TBD	2-B-	Autism Spectrum Disorder		
106.	2	Annually	2-E-3	Provider Directory Delivery Report	6.E	Member Services
107.	2	Monthly	2-F-5	Resubmission of Authorized Maternity Delivery Report	9.O	Quality Management
108.	2	Monthly	2-K-1	Provider Network - X08 Providers		
109.	2	Quarterly	2-K-2	0359T Behavior Identification Assessments		
110.	2	Monthly	2-K-3	ASD Claims		
111.	2	Monthly	2-K-4	Care Management		
112.	2	Monthly	2-K-5	Beneficiary Appeals		
113.	2	Monthly	2-K-6	Provider Appeals		

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
114.	2	Monthly	2-H-5	Medical Member Appeals Summary (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
115.	2	Monthly	2-H-6	Medical Member Appeals Detail (excludes behavioral health)	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
116.	2	Monthly	2-H-11	Behavioral Health Member Appeals Summary	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
117.	2	Monthly	2-H-12	Behavioral Health Member Appeals Detail	6-K	Member Complaint, Grievance, Appeal and State Fair Hearing Process
118.	2	Monthly	2-I-5	Provider Appeals Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
119.	2	Monthly	2-I-6	Provider Appeals Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
120.	2	Monthly	2-I-11	Behavioral Health Provider Appeals Summary	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
121.	2	Monthly	2-I-12	Behavioral Health Provider Appeals Detail	7-I	Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
122.	3	Annually	3-A-1	Appointment Availability – PCPs	7-B	Provider Network Requirements
123.	3	Annually	3-A-2	Appointment Availability – Behavioral Health Providers	7-B	Provider Network Requirements
124.	3	Annually	3-A-3	Appointment Availability – OB/GYN Providers	7-B	Provider Network Requirements

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
125.	3	Quarterly	3-A-4	Contracted Hospitals	7-B	Provider Network Requirements
126.	3	Quarterly	3-A-5	GeoAccess Reporting Requirements	7-B	Provider Network Requirements
127.	3	Quarterly	3-A-6	Insure Kids Now Provider Data	7-B	Provider Network Requirements
128.	3	Quarterly	3-B-1	Provider Call Center Audit	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
129.	3	AdHoc	3-B-1-AH	Provider Call Center Issues	7-H-1; 15-E	Provider Services Call Center; Liquidated Damages
130.	3	Quarterly	3-B-2	CCO Member Call Center Audit	6-A; 15-E	Member Services Call Center; Liquidated Damages
131.	3	AdHoc	3-B-2-AH	CCO Member Call Center Issues	6-A; 15-E	Member Services Call Center; Liquidated Damages
132.	3	Quarterly	3-B-3	CCO Provider Services Call Center Training Report	7-H-1	Provider Services Call Center
133.	3	Quarterly	3-B-4	CCO Member Services Call Center Training Report	6-A-4	Staff Training
134.	3	Quarterly	3-B-5	CCO Nurse Line Call Center Training Report	6-A-4	Staff Training
135.	3	Annually	3-C-1-A	Marketing Work Plan-Annual	6-I	Marketing
136.	3	Quarterly	3-C-1-Q	Marketing Work Plan Updates-Quarterly	6-I	Marketing
137.	3	Quarterly	3-C-2	Marketing Activities Log	6-I	Marketing
138.	3	Quarterly	3-C-3	Marketing Complaints Tracking Log	6-I	Marketing
139.	3	Monthly	3-D-1	New Member Card Report	6-I	Marketing
140.	3	Monthly	3-D-2	Returned Card Report	6-C	Member Identification Card
141.	3	Quarterly	3-E-1	Provider Credentialing	7-E	Provider Credentialing and Qualifications
142.	3	Quarterly	3-E-2	List of Providers Credentialed Over 90 Days	7-E	Provider Credentialing and Qualifications

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
143.	3	Annually	3-F-1	Health Education and Prevention Work Plan-Annual	6-B	Member Education
144.	3	Quarterly	3-F-2	Health Education and Prevention Work Plan Updates-Quarterly	6-B	Member Education
145.	3	Annually	3-G-1	EPSDT Report	5-D; 7-C; 9-R	EPSDT Services; PCP Responsibilities; EPSDT Audit
146.	3	Quarterly	3-G-2	PHRMS/ISS Report	8-A-3	Perinatal High Risk Management/Infant Services System
147.	3	Monthly	3-H-1	Pharmacy Lock-In Program Report	10-F	Pharmacy Lock-In Program
148.	4	Semi-Annually	4-A-1	Provider Incentive Plan	7-K	Physician Incentive Plans
149.	4	AdHoc	4-A-2	Patient-Centered Medical Home	7-B-5	Patient-Centered Medical Homes
150.	4	Annually	4-B-1	HEDIS® Compliance Audit	9-E; Exhibit F	Performance Measures; Performance Measures
151.	4	Annually	4-B-2	CAHPS® Survey Report	9-F; Exhibit F	CAHPS® Member Satisfaction Survey; Performance Measures
152.	4	Annually	4-B-3	Performance Measure Results	9-E; Exhibit F	Performance Measures; Performance Measures
153.	4	Annually	4-C-1	Quality Management Program Description (Medical)	9-K; Exhibit G	Quality Management Committee; Quality Management
154.	4	Annually	4-C-1-1	Quality Management Program Description (Behavioral Health)	9-K; Exhibit G	Quality Management Committee; Quality Management
155.	4	Annually	4-C-1-2	Quality Management Work Plan (Behavioral Health)	9-K; Exhibit G	Quality Management Committee; Quality Management
156.	4	Annually	4-C-1-3	Quality Management	9-K; Exhibit G	Quality

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
				Program Evaluation (Behavioral)		Management Committee; Quality Management
157.	4	Annually	4-C-2	Quality Management Work Plan (Medical)	9-K; Exhibit G	Quality Management Committee; Quality Management
158.	4	Annually	4-C-3	Quality Management Program Evaluation (Medical)	9-K; Exhibit G	Quality Management Committee; Quality Management
159.	4	Quarterly	4-C-4	Performance Improvement Project Updates	9-I	Performance Improvement Projects
160.	4	Annually	4-C-5	Performance Improvement Project Results	9-I	Performance Improvement Projects
161.	4	Annually	4-D-1	Utilization Management Program Description	9-N	Utilization Review
162.	4	Annually	4-E-1	Provider Satisfaction Survey Questions and Methodology	9-G	Provider Satisfaction Survey
163.	4	Annually	4-E-2	Provider Satisfaction Survey Results	9-G	Provider Satisfaction Survey
164.	4	Monthly	4-E-3	Provider Services Representative Visit Log	7-H; 7-I	Provider Services; Provider Complaint, Grievance, Appeal and State Administrative Hearing Process
165.	5	Monthly	5-A-1	Cash Disbursement Journal	10-R-6	Accuracy of Data
166.	5	Annually	5-A-2	Encounter Data Completeness Plan	10-R-5	Data Completeness
167.	5	Quarterly	5-A-3	Provider Preventable Conditions	7-J-2	Payments for Provider-Preventable Conditions
168.	5	Quarterly	5-B-1	New Provider Investigations/Complaints	10-U; Section 11	Fraud and Abuse Reporting; Program

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
						Integrity
169.	5	Quarterly	5-B-10	Internal Contractor Reporting	10-V	Internal Contractor Reporting
170.	5	Monthly	5-B-11	Third Party Casualty	11-L; 11-M; Section 13	Third Party Liability Audit; Third Party Liability Reporting; Third Party Liability
171.	5	Monthly	5-B-12	Third Party Leads	11-L; 11-M; Section 13	Third Party Liability Audit; Third Party Liability Reporting; Third Party Liability
172.	5	Monthly	5-B-13	Cost Avoidance & TPL Recoveries	11-L; 11-M; Section 13	Third Party Liability Audit; Third Party Liability Reporting; Third Party Liability
173.	5	Quarterly	5-B-2	New Member Investigations/Complaints	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
174.	5	Annually	5-B-3	Annual Provider Report of New Investigations/Complaints	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
175.	5	Annually	5-B-4	Annual Member Report of New Investigations/Complaints	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
176.	5	Semi-Annually	5-B-5	Semi-Annual Provider New Investigations/Complaints Activity Report	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
177.	5	Semi-Annually	5-B-6	Semi-Annual Member New Investigations/Complaints Activity Report	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
178.	5	Quarterly	5-B-7	Credible Allegation of Fraud Referrals	10-U; Section 11	Fraud and Abuse Reporting; Program Integrity
179.	5	Annually	5-B-8	Fraud and Abuse Compliance Plan	11-B	Fraud and Abuse Compliance Plan
180.	5	Quarterly	5-B-9	Prepayment Review	5-J; 10-U	Prior Authorizations; Fraud and Abuse Reporting

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
181.	5	Annually	5-C-1	Medical Loss Ratio Rebate Calculation - MSCAN	Exhibit C	Medical Loss Ratio (MLR) Requirements
182.	5	Annually	5-D-1	Disenrollment Survey	9-J	Disenrollment Survey
183.	5	Quarterly	5-D-2	Disenrollment Survey Results	9-J	Disenrollment Survey
184.	5	Annually	5-E-1	Department of Insurance (DOI) Filings	10-I	Financial Reports
185.	5	Annually	5-E-2	Contractor Licensures	1-F	Contractor Representations
186.	5	Annually	5-E-3	Small and Minority Business Reporting	10-Y	Small and Minority Business Reporting
187.	5	Monthly	5-E-4	Fee Schedule Validation	12-A	Capitation Payments
188.	5	Monthly	5-E-5	Systems Updates of PDL Indicators	5-F; 12-A	Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices; Capitation Payments
189.	5	Quarterly	5-E-6	Provider Licensure Information	7-E	Provider Credentialing and Qualifications
190.	5	Quarterly	5-E-7	NCCI Savings Report	Section 11	Program Integrity
191.	5	AdHoc	5-G-1	Inpatient Provider Statistical and Summary Report	10-K	Provider Statistical and Summary Report
192.	5	AdHoc	5-G-2	Outpatient Provider Statistical and Summary Report	10-K	Provider Statistical and Summary Report
193.	5	Monthly	5-H-1	Claims Denial Report	10-J; 10-Q; 17-A; 17-B	Claims Denial Report; Health Information System; Claims Payment; Claims

	Report Section	Submission Frequency	Report ID	Report Name	Primary Applicable Contract Sections	Primary Applicable Contract Section Names
						Processing and Information Retrieval Systems
194.	7	Monthly	7-A-1	Summary of Allowed Amount by Medicaid Category	10-R	Member Encounter Data
195.	7	Monthly	7-A-10	Allowed Amount by Provider by Mental Health DRGs, Pediatric	10-R	Member Encounter Data
196.	7	Monthly	7-A-2	Summary of Allowed Amount by APR-DRG, Top 50 DRGs by Stays	10-R	Member Encounter Data
197.	7	Monthly	7-A-3	Summary of Allowed Amount by APR-DRG, Top 50 DRGs by Allowed Amount	10-R	Member Encounter Data
198.	7	Monthly	7-A-4	Summary of Allowed Amount by Peer Group- Top 8 Providers	10-R	Member Encounter Data
199.	7	Monthly	7-A-4-A	Summary of Allowed Amount by All Hospitals sorted by Peer Group	10-R	Member Encounter Data
200.	7	Monthly	7-A-5	Highest Paying Claims- Top 100 Claims by Allowed Amount	10-R	Member Encounter Data
201.	7	Monthly	7-A-6	DRG Cost Outlier Allowed Amount- Top 25	10-R	Member Encounter Data
202.	7	Monthly	7-A-7	Allowed Amount by Patient Discharge Status	10-R	Member Encounter Data
203.	7	Monthly	7-A-8	Long Stays, Top 50 by Length of Stay	10-R	Member Encounter Data
204.	7	Monthly	7-A-9	Short Stays, Days < National ALOS * 10%	10-R	Member Encounter Data

Appendix E: Adult and Child Quality Measures

Child Health Quality Measures

Measure Name	HEDIS ® 2016 Baseline	HEDIS ® 2017 Update	2019 Goal
Timeliness of Prenatal Care	79.03%	91.09%	95.09%
Frequency of Ongoing Prenatal Care (FPC) 81+ Percent	57.80%	72.34%	77.34%
Childhood Immunization Status			
DTaP/DT	80.87%	78.59%	83.59%
IPV	92.97%	92.39%	97.39%
MMR	91.89%	90.57%	95.57%
HiB	90.43%	87.78%	92.78%
Hepatitis B	93.21%	91.45%	96.45%
VZV	92.01%	90.08%	95.08%
Pneumococcal Conjugate	81.12%	79.19%	84.19%
Hepatitis A	80.29%	76.06%	81.06%
Rotavirus	64.33%	75.45%	80.45%
Influenza	22.96%	26.95%	31.95%
Combination 2	79.17%	74.59%	79.59%
Combination 3	75.43%	71.69%	76.69%
Combination 4	66.37%	60.45%	65.45%
Combination 5	56.59%	62.99%	67.99%
Combination 6	20.42%	21.71%	26.71%
Combination 7	49.23%	53.32%	58.32%
Combination 8	19.45%	42.79%	47.79%
Combination 9	14.38%	19.62%	24.62%
Combination 10	13.65%	19.22%	24.22%
Adolescent Immunization Status			
Meningococcal	48.24%	48.03%	53.05%
Tdap/Td	76.56%	76.69%	81.69%
Combination 1	47.28%	47.19%	52.19%
Weight Assessment and Counseling for Nutritional and Physical Activity for Children/ Adolescents			
BMI Percentile (3-11 years)	34.21%	48.36%	53.36%
BMI Percentile (12-17 years)	33.94%	40.68%	45.68%
Counseling for Nutrition (3-11 years)	37.37%	50.52%	55.52%
Counseling for Nutrition (12-17 years)	42.08%	41.44%	46.44%
Counseling for Physical Activity (3-11 years)	36.84%	35.44%	40.44%
Counseling for Physical Activity (12-17 years)	42.53%	41.82%	46.82%
Chlamydia Screening	58.71%	51.00%	56.00%
Well-Child Visits in the First 15 Months of Life: Six or More Visits	43.94%	44.50%	49.50%
Well-Child Visits in the 3rd, 4th, 5th, and 6th years of Life	53.72%	55.98%	60.98%
Adolescent Well-Care Visits	41.61%	39.52%	44.52%

Child Health Quality Measures

Measure Name	HEDIS ® 2016 Baseline	HEDIS ® 2017 Update	2019 Goal
Child and Adolescent Access to Primary Care Practitioners			
12-24 months	96.37%	97.04%	99.04%
25 months – 6 years	92.06%	87.76%	93.76%
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity disorder (ADHD) Medication			
Initiation Phase	49.19%	57.40%	62.40%
Continuation and Follow-Up Phase	67.65%	68.33%	73.33%
Follow-Up After Hospitalization for Mental Illness			
7 day follow-up	38.96%	43.08%	49.08%
30 day follow-up	60.83%	66.05%	71.05%
Medication Management for People with Asthma - 75%			
Ages 5-11	26.33%	20.60%	25.60%
Ages 12-18	24.24%	20.67%	25.67%
Human Papillomavirus Vaccine for Female Adolescents	11.79%	6.05%	12.00%
Consumer Assessment of Health Plans - Children With Chronic Conditions			
Getting Needed Care (Always/Usually)	80.19%	78.65%	83.65%
Getting Care Quickly (Always/Usually)	86.41%	87.41%	92.41%
How Well Doctors Communicate (Always/ Usually)	88.93%	88.79%	93.79%
Customer Service (Always/ Usually)	80.75%	83.79%	85.79%
Shared Decision Making (Yes)	87.61%	85.92%	90.92%
Rating of All Health Care (8-10)	75.52%	78.05%	83.05%
Rating of Personal Doctor (8-10)	85.55%	84.54%	89.54%
Rating of Specialist (8-10)	80.72%	83.28%	85.28%
Rating of Health Plan (8-10)	75.72%	79.05%	84.05%
Annual Monitoring for Patients on Persistent Medications (MPM-AD)	86.42%	87.81%	92.81%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)		71.47%	76.47%

Adult Quality Measures

Measure Name	HEDIS ® 2016 Baseline	HEDIS ® 2017 Update	2019 Goal
Adult BMI Assessment	71.34%	82.43%	87.43%
Breast Cancer Screening	51.48%	53.89%	58.89%
Cervical Cancer Screening	59.57%	58.58%	63.58%
Chlamydia Screening in Women Ages 21-24	31.20%	56.58%	61.58%
Follow-Up After Hospitalization for Mental Illness			
7 day follow-up	38.96%	40.41%	45.41%
30 day follow-up	60.83%	59.30%	64.30%
Controlling High Blood Pressure	37.65%	44.96%	49.96%
Comprehensive Diabetes Care: Hemoglobin A1c Testing	82.12%	86.63%	91.63%
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	66.80%	56.98%	61.98%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment			
Initiation of AOD Treatment	46.22%	39.23%	46.23%
Engagement of AOD Treatment	8.04%	5.64%	9.83%
Prenatal and Postpartum Care: Postpartum Care Rate			
Timeliness of Prenatal Care	69.85%	91.09%	96.09%
Postpartum Care	53.35%	62.94%	67.94%
Antidepressant Medication Management			
Effective Acute Phase Treatment	56.19%	40.16%	57.25%
Effective Continuation Phase Treatment	41.55%	23.79%	45.55%
Flu Vaccinations for Adults Ages 18-64	74.23%	37.64%	50.64%
Medical Assistance with Smoking and Tobacco Use Cessation			
Advising Smokers and Tobacco Users to Quit	78.35%	78.72%	83.72%
Discussing Cessation Medications	47.23%	47.85%	52.85%
Discussing Cessation Strategies	42.49%	41.91%	46.91%
Consumer Assessment of Health Plans Survey - Adult			
Getting Needed Care (Always/Usually)	82.06%	82.66%	87.66%
Getting Care Quickly (Always/Usually)	81.55%	82.11%	87.11%
How Well Doctors Communicate (Always/Usually)	91.23%	92.38%	95.38%
Customer Service (Always/Usually)	89.25%	89.11%	93.11%
Shared Decision Making (Yes)	74.71%	76.43%	81.43%
Rating of Health Care (8-10)	67.45%	67.51%	72.51%
Rating of Personal Doctor (8-10)	78.54%	79.96%	83.96%
Rating of Specialist (8-10)	75.09%	78.58%	82.58%
Rating of Health Plan (8-10)	69.54%	72.05%	76.05%

Appendix F: Evidence Based Clinical Practice Guidelines

Evidence Based Clinical Practice Guidelines

The CCOs develop and make available to Providers clinical practice guidelines consistent with national standards for disease and chronic illness management of beneficiaries. These clinical practice guidelines are based on reasonable scientific evidence, reasonable medical evidence, reviewed annually by Network Providers who can recommend adoption of clinical practice guidelines to the CCOs, and communicated to those whose performance will be measured against them. The CCOs review the guidelines at least every two (2) years and update them as appropriate.

Annually, the CCOs measure Provider performance against at least two (2) of the clinical guidelines and provide DOM the results of the study and a summary of any corrective actions taken to ensure compliance with the guidelines.

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
Adult Preventive Care	American Cancer Society Guidelines for the Early Detection of Cancer (Revised July 2016)	American Cancer Society (ACS)	http://www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer
	Morbidity and Mortality Weekly Report (MMWR)(Last updated June 15, 2017)	Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/mmwr/
	U.S. Preventive Services Task Force Recommendations. (Publication dates vary)	U.S. Preventive Services Task Force (USPSTF)	http://www.uspreventiveservicestaskforce.org/uspstopics.htm
Asthma	Asthma Care Quick Reference Diagnosing and managing asthma. Guidelines from the National Asthma Education and Prevention Program. Expert Panel Report 3. (Revised 2012.)	U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)	http://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
	Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (Full Report July 2007) and Changes to the Guidelines (August 2008)	U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)	http://www.nhlbi.nih.gov/guidelines/asthma/index.htm
	2017 GINA Report, Global Strategy For Asthma Management and Prevention. Updated 2017	Global Initiative for Asthma (GINA)	http://ginasthma.org/2017-gina-report-global-strategy-for-asthma-management-and-prevention/
Back Pain	Adult Acute Low Back Pain (Updated November 2012)	Institute for Clinical Systems Improvement (ICSI)	https://www.guideline.gov/summaries/summary/39319/adult-acute-and-subacute-low-back-pain

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
			and https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_musculoskeletal_guidelines/low_back_pain/
	Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society (October 2, 2007)	American College of Physicians; American Pain Society	http://annals.org/article.aspx?articleid=736814
	Low back pain: clinical practice guidelines linked to the International Classification of Functioning, Disability, and Health from the Orthopedic Section of the American Physical Therapy Association (April 2012)	American Physical Therapy Association	http://www.guideline.gov/content.aspx?id=36828
Chlamydia Screening	Final Recommendation Statement Gonorrhea and Chlamydia: Screening, September 2014	U.S. Preventive Services Task Force (USPSTF)	http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening
COPD	Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease (2017 Report)	The Global Initiative for Chronic Obstructive Lung Disease	http://goldcopd.org/gold-2017-global-strategy-diagnosis-management-prevention-copd/
Coronary Artery Disease	Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children	U.S. Department of Health and Human Services (HHS);	http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
	and Adolescents. The Report of the Expert Panel (October 2012)	National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)	
	ACC/AHA Prevention Guideline: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk. (Circulation. 2014; 129:S49-S73) (Published online November 12, 2013)	American College of Cardiology (ACC) and American Heart Association (AHA) Task Force	http://circ.ahajournals.org/lookup/doi/10.1161/01.cir.0000437741.48606.98
	AHA Scientific Statement: Exercise and Physical Activity in the Prevention and Treatment of Atherosclerotic Cardiovascular Disease (Circulation. 2003; 107:3109-3116)	The Council on Clinical Cardiology and the Council on Nutrition, Physical Activity, and Metabolism	http://circ.ahajournals.org/content/107/24/3109.long
	AHA Scientific Statement: Secondary Prevention of Atherosclerotic Cardiovascular Disease in Older Adults. (Circulation. 2013; 128:2422-2446)	American Heart Association (AHA)	http://circ.ahajournals.org/content/128/22/2422.full
	AHA/ACC/ASH Scientific Statement Treatment of Hypertension in Patients with Coronary Artery Disease. (Circulation 2015;131:e435-e470)	American Heart Association (AHA), American College of Cardiology (ACC), and American Society of Hypertension	http://circ.ahajournals.org/content/131/19/e435.full
	AHA/ACCF Guideline: AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and	American Heart Association (AHA) and American College	http://circ.ahajournals.org/content/124/22/2458.full.pdf

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
	Other Atherosclerotic Vascular Disease, 2011 Update (Circulation. 2011; 124: 2458-2473) and	of Cardiology Foundation (ACC)	
	The Primary and Secondary Prevention of Coronary Artery Disease: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition)(June 2008)	American College of Chest Physicians	http://journal.chestnet.org/article/S0012-3692(08)60130-0/fulltext
Critical Care	Surviving Sepsis Campaign: International Guidelines for Management of Severe Sepsis and Septic Shock: 2016	Society of Critical Care Medicine and European Society of Intensive Care Medicine.	http://www.survivingsepsis.org/Guidelines/Pages/default.aspx
Diabetes	AACE/ACE Guidelines: American Association of Clinical Endocrinologists and American College of Endocrinology-Clinical Practice Guidelines for Developing a Diabetes Mellitus Comprehensive Care Plan (*Endocrine Practice 2015, Volume 21, S1-87*).	American Association of Clinical Endocrinologists and American College of Endocrinology	https://www.aace.com/files/dm-guidelines-ccp.pdf
	Clinical Practice Recommendations – 2017. Standards of Medical Care in Diabetes (Diabetes Care 2017, Volume 40, Supplement 1)	American Diabetes Association (ADA)	http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160
	Standards of Medical Care in Diabetes (Diabetes Care July 2017, 40: 811-987)	American Diabetes Association (ADA	http://care.diabetesjournals.org/content/current

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
Heart Failure	2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the ACC, AHA and HFSA (Circulation. 2017; CIR.0000000000000509, originally published April 28, 2017)	American College of Cardiology (ACC) Foundation, American Heart Association (AHA) Task Force on Practice Guidelines and the Heart Failure Society of America (HFSA)	http://circ.ahajournals.org/content/early/2017/04/26/CIR.0000000000000509
	AHA Scientific Statement: Exercise and Heart Failure (Circulation. 2003; 107:1210-1225)	American Heart Association (AHA) Committee on Exercise, Rehabilitation, and Prevention	http://circ.ahajournals.org/content/107/8/1210
	HFSA 2010 Comprehensive Heart Failure Practice Guideline. (June 2010; 16: e1-e194)	Heart Failure Society of America (HFSA)	https://www.ncbi.nlm.nih.gov/pubmed/20610207 and http://www.hfsa.org/heart-failure-guidelines-2/
	Updated Clinical Practice Guidelines on Heart Failure: An International Alignment (May 2016)	American Heart Association (AHA), American College of Cardiology (ACC) Foundation, Heart Failure Society of American (HFSA), and the Heart Failure Association and the European Society of Cardiology	http://circ.ahajournals.org/content/early/2016/05/18/CIR.0000000000000436

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
Hyperlipidemia	ACC/AHA Prevention Guideline: 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. (Circulation 2014; 129:S1-S45)	American College of Cardiology (ACC), American Heart Association (AHA) Task Force on Practice Guidelines	http://circ.ahajournals.org/content/129/25_suppl_2/S1
	Management of Blood Cholesterol in Adults: Systematic Evidence Review from the Cholesterol Expert Panel (2013)	U.S. Department of Health and Human Services, National Institute of Health, National Heart, Lung, and Blood Institute	http://www.nhlbi.nih.gov/guidelines/cholesterol/ser/index.htm
	Third Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report September 2002	National Institute of Health and National Heart, Lung, and Blood Institute	http://circ.ahajournals.org/content/106/25/3143.short?rss=1&ssource=mfc
Hypertension	2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8) (JAMA. 2014;311(5):507-520. doi:10.1001/jama.2013.284427)	The Journal of the American Medical Association (JAMA)	http://jama.jamanetwork.com/article.aspx?articleid=1791497
	Seventh Report of the Joint National Committee on Prevention, Detection,	U.S. Department of Health and Human Services, National	http://www.nhlbi.nih.gov/files/docs/guidelines/jnc7full.pdf

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
	Evaluation and Treatment of High Blood Pressure (JNC7) (August 2004)	Institutes of Health, National Heart, Lung and Blood Institute	
Immunizations	Adult Immunization Schedule , United States 2017	Advisory Committee on Immunization Practices (ACIP)	http://www.cdc.gov/vaccines/schedules/hcp/adult.html
	Birth-18 Years & "Catch-up" Immunization Schedules, United States, 2017	Advisory Committee on Immunization Practices (ACIP)	http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
	Prevention and Control of Influenza with Vaccines: Recommendations of the ACIP — United States, 2016–17 Influenza Season	Advisory Committee on Immunization Practices (ACIP)	https://www.cdc.gov/mmwr/volumes/65/rr/rr6505a1.htm
Lead Screening	Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention Report of the Advisory Committee on Childhood Lead Poisoning Prevention of the Centers for Disease Control and Prevention (January 4, 2012)	Advisory Committee for Childhood Lead Poisoning Prevention	http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf
	Recommendations for Blood Lead Screening of Medicaid-Eligible Children Aged 1-5 Years: an Updated Approach to Targeting a Group at High Risk (Last Reviewed 07/28/2009)	Advisory Committee on Childhood Lead Poisoning, Division of Environmental and Emergency Health Services, and National Center for Environmental Health	http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5809a1.htm

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
Pediatric Preventive Care	Guidelines on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents (Revised 2013)	American Academy of Pediatric Dentistry	http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf
	Periodicity Schedule: Recommendations for Preventive Pediatric Health Care (2017)	American Academy of Pediatrics (AAP)	http://www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx
Perinatal Care	AFP by Topic: Prenatal (2017)	American Academy of Family Physicians (AAFP)	http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=25
	Guidelines for Perinatal Care, Seventh Edition (October 2012)	The American College of Obstetricians and Gynecologists (ACOG)	Available online for ACOG members only. http://www.acog.org/About-ACOG/ACOG-Departments/Deliveries-Before-39-Weeks/ACOG-Clinical-Guidelines
Respiratory Illness	Adult and Pediatric treatment recommendations. (Last updated April 17, 2015)	Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/getsmart/community/for-hcp/outpatient-hcp/index.html
	Clinical Practice Guideline for the Diagnosis and Management of Group A Streptococcal Pharyngitis: 2012 Update by the Infectious Diseases Society of	Infectious Disease Society of America	http://cid.oxfordjournals.org/content/55/10/e86.full.pdf+html

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
	America. (Clin Infect Dis 2012; 55: e86-e102.) First published online Sept. 9, 2012.		
	Upper Respiratory Tract Infections (Publication dates vary)	American Academy of Family Physicians (AAFP)	http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=29
	Diagnosis and Treatment of Respiratory Illness in Children and Adults. (Updated January 2013)	Institute for Clinical Systems Improvement (ICSI)	https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_respiratory_guidelines/respiratory_illness/ and https://www.guideline.gov/summaries/summary/43792/diagnosis-and-treatment-of-respiratory-illness-in-children-and-adults
Sickle Cell	Evidence-Based Management of Sickle Cell Disease. Expert Panel Report, 2014.	U.S. Department of Health and Human Services; National Institutes of Health; National Heart, Lung, and Blood Institute	http://www.nhlbi.nih.gov/sites/www.nhlbi.nih.gov/files/sickle-cell-disease-report.pdf
	Sickle Cell Disease, Recommendations (Last updated September 14, 2015)	Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/ncbddd/sicklecell/recommendations.html
	The Management of Sickle Cell Disease, Fourth Edition (2004)	National Institutes of Health; National Heart, Lung, and Blood Institute	http://www.nhlbi.nih.gov/health/prof/blood/sickle/index.htm

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
Weight Management	Active Healthy Living: Prevention of Childhood Obesity Through Increased Physical Activity**.** (Pediatrics Vol. No.5 May 1, 2006 pp.1834-1842)	American Academy of Pediatrics (AAP)	http://pediatrics.aappublications.org/content/117/5/1834.full
	Adult Weight Management (AWM) Guideline (2014)	Academy of Nutrition and Dietetics	http://www.andeal.org/topic.cfm?menu=5276&cat=4688
	Managing Overweight and Obesity in Adults: Systematic Evidence Review from the Obesity Expert Panel (2013)	U.S. Department of Health and Human Services, National Institute of Health, National Heart, Lung, and Blood Institute	http://www.nhlbi.nih.gov/health-pro/guidelines/in-develop/obesity-evidence-review
	Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report (December 2007)	American Academy of Pediatrics (AAP)	http://pediatrics.aappublications.org/content/suppl/2007/12/03/120.Supplement_4.S163.DC1/Obesity_Supplement_120-6.pdf
	Final Recommendation Statement Obesity in Children and Adolescents: Screening, June 2017	U.S. Preventive Services Task Force (USPSTF)	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-children-and-adolescents-screening1
ADHD	ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-deficit/Hyperactivity Disorder in Children and Adolescents.	American Academy of Pediatrics (AAP)	http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654.full.pdf+html

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
	(Published online October 16, 2011; DOI: 10.1542/peds.2011-2654)		
	Clinical Practice Guideline: Treatment of the School-Aged Child with Attention-Deficit/Hyperactivity Disorder (Pediatrics Vol. 108 No. 4 October 1, 2001 pp. 1033 - 1044)	American Academy of Pediatrics (AAP)	http://pediatrics.aappublications.org/content/108/4/1033.full?sid=6dac3588-095c-49c7-adc5-62643dc1641a
	Practice Parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder (AACAP Revised: 7/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)62182-1/pdf
Anxiety Disorder	Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders (Revised: 2/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)61838-4/pdf
Bipolar Disorder	Practice Guideline for the Treatment of Patients with Bipolar Disorder. Second Edition. (April 2002) and Guideline Watch (November 2005)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf and http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar-watch.pdf
	Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder.(Revised: 1/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)61968-7/pdf

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
Major Depressive Disorder	Practice Guideline for the Treatment of Patients With Major Depressive Disorder. Third Edition. (2010)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf
	Practice parameter for the assessment and treatment of children and adolescents with depressive disorders (Revised 11/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)62053-0/pdf
Oppositional Defiant Disorder	Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. (1/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)61969-9/pdf
Panic Disorder	Practice Guideline for the Treatment of Patients with Panic Disorder. Second Edition. (January 2009)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/panicdisorder.pdf
Schizophrenia	The Practice Guideline for the Treatment of Patients With Schizophrenia. Second Edition.(April 2004) and Guideline Watch(September 2009)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia.pdf and http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia-watch.pdf
	The Practice Parameter for the Assessment and Treatment of Children	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(13)00112-3/pdf

Adopted Clinical Practice and Preventive Health Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
	and Adolescents with Schizophrenia (September 2013)		
Stress Disorder	The Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder. (November 2004) and Guideline Watch (March 2009)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd.pdf and http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd-watch.pdf
Substance Use Disorders	Practice Guideline for the Treatment of Patients With Substance Use Disorders(May 2006) and Guideline Watch (April 2007)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf and http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse-watch.pdf
Tobacco Cessation	Smoking Cessation During Pregnancy (Obstet Gynecol 2010; 116: 1241-4)	American College of Obstetricians and Gynecologists (ACOG)	http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Smoking-Cessation-During-Pregnancy
	Treating Tobacco Use and Dependence: 2008 update (May 2008)	U.S. Department of Health and Human Services (HHS); Public Health Service	http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-

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Condition/Disease	Guideline Title	Recognized Source	URL
			providers/guidelines-recommendations/tobacco/clinicians/update/treating_tobacco_use08.pdf
Use of Psychotropic Medication	Practice parameter for the use of psychotropic medication in children and adolescents (9/2009)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)60156-8/pdf

Clinical Practice Guidelines

UnitedHealthcare Community Plan has compiled a list of evidence-based clinical guidelines, and the websites where they can be found, for our quality and health management programs. We respect the expertise of the physicians and other health care professionals in our network and appreciate your help as we work together to offer our members better quality, better health outcomes and better cost.

If you have questions, please contact your Physician Advocate. Or, call the number on the back of the member's ID card. Thank you.

Topic	Guideline	Organization
Acute Myocardial Infarction *with* ST Elevation	2013 ACC/AHA Guideline for the Management of ST-Elevation Myocardial Infarction	American College of Cardiology/American Heart Association
Acute Myocardial Infarction *without* ST Elevation	2014 AHA/ACC Guideline for the Management of Patients with Non- ST-Elevation Acute Coronary Syndromes	American Heart Association/ American College of Cardiology
Asthma	2007 National Asthma Education and Prevention Program Expert Panel Report 3 Guidelines for the Diagnosis	National Heart, Lung and Blood Institute
Attention Deficit Hyperactivity Disorder (ADHD)	2007 Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention Deficit Hyperactivity Disorder	American Academy of Child and Adolescent Psychiatry
Bipolar Disorder: Adults	Guideline Watch (November 2005): Practice Guidelines for the Treatment of Patients with Bipolar Disorder, 2nd Edition	American Psychiatric Association
Bipolar Disorder: Children & Adolescents	2007 Practice Parameter for the Assessment and Treatment of Children and Adolescents with Bipolar Disorder	American Academy of Child and Adolescent Psychiatry

Cardiovascular Disease: Prevention in Women	Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women 2011 Update: A Guideline from the American Heart Association	American Heart Association
Cardiovascular Disease: Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease	2011 AHA/ACC Guidelines for Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease	American College of Cardiology/American Heart Association
Cervical Cancer Screening	ACOG Practice Bulletin #157 Cervical Cancer Screening and Prevention How to access the document: • Click on above Link • Click on member Login and enter • Username: cpgacog@uhc.com • Password: cpgacog#1 • Click Login • Locate and click Practice and Educational Bulletins • Search by Keyword "Cervical Cancer Screening" Approval requested by Community and State for all customers. **To be posted on UHCCommunityPlan.com only.** Guidelines for the Prevention and Early Detection of Cervical Cancer	American College of Obstetricians and Gynecologists **Note:** This guideline is not publically available. A user ID and password are required to access the document via the link provided. *The National Guideline Clearinghouse does not have a synopsis of updated guidelines. American Society for Colposcopy and Cervical Pathology (ASCCP)

Cholesterol Management	2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults	American College of Cardiology/American Heart Association
Chronic Obstructive Lung Disease (COPD)	2017 Global Strategy for the Diagnosis, Management and Prevention of COPD	Global Initiative for Chronic Obstructive Lung Disease (GOLD)
Depression/ Major Depressive Disorder	Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition	American Psychiatric Association
Diabetes	Standards of Medical Care in Diabetes – 2017	American Diabetes Association
Dietary Guidelines	Dietary Guidelines for Americans, 2015- 2020, Eighth Edition	U.S. Department of Health and Human Services
Heart Failure	2013 ACCF/AHA Guideline for the Management of Heart Failure	American College of Cardiology/American Heart Association
	2016 ACC/AHA/HFSA Focused Update on New Pharmacological Therapy for Heart Failure	

Hemophilia and von Willebrand Disease	Guidelines for the Management of Hemophilia, 2nd Edition	World Federation of Hemophilia
	The Diagnosis, Management and Treatment of von Willebrand Disease: 2007 NHLBI Guidelines	National Heart, Lung & Blood Institute
Human Immuno-deficiency Virus (HIV)	Primary Care Guidelines for the Management of Persons Infected with HIV: 2013 Update	HIV Medicine Association of the Infectious Diseases Society of America
Hyperbilirubinemia in Newborns	American Academy of Pediatrics Clinical Practice Guideline (2004): Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation	American Academy of Pediatrics
	American Academy of Pediatrics (2009): Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update with Clarifications	American Academy of Pediatrics **Note**: This guideline update is not publically available. A user ID and password are required to access the document.
Hypertension	2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)	Panel Members Appointed to the Eighth Joint National Committee (JNC 8) **Note:** Guideline is freely available, but registration may be required.

Lifestyle Management to Reduce Cardiovascular Risk	2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk	American Heart Association/American College of Cardiology
Obesity	2013 American Heart Association/American College of Cardiology/ The Obesity Society Guideline for the Management of Overweight and Obesity in Adults	American Heart Association/American College of Cardiology/The Obesity Society
	2013 Evidence Report: Managing Overweight and Obesity in Adults Created as a public resource to complement the AHA/ACC/TOS guidelines (see above) Approval requested by Community and State for all customers. **To be posted on UHCCommunityPlan.com only**	National Heart, Lung and Blood Institute
	American Academy of Pediatrics (AAP) Obesity Portal Approval requested by Community and State for all customers. **To be posted on UHCCommunityPlan.com only**	American Academy of Pediatrics Institute for Healthy Childhood Weight

Perinatal Care	Guidelines for Perinatal Care, 7th Edition Approval requested by Community and State for all customers. **To be posted on UHCCommunityPlan.com only.** **Providers and Members Download Adobe Digital Editions**. Once downloaded, access the 83.EB156 Guidelines for Perinatal Care, 7th Edition eBook Link. *UnitedHealthcare employees will need to contact the Business Segment Liaison and obtain Adobe Digital Editions. Once downloaded, click on above link to access.	American Academy of Pediatrics and American College of Obstetricians and Gynecologists Note: This resource is not publically available. Alternatively, the book can be purchased from the American Academy of Pediatrics website.
	Society for Maternal Fetal Medicine (SMFM) Clinical Guidelines Approval requested by Community and State for all customers. **To be posted on UHCCommunityPlan.com only.**	Society for Maternal Fetal Medicine Guidelines are searchable by topic
Physical Activity	2008 Physical Activity Guidelines for Americans Approval requested by OptumHealth	U.S. Department of Health and Human Services

Preventive Pediatric Health Care Screening	2017 Recommendations for Preventive Pediatric Health Care If you experience a script error with this URL, click No and close out of dialog box. Approval requested by Community and State. Document needed for New Mexico market requirements for visit periodicity per Bright Futures guideline **To be posted on the UHCCommunityPlan.com only.**	American Academy of Pediatrics
Preventive Services	Guide to Clinical Preventive Services, 2014: Recommendations of the U.S. Preventive Services Task Force	Agency for Healthcare Research and Quality
Schizophrenia	Practice Guideline for the Treatment of Patients with Schizophrenia, 2nd edition (2004) Guideline Watch (September 2009)	American Psychiatric Association
Sickle Cell Disease	Evidence-Based Management of Sickle Cell Disease: Expert Panel Report, 2014	National Heart, Lung and Blood Institute
Spinal Stenosis	2011 Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care: Diagnosis and Treatment of Degenerative Lumbar Spinal Stenosis	North American Spine Society

Stable Ischemic Heart Disease	2012 Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease	American College of Cardiology/American Heart Association et al.
	2014 ACC/AHA/AATS/PCNA/SCAI/STS Focused Update of the Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease	
Substance Use Disorders	Practice Guideline for the Treatment of Patients with Substance Use Disorders, 2nd edition (2006)	American Psychiatric Association
	Guideline Watch (April 2007)	
Tobacco Use	Treating Tobacco Use and Dependence: 2008 Update Approval requested by Optum Behavioral Health.	U.S. Department of Health and Human Services
	Supplement: Corrections and Additions to the 2008 Guideline Update	