

2011 MEDICAID MANAGED CARE ENROLLMENT DATA  
DICTIONARY  
FOR THE  
MEDICAID MANAGED CARE DATA COLLECTION  
SYSTEM (MMCDCS)

CENTERS FOR MEDICARE & MEDICAID SERVICES  
CENTER FOR MEDICAID AND STATE OPERATIONS  
FINANCE, SYSTEMS, AND BUDGET GROUP  
DIVISION OF INFORMATION, ANALYSIS, AND TECHNICAL ASSISTANCE  
**2011 MEDICAID MANAGED CARE DATA COLLECTION**  
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## Data Element: STATE NAME

Definition: The name of the State that operates the managed care entity. The default value is the name of the appropriate State.

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## DATA ELEMENT: MANAGED CARE ENTITY NAME

Definition: Name of the managed care entity servicing Medicaid managed care eligibles. This includes all managed care entities providing managed care services to Medicaid beneficiaries. For Commercial MCO's, Medicaid-only MCOs, HIOs, and **Other**, provide the name of each individual managed care entity. For PIHPs/ PAHPs (especially Mental Health and Substance Use Disorders PIHPs/PAHPs), provide the name of each individual managed care entity (such as: Behavioral Health Organizations, CMHC Operated Entity/County Operated Entity/Regional Authority Operated Entity, etc.) that the State contracts with. For PCCMs, provide the name of the program as a whole (not the name of each individual PCP). For PACE programs, provide the name of the approved PACE organization.

Valid Choices:

Text box:

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

Edit Conditions:

1. If names are entered in text box, all text should be spelled out completely. No abbreviations should be used.
  2. Field must be completed.
  3. May make more than one entry.
  4. Allow entries up to 100 characters each.
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## DATA ELEMENT: REGION

Definition: One of 10 CMS Regional Offices. This will default to the region based upon the State selected.

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## DATA ELEMENT: DATA COLLECTION DATE

Definition: The database will be updated once each year and all States must report the managed care entities and policies in effect on the same specific date within that year. This is already defaulted to reflect the current data collection date as of 7/1/2011.

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## DATA ELEMENT: MANAGED CARE ENTITY (PLAN) TYPES

Definition: The structure of the managed care entity.

Valid Choices:

1. **Primary Care Case Manager(PCCM)**--A PCCM provider is a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but may include nurse practitioners, nurse midwives, or physician assistants who contracts directly with the State to locate, coordinate, and monitor covered primary care. This category also includes those PAHPs that contract with the State as “primary care case managers.” If both individual physicians and/or group practices, as well as an entity, provide services in the State, select this choice to reflect the individual physician/group practice PCCM. Select “other” below to reflect the entity PCCM.
2. **Commercial Managed Care Organization (MCO)** –A Commercial MCO is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare Advantage organization, a provider sponsored organization or any other private or public organization, which meets the requirements of §1903(m). A Commercial MCO provides comprehensive services to both Medicaid and commercial and/or Medicare enrollees.
3. **Medicaid-only Managed Care Organization (MCO)** -- A Medicaid-only MCO provides comprehensive services to only Medicaid beneficiaries, not to commercial or Medicare enrollees.
4. **Health Insuring Organization (HIO)**--A HIO is a managed care entity which, by law, is exempt from certain rules governing MCO program operation such as the requirement for beneficiaries to

have a choice of at least two managed care entities in mandatory programs. **A HIO provides comprehensive services, and operates solely in California.**

5. **Prepaid Inpatient Health Plan (PIHP)** – A PIHP is a prepaid inpatient health plan that provides less than comprehensive services under a risk contract or other than state plan reimbursement basis or comprehensive services under a non-risk contract; and provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are defined in 42 CFR 438.2}
6. **Prepaid Ambulatory Health Plan (PAHP)** – A PAHP is a prepaid ambulatory health plan that provides less than comprehensive services on an at-risk, non-risk, or other than state plan reimbursement basis, and does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are defined in 42 CFR 438.2}
7. **PACE** – PACE is a program that provides pre-paid, capitated comprehensive, health care services to the frail elderly and which combines both Medicaid and Medicare benefits and payment.
8. **Other** – The structure of the managed care entity is not considered a PIHP, PAHP, Commercial MCO, Medicaid-only MCO, HIO, or PACE, but may include an entity which serves as a PCCM provider.

Valid Choices:

1. PCCM Provider
2. Commercial MCO (comprehensive services/risk contract/Medicaid and commercial and/or Medicare enrollees)
3. Medicaid-only MCO (comprehensive services/risk contract/Medicaid enrollees only)
4. HIO
5. Medical-only PIHP (risk or non-risk/non-comprehensive/with inpatient hospital or institutional services)
6. Medical-only PAHP (risk or non-risk/non-comprehensive/no inpatient hospital or institutional services)
7. Long-Term Care (LTC) PIHP

8. Mental Health (MH) PIHP
9. Mental Health (MH) PAHP
10. Substance Use Disorders (SUD) PIHP
11. Substance Use Disorders (SUD) PAHP
12. Mental Health (MH) and Substance Use Disorders (SUD) PIHP
13. Mental Health (MH) and Substance Use Disorders (SUD) PAHP
14. Dental PAHP
15. Transportation PAHP
16. Disease Management PAHP
17. PACE
18. Other

Text box:

If "**18**" is selected, provide a text box with the statement "Specify other managed care entity type. Do not use abbreviations. Enter text in initial capital format. If more than one, click "Enter" after each type."

Edit Condition:

1. Must select one valid choice.
  2. May only select one valid choice (except if 1 and 18 need to be selected to reflect the different PCCM arrangements).
  3. If "Other" is selected, must complete text box, specifying other managed care entity type using initial capital letters.
- 

## **DATA ELEMENT: MSIS PLAN-ID-NUMBER**

**Definition:** A unique number that represents the managed care health plan under which the non-fee-for-service encounter was provided or the capitation was made and was assigned specifically for the Medicaid Statistical Information System (MSIS). The plan ID number could be State generated number or National Plan ID number that's assigned to the managed care plan. The plan ID should match exactly what is reported in MSIS. A plan could have multiple IDs depending how the States assign the plan ID number to each managed care plan.

Valid Choices:

Alpha-numeric = the value for the MSIS Plan-ID-Number may contain up to 12 positions

**Edit Conditions:**

1. Must complete if payment arrangement is “Risk-based Capitation” or “Non-risk Capitation”.
  2. Must complete if MANAGED CARE ENTITY TYPE is “Medical-only PAHP (risk or non-risk, non-comprehensive)”, “Medical-only PIHP (risk or non-risk, non-comprehensive)”, “Commercial MCO (comprehensive services/risk contract)”, “Medicaid MCO (comprehensive services/risk contract)”, “Long-Term Care (LTC) PIHP”, “Mental Health (MH) PIHP”, “Mental Health PAHP”, “Substance Use Disorders (SUD) PIHP”, “Substance Use Disorders (SUD) PAHP”, “MH/SUD PAHP”, “MH/SUD PIHP”, “Dental PAHP”, “Transportation PAHP”, or “PACE”.
  3. May enter more than one plan ID.
  4. Plan IDs must match what reported in MSIS.
  5. May not exceed 12 characters.
- 

**DATA ELEMENT: REIMBURSEMENT ARRANGEMENTS**

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

Valid Choices:

1. **Risk-based Capitation** -- The managed care entity is paid a fixed amount each month for providing services to enrollees. The managed care entity is responsible for all costs whether or not the fixed amount is sufficient to cover those costs. (There may be other payments under the contract such as incentive arrangements or risk sharing.)
2. **Non-risk Capitation** -- The managed care entity is paid a fixed amount each month for providing services to enrollees through capitation, but payments are settled at the end of the year at amounts that do not exceed the FFS cost for services actually provided, plus an amount for administration.
3. **Fee-For-Service**-- The managed care entity is paid for providing services to enrollees solely through fee-for-service payments.
4. **Primary Care Case Management Fee** - The managed care entity is paid a monthly fee for each enrollee each month to provide primary care case management services.

5. **Other**-- The managed care entity provides services to enrollees through means other than through capitation and fee-for-service reimbursements.

Edit Condition:

1. If “2” (Commercial MCO), “3” (Medicaid-only MCO), or “4” (HIO) is chosen for Managed Care Entity Type, 1 is the only valid option.
2. If **17** (PACE) is chosen for Managed Care Entity Type, 1 is the only valid option.
3. If **18** (Other) is chosen for Managed Care Entity Type, 1, 2, 3 and 4 are all valid options.
4. One number, 1 - 4.

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## DATA ELEMENT: MANAGED CARE ENTITY SERVICE AREA

Definition: The area in which the managed care entity provides services to Medicaid beneficiaries. For MCOs, PIHPs, PAHPs and HIOs, this refers to the individual managed care entity. For PCCMs, this refers to the program as a whole. For PACE, this refers to the approved PACE organizations.

Valid Choices:

1. **Statewide** - The managed care entity provides services to Medicaid beneficiaries throughout the entire State.
2. **County** - The managed care entity provides services to Medicaid beneficiaries in specified counties.
3. **City** - The managed care entity provides services to Medicaid beneficiaries in specified cities.
4. **Region** - The managed care entity provides services to Medicaid beneficiaries in specified regions, not defined by individual counties within the State (“region” is State-defined).
5. **Zip Code** - The PACE program provides services to Medicaid beneficiaries in specified zip codes.



6. **Other** - The managed care entity provides services to Medicaid beneficiaries in "other" area(s), not Statewide, County, City, or Region.

Edit Condition:

1. Must select one valid choice.
2. May only select one valid choice.
3. If "Statewide" is selected, no other service area selection is valid.
4. If "County", "City", "Region" or "Other" is selected, Statewide is not a valid choice.
5. If "17" (PACE) is chosen for Managed Care Entity type, may select "County" and/or "City" and/or Zip Code.
6. If "18" (Other) is selected, must complete text box using initial capital letters.

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## DATA ELEMENT: SERVICES COVERED

Definition: The types of services the managed care entity covers to provide services to Medicaid beneficiaries.

Valid Choices:

1. **Comprehensive Services** - Managed care entity provides the full range of State plan services - medical services (e.g. physician, hospital, lab) services as well as optional, more specialized services (e.g. mental health, substance use disorders, dental, transportation) to Medicaid beneficiaries.
2. **Medical Services** - Managed care entity provides only medical services (physician, hospital, lab, etc.). The managed care entity does not provide optional, specialized services.
3. **Mental Health Services** - Managed care entity provides only mental health services. The managed care entity does not provide medical services or any other optional, specialized services.
4. **Substance Use Disorders Services** - Managed care entity provides only substance use disorders services. The plan does not provide medical services or any other optional, specialized services.

5. **Dental Services** – Managed care entity provides only dental services. The managed care entity does not provide medical services or any other optional, specialized services.
6. **Transportation Services** – Managed care entity provides only non-emergency transportation services. The managed care entity does not provide medical services or any other optional, specialized services.
7. **Disease Management Services** – Managed care entity provides only disease management services. The managed care entity does not provide medical services or any other optional, specialized services.
8. **"Other" Services** – Managed care entity provides only "other" optional, specialized services (not captured in previous valid choices).

Edit Condition:

1. If “Comprehensive Services” is selected, no other services can be selected.
  2. If “1” is selected, may not select 2-8.
  3. If 2-7 is selected, “1” or “8” cannot be selected.
  4. User may select both “Substance Use Disorders Services” and/or “Mental Health Services” if both services are provided.
  5. If **“17” (PACE)** is chosen for Managed Care Entity Type, “1” is the only valid option.
  6. If “8” is selected, use text box to enter "Other" types of services covered. Click Enter after each entry.
- 

## **DATA ELEMENT: OPERATING AUTHORITY**

Definition: The type of program under which the managed care entity operates.

Valid Choices:

1. **1115 demonstration waiver** program – demonstration projects under which most provisions of Section 1902 of the Social Security Act are waived and/or expenditures that would not otherwise be eligible for FFP are authorized. States use these to expand

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

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

Edit Condition:

1. Must select one valid value.
  2. May select more than one valid value.
  3. If "17" (PACE) is chosen for the Managed Care Entity Type, Operating Authority "8" (PACE) is the only valid option.
  4. If "9" (1905t) is chosen as Operating Authority, the Managed Care Entity Type must be "PCCM" or "Other".
  5. If "11" (1902)(a)(70) is chosen as Operating Authority, the Managed Care Entity Type must be "Transportation PAHP".
- 

## DATA ELEMENT: MEDICARE CONTRACT

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

Valid Choices:

1. The Medicaid managed care entity has a Medicare contract to include dual eligibles.
2. The Medicaid managed care entity does not have a Medicare contract to include dual eligibles.

Edit Condition:

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

## DATA ELEMENT: MEDICARE CONTRACT AND PROVISION OF PART D BENEFIT

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

Valid Choices:

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

Edit Condition:

1. Skip if Medicare Contract is "2"
  2. Must select one valid value
  3. May only select one valid value
- 

## **DATA ELEMENT: NUMBER OF MANAGED CARE ENTITY ENROLLEES**

Definition: The unduplicated number of Medicaid beneficiaries enrolled in the managed care entity on 7/1/2011. This is an aggregate number and should include all Medicaid beneficiaries enrolled in managed care entity, including dual eligibles. This number should also include the CHIP population, only if CHIP is operated as a Medicaid expansion program. For MCOs, PIHPs, PAHPs, HIOs, and PACE, provide the unduplicated number of Medicaid beneficiaries of each individual managed care entity. For PCCMs, provide the unduplicated number of Medicaid beneficiaries as a whole (not the enrollment number of each PCP). For PACE, provide the unduplicated number of Medicaid beneficiaries that are receiving some or all benefits from Medicaid (e.g. strictly Medicaid beneficiaries and dual eligibles) not strictly Medicare beneficiaries.

Valid Choices:

Numeric Field =Number of managed care entity enrollees

Edit Condition:

1. Numbers only.
  2. Should not exceed "State Medicaid Managed Care Enrollment and/or "State Medicaid Enrollment".
-

## DATA ELEMENT: POPULATION CATEGORIES INCLUDED ENROLLMENT

### Definition:

The unduplicated number of managed care enrollees for each population category that's enrolled in the managed care entity. This data element should only capture the population categories that were enrolled in the managed care entity.

- **Section 1931 Children and Related Populations** are AFDC (sometimes referred to as TANF) -related children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
- **Section 1931 Adults and Related Populations** are AFDC (sometimes referred to as TANF) -related adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
- **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Blind/Disabled Adults who are age 65 or older should be reported in this category, not in Aged.
- **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
- **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.
- **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.
- **Title XXI CHIP** is an optional group of targeted low income children who are eligible to participate in Medicaid if the State decides to administer the Children's Health Insurance Program (CHIP) through the Medicaid program, as a Medicaid expansion.
- **Special Needs Children (State Defined)** are Medicaid beneficiaries who are special needs children as defined by the State.
- **Special Needs Children (BBA Defined)** are children on SSI, children in foster care or out-of-home placement, and children eligible for and receiving Title V services, and "Katie Beckett" children who are eligible for an institutional level of care.

- **Poverty Level Pregnant Women (SOBRA)** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.
- **Medicare Dual Eligibles** -- Individuals entitled to Medicare and eligible for some or all category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E)).
- **Other** - enrollees that don't fall under any of the categories above.

Edit Condition:

1. Must be numeric.
2. The total of all populations categories included for the managed care entity should equal to the "number of Managed Care Entity Enrollees".
3. Should not exceed the "Number of Managed Care Entity Enrollees", "State Medicaid Managed Care Enrollment" and/or "State Medicaid Enrollment".

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## DATA ELEMENT: STATE MEDICAID ENROLLMENT

Definition: The unduplicated number of Medicaid eligibles in the State as of 7/1/2011. Include retroactive eligibles in the total count. Retroactive eligibles include those persons who filed applications for Medicaid after 7/1/2011 and were determined eligible retroactively for a period of time, which included 7/1/2011. Include up to 3 months (reporting period) of retroactive eligibles. If applicable this number should also include QMB, SLMB, QI, QDWI, and Medicaid-only Dual Eligibles (Non QMB, SLMB, QDWI, or QI). If applicable, this number should also include any 1115 expansion, PACE, and CHIP populations (but include CHIP **only if** it is operated as a Medicaid expansion program).

- QMB (Qualified Medicare Beneficiary)-Refers to a low-income Medicare beneficiary for whom Medicaid must cover the costs of Medicare premiums, copayments and deductibles.
- SLMB (Specified Low-income Medicare Beneficiary)-Refers to an individual who meets the QMB criteria for Medicaid assistance, except for having slightly higher income. Medicaid must pay the Medicare Part B premiums for people who meet the SLMB standards.

- QI-These individuals are entitled to Medicare Part A, have income of at least 120% FPL, but less than 135% FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.
- Qualified Disabled and Working Individuals (QDWIs) - These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.
- Medicaid only Dual Eligibles (Non QMB, SLMB, QDWI, or QI) - These individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, QDWI or QI. Typically, these individuals need to spend down to qualify for Medicaid or fall into a Medicaid eligibility poverty group that exceeds the limits listed in other dual eligible groups. Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but only to the extent that the Medicaid rate exceeds any Medicare payment for services covered by both Medicare and Medicaid. Payment by Medicaid of Medicare Part B premiums is a State option.

Valid Choices:

Numeric Field =number of Medicaid eligibles in the State

Edit Condition:

1. Numbers only (0 not valid number).

\*\*\*NOTE: This should be an UNDUPLICATED COUNT--For example, if a beneficiary obtains their medical service under traditional FFS and get their mental health and/or dental services through a capitated managed care entity, this beneficiary should be counted only once.

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## **DATA ELEMENT: STATE MEDICAID DUAL ELIGIBLE ENROLLMENT**

Definition: The unduplicated number of Medicaid dual eligible in the State as of 7/1/2011. Include retroactive dual eligibles in the total counts. Retroactive eligibles include those dual eligibles who filed applications for



Medicaid after 7/1/2011 and were determined eligible retroactively for a period of time, which included 7/1/2011. Include up to 3 months (reporting period) of retroactive dual eligibles. This number should include QMB, SLMB, QI1, QI2, QDWI, and Medicaid-only Dual Eligibles (Non QMB, SLMB, QDWI, or QI).

- o QMB (Qualified Medicare Beneficiary)-Refers to a low-income Medicare beneficiary for whom Medicaid must cover the costs of Medicare premiums, copayments and deductibles.
- o SLMB (Specified Low-income Medicare Beneficiary)-Refers to an individual who meets the QMB criteria for Medicaid assistance, except for having slightly higher income. Medicaid must pay the Medicare Part B premiums for people who meet the SLMB standards.
- o QI-These individuals are entitled to Medicare Part A, have income of at least 120% FPL, but less than 135% FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.
- o Qualified Disabled and Working Individuals (QDWIs) - These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.

Valid Choices:

Numeric Field = number of partial dual eligibles in the State  
Numeric Field = number of full dual eligibles in the State  
Number Field = number of partial and full eligibles in the State

Edit Condition:

2. Numbers only (0 not valid number).

\*\*\*NOTE: This should be an UNDUPLICATED COUNT--For example, if a dual eligible obtains their medical service under traditional FFS and get their mental health and/or dental services through a capitated managed care entity, this dual eligible should be counted only once.

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## DATA ELEMENT: STATE DUPLICATED ENROLLMENT

Definition: The total number of Medicaid managed care enrollees in the State who are enrolled in more than one managed care entity. For example, a beneficiary receives their medical services from one managed care entity but receives optional, specialized services (e.g. mental health, dental, transportation.) through another managed care entity as of 7/1/2011.

Valid Choices:

Numeric Field = number of Medicaid eligibles in the State who are services from more than one managed care entity.

Edit Condition:

1. Must be numeric.
- 

## DATA ELEMENT: STATE MEDICAID MANAGED CARE ENROLLMENT

Definition: The unduplicated number of managed care enrollees as of 7/1/2011. This number should include all beneficiaries that were enrolled in all managed care entities (PCCMs, MCOs, PIHPs, PAHPs, HIOs, PACE, Other, etc) to receive Medicaid services as of 7/1/2011. The total should include QMB, SLMB, QI, QDWI, and Medicaid only Dual Eligibles (Non QMB, SLMB, QDWI, or QI) if they were enrolled in a managed care entity. If applicable, this number should also include any 1115 expansion and CHIP populations if they were enrolled in a managed care entity.

Valid Choices:

Numeric Field = number of Medicaid managed care enrollees in the State

Edit Condition:

1. Must be numeric.
2. Should not exceed "State Medicaid Enrollment".

\*\*\*NOTE: THIS SHOULD BE AN UNDUPLICATED COUNT -- For example, if a beneficiary obtains their medical services through a capitated managed care entity and get their mental health and/or dental services through another capitated managed care entity, this beneficiary should only be counted once.

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## DATA ELEMENT: 1115 ELIGIBILITY EXPANSION ENROLLMENT

Definition: The number of Medicaid eligibles who became eligible for Medicaid as a result of a coverage expansion authorized under section 1115(a)(2) of the Social Security Act, as of 7/1/2011. This number should not include ANY individuals who are eligible under the State's state plan.

Valid Choices:

Numeric Field =Number of State Medicaid expansion enrollment.

Edit Condition:

4. Must be numeric. **"0" is valid.**
  5. Must complete if Operating Authority is "1115".
  6. Disable field if Operating Authority is not "1115".
  7. Should not exceed the "State Medicaid Managed Care Enrollment" and/or "State Medicaid Enrollment".
- 

## DATA ELEMENT: NUMBER OF MANAGED CARE ENTITY DUAL ELIGIBLES

Definition: The unduplicated number of dual eligible beneficiaries enrolled in the managed care entity on 7/1/2011. This is an aggregate number and should include all dual eligible beneficiaries enrolled in managed care entity. For MCOs, PIHPs, PAHPs, HIOs, and PACE, provide the unduplicated number of dual eligible beneficiaries of each individual managed care entity. For PCCMs, provide the unduplicated number of dual eligible beneficiaries as a whole (not the enrollment number of each PCP). For PACE, provide the unduplicated number of dual eligible beneficiaries that are receiving some or all benefits from Medicaid not strictly Medicare beneficiaries.

Valid Choices:

Numeric Field =Number of dual eligibles enrolled in the managed care entity.

Edit Condition:

1. Numbers only (0 is valid).

2. Should not exceed “Managed Care Entity Enrollees” and/or “State Medicaid Enrollment and/or “State Medicaid Managed Care Enrollment”.
- 

### **DATA ELEMENT: UNIQUE CIRCUMSTANCES**

Definition: Unique circumstances are those that are not captured in prior data elements to explain or identify any special conditions associated with any of the managed care entity names.