Indiana Medicaid Managed Care:

OFFICE OF MEDICAID POLICY AND PLANNING
FAMILY AND SOCIAL SERVICES ADMINISTRATION
STATE OF INDIANA

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SECTION I. INTRODUCTION

MANAGED CARE GOALS, OBJECTIVES, OVERVIEW

Overview of Indiana Health Coverage Programs

Indiana continues to engage in activities to improve the lives of its members through thoughtful planning and concentration toward health care cost, quality, and timely access in Medicaid managed care. This strategy applies an interdisciplinary, collaborative approach through partnerships with enrollees, governmental departments and divisions, providers, contractors, care management organizations (CMOs, MCEs or contracted health plans), academics, and community and advocacy groups.

The Indiana Family and Social Services Administration (FSSA) is the single state agency responsible for administering Medicaid programs. Medicaid provides vital health care to nearly one in six Hoosiers. Health care coverage may be through the Hoosier Healthwise program (HHW), Children's Health Insurance Program (CHIP), Healthy Indiana Plan (HIP), Care Select (CS) or fee-for-service. Combined, HHW, CHIP, HIP and CS are referred to as Care Programs.

The FSSA is charged with oversight of the managed care entities and the care management organizations through reporting, contract compliance and quality initiatives specific to HHW, CHIP, HIP, and Care Select programs. The FSSA Operations Team works with the Office of Medicaid Policy and Planning (OMPP) Quality/Policy Team. The Quality/Policy team monitors data and reporting and seeks opportunities to enhance the quality of care provided to beneficiaries. The Operations team provides contract compliance monitoring and supervision. Data collection and reporting is facilitated through contracted health plan quarterly and annual reporting as well as the Enterprise Data Warehouse.

The OMPP Quality/Policy team utilizes the efforts of on-going activities with contract compliance and data reporting to identify areas of improvement. To this end, the Managed Care Entities (MCEs) and Care Management Organizations (CMOs) must meet FSSA contract requirements which include a Quality Management and Improvement Program (QMIP) to monitor, evaluate and take action on aspects that impact the quality of care provided to members. Four important components of the QMIP are the plan's Consumer Assessment of Healthcare Providers and Systems (CAHPS), Healthcare Effectiveness Data and Information Set (HEDIS), meeting the requirements of the National Committee for Quality Assurance (NCQA) and addressing opportunities for improvements identified in the External Quality Review. As a portion of each plan's QMIP, each plan must annually conduct and submit to OMPP the CAHPS results, the HEDIS results and the NCQA rankings.

With consideration of the delivery of healthcare to Hoosiers via a managed care model, it is Indiana's goal to ensure that the contracted health plans not only perform the administrative functions of a typical insurer, but also be adept at addressing the unique challenges and needs of low-income populations, as well as manage and integrate care along the continuum of health care services. The OMPP expects the contracted health plans to:

- Improve overall health outcomes
- Foster personal responsibility and healthy lifestyles
- Develop informed health care consumers by increasing health literacy and providing price and quality transparency
- Improve access to health care services

- Engage in provider and member outreach regarding preventive care, wellness and a holistic approach
- Develop innovative utilization management techniques that incorporate member and provider education to facilitate the right care, at the right time, in the right location

To ensure that these expectations are met, the State oversees the allocation of care administratively, fiscally and through the delivery of member services, provider services, service utilization, care management, and claims payments. The OMPP may invoke corrective action(s) when a contracted health plan or CMO fails to provide the requested services or otherwise fail their contractual responsibilities to the State. It is the mission of the State to ensure that members receive services in an efficient and effective manner.

The three MCEs contracted with the State of Indiana are Anthem Insurance Companies, Inc. (Anthem), Coordinated Care Corporation, Inc. d/b/a Managed Health Services (MHS), and MDwise, Inc. The Care Select program contracts with two care management organizations (CMOs), ADVANTAGE Health Solutions and MDwise Inc. The contracted health plans and CMOs are expected to achieve the goals and objectives set forth by the OMPP and manage the care of enrolled members of the Hoosier Healthwise, Healthy Indiana Plan and Care Select

The OMPP has identified four overarching aims that equally support Hoosier Healthwise, HIP and Care Select goals and objectives. These are:

1. **Quality** – Monitor quality improvement measures, and strive to maintain high standards
   a) Improve health outcomes
   b) Encourage quality, continuity and appropriateness of medical care

2. **Prevention** – Foster access to primary and preventive care services with a family focus
   a) Promote primary and preventive care
   b) Foster personal responsibility and healthy lifestyles

3. **Cost** – Ensure medical coverage in a cost-effective manner
   a) Deliver cost-effective coverage
   b) Assure the appropriate use of health care services
   c) Ensure Utilization Management best practices

4. **Coordination/Integration** – Encourage the organization of patient care activities to ensure appropriate care
   a) Integrate physical and behavioral health services
   b) Emphasize communication and collaboration with network providers

HISTORY AND OVERVIEW OF INDIANA CARE PROGRAMS

Collectively, Hoosier Healthwise, Healthy Indiana Plan, and Care Select share in the goals of ensuring access to primary and preventive care services seeking to improve quality, continuity and appropriateness of medical care.

- **Hoosier Healthwise (HHW)** - Indiana established the Hoosier Healthwise program in 1994 under the administration of the OMPP. The State first introduced a Primary Care Case Management (PCCM) delivery system called *Prime*Step. Two years later, the State added a Risk-Based Managed Care (RBMC)

delivery system made up of MCE contracted health plans, which are Health Maintenance Organizations (HMOs), authorized by the Indiana Department of Insurance, and contracted with the OMPP.

Hoosier Healthwise Historical Timeline:

- **1994** Began with PCCM delivery system
- **1996** Enrollment into MCE contracted health plans was optional
- **1998** Expanded to include CHIP Package A (Medicaid Expansion; up to 150% FPL)
- **2000** Expanded to include CHIP Package C (Separate State-designed benefit package; to 200% FPL)
- **2005** Enrollment into MCE contracted health plans became mandatory statewide, PCCM discontinued
- **2007** New MCE contracted health plans contract cycle; Behavioral health "carved-into" MCE contracted health plans capitation
- **2007** Expansion of pregnancy-related coverage (Package B) from 150 to 200 %FPL
- **2008** Expansion of CHIP Package C from 200 to 250 %FPL;
- **2009** Implementation of Open Enrollment (Plan Lock-in); Notification of Pregnancy (NOP); and Rx carve-out implemented.
- **2011** HIP and Hoosier Healthwise aligned under a family-focused approach.

Hoosier Healthwise provides health care coverage for low income families, pregnant women, and children. The program covers medical care like doctor visits, prescription medicine, mental health care, dental care, hospitalizations, surgeries, and family planning at little or no cost to the member or the member's family.

Hoosier Healthwise members are eligible for benefits either through Medicaid or through the Children's Health Insurance Program (CHIP). CHIP health care coverage is for children up to age 19 and available to members who may earn too much money to qualify for the standard Hoosier Healthwise coverage. A child may be covered in CHIP Package C by paying a low-cost monthly premium.

Hoosier Healthwise Strategic Objectives for Quality Improvements, 2014

The development of the Quality Strategy Initiatives are based on identified trends in health care issues within the state of Indiana, attainment of the current quality strategy goals, close monitoring by OMPP of the managed care entities' performance and unmet objectives, opportunities for improvement identified in the EQR and issues raised by external stakeholders and partners. OMPP has outlined 2014 initiatives specific to the Hoosier Healthwise Program (See Table 1).Some of these objectives have been monitored and maintained from previous years, while other measures are new for the 2014 Quality Strategy.

TABLE 1	2014 Hoosier Healthwise Initiatives	
OBJECTIVE	METHODOLOGY	GOAL
1. Improvements in Children and Adolescents Well-Care: Percentage of members with well child visits during first 21 years of life. HEDIS measure using hybrid data.	The OMPP utilizes HEDIS measures for tracking the percentages of well-child services in children and adolescents.	Achieve at or above the 90th percentile for improvements in children and adolescent well-child (HEDIS).
2. Early Periodic Screening, Diagnosis and Treatment (EPSDT)	The OMPP is aligning its EPSDT program requirements with the American Academy of Pediatrics Bright Futures Guidelines. OMPP anticipates the contracted health plans will provide follow-up and outreach to providers about the Bright Futures Guidelines and provider toolkits.	Improve the EPSDT participation rate to 80% in 2014.
3. Improvement in Behavioral Health: Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders	The OMPP uses HEDIS measures for tracking the percentages of members receiving follow-up.	Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).
4. Ambulatory Care: Number of outpatient and emergency department visits per member months	The OMPP is using HEDIS AMB to track the utilization of ambulatory outpatient and emergency department visits to promote best practices in Utilization Management.	Achieve at or above the 75 percentile of Ambulatory Outpatient Care Visits (HEDIS). Achieve at or below the 10% percentile of Ambulatory Emergency Department Care Visits (HEDIS).
5. Smoking Cessation: Percentage of smokers advised to quit during at least one visit with health care provider during measurement year.	The OMPP will utilize the CAHPS survey for tracking the percentages of members advised to quit smoking.	Achieve at or above 50th percentile for members who are advised to quit during at least one visit with a health care provider.
6. Diabetes Care: Percentage of diabetic members that received a LDL-C screening during the measurement year.	The OMPP is using HEDIS measures for tracking the percentages of members who receive a LDL-C Screening.	Achieve a rate at or above the 75th percentile of diabetic members who receive a LDL-C Screening.

7. FULL TERM PREGNANCY Decrease the number of elective inductions and cesareans.	The OMPP has developed collaboration with the contracted health plans and external stakeholders to reduce the number of elective inductions and cesarean deliveries prior to 39 weeks gestation to improve birth outcomes.	Achieve a rate of less than 27% Cesarean Delivery Rate.
8. Frequency of Prenatal (HEDIS), Post-Partum Care	The OMPP is using HEDIS measures for tracking the percentage of women receiving prenatal and postpartum care. Prenatal care – HEDIS FPC Post-partum care – PPC	Achieve at or above the 90th percentile for the frequency of prenatal, and at or above the 90th percentile for post-partum care.
9. Notification of Pregnancy (NOP): Increase the number of provider completed NOP forms to identify high-risk pregnancies for case management by the MCEs.	The Neonatal Quality Subcommittee will review utilization of NOP forms on a quarterly basis and develop initiatives as necessary to meet objectives.	Increase the overall number of provider submitted NOP forms by 1% above 2013 rate.
10. Monitoring Presumptive Eligibility for Pregnant Women (PE): Improve access to early prenatal care for low income pregnant women through PE.	The Neonatal Quality Subcommittee will review utilization of PE applications on a quarterly basis and collaborate with MCEs and other stakeholders to meet objectives.	Increase the number of submitted PE applications during the 1st trimester of pregnancy by 2%.
11. Right Choices Program (RCP): Provide quality healthcare through healthcare management; RCP administrators conduct utilization reviews, create a care coordination team and collaborate with the member to assure that the member receives appropriate, medically necessary care.	The OMPP monitors monthly data to assess the contracted health plans' utilization management efforts to reduce inappropriate hospital, pharmacy, and physician utilization while making efforts to improve the member's health status and increase provider participation in the RCP program.	Achieve at or above the 96% of the RCP Periodic reviews that are completed on time.

- **Healthy Indiana Plan (HIP) -** Indiana established the Healthy Indiana Plan in 2008 under the administration of the OMPP. HIP is a health insurance program for uninsured adults between the ages of 19 and 64. HIP is a state-sponsored program and requires minimal monthly contributions from the participant. It offers health benefits including hospital services, mental health care, physician services, prescriptions and diagnostic exams.

- **Healthy Indiana Plan - Enhanced Services Plan (HIP-ESP)** – The HIP-ESP was a special plan for some HIP enrollees with certain high risk medical conditions and administered by the Indiana Comprehensive Health Insurance Association (ICHIA). Members were screened for high cost, complex medical conditions such as cancer, HIV/AIDS, hemophilia, transplants, and aplastic anemia. Due to changes with the ACA, this group of members are now included in the HIP program and no longer a stand-alone program

  Healthy Indiana Plan & Enhanced Services Plan Historical Timeline:

  - **2007** Indiana Check-up Plan legislation signed into law authorizing the Healthy Indiana Plan and a Request for Services is released to procure health plans; Initial 1115 Demonstration Waiver Application submitted to CMS and is approved in December; DFR began processing applications
  - **2008** Enrollment into HIP began
  - **2009** HIP waitlist began. Waitlist opened in November of 2009 and five thousand (5,000) individuals on waitlist invited to apply for the Healthy Indiana Plan
  - **2011** Implementation of the POWER account debit card; HIP and Hoosier Healthwise aligned under a family-focused approach; HIP opens 8,000 slots and waitlist members are invited to apply
  - **2014** HIP-ESP is folded into the HIP program

  The Hoosier Healthwise and the Healthy Indiana Plan were aligned in 2011 to function under a family-focused approach. The family-approach between these two programs allows a seamless experience for Hoosier families to establish a medical home model for increased continuity of care. The programs remain two distinct programs with two waivers/demonstrations from the federal government.

  <u>HIP Strategic Objectives for Quality Improvement 2014</u>

  Table 2, demonstrates the objectives specific to the OMPP's Healthy Indiana Plan. Some of these objectives have been monitored and maintained from previous years while other measures are new for the 2014 quality strategy.

TABLE 2	**2014 Healthy Indiana Plan Initiatives**	
GOAL/OBJECTIVE	**METHODOLOGY**	**MEASURE**
1. Access to Care: HIP members shall have access to primary care within a maximum of 30 miles of the member's residence; and at least two providers of each specialty type within 60 miles of member's residence	The MCO must ensure that each member has an ongoing source of primary care appropriate to the member's needs	90 % of all HIP members shall have access to primary care within a minimum of 30 miles of member's residence; and at least two providers of each specialty type within 60 miles of member's residence

2. POWER Account Roll-Over: HIP members that obtain a preventive exam during the measurement year receive power account roll-over. Only codes and code combinations listed in the categories 'Preventive Care Counseling Office Visit' and 'Alternative Preventive Care Counseling Visit' apply to this measure	The OMPP will track the number of HIP members who receive a qualifying preventive exam.	Achieve at or above 85 % of the number of members who receive a preventive exam during the year
3. ER Admissions per 1000 member months.	The OMPP is using HEDIS measures for tracking ER admissions per 1000 member months.	Achieve at or below 80 visits per 1000 member months
4. Improvement in Behavioral Health: Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders	The OMPP is using HEDIS measures for tracking the percentages of members receiving follow-up.	Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders
5. Ambulatory Care: Number of outpatient and emergency department visits per member months	The OMPP is using HEDIS AMB as a data based evidence to promote best practices in Utilization Management.	Achieve at or above the 90% percent of Ambulatory Care Visits (HEDIS)
6. Smoking Cessation: Smokers advised to quit smoking during at least one visit with health care provider.	The OMPP will utilize the CAHPS survey for tracking the percentages of members advised to quit smoking.	Achieve at or above 50th percentile for members who are advised to quit smoking during at least one visit with a health care provider
8. Right Choices Program (RCP): Provide quality healthcare through healthcare management, RCP administrators conduct utilization reviews, create a care coordination team and collaborate with the member to assure that the member receives appropriate, medically necessary care.	The OMPP monitors monthly data to assess the MCEs' utilization management efforts to reduce inappropriate hospital, pharmacy, and physician utilization while making efforts to improve the member's health status and increase provider participation in the RCP program.	Achieve at or above the 96% of the RCP Periodic reviews that are completed on time

- **Care Select** - health care program serving Medicaid recipients who may have special health needs or benefit from specialized attention. Care Select assists members in coordinating health care benefits tailored to the individual's needs, circumstances and preferences. Members served by Care Select may

be aged, blind, disabled, wards of the court and foster children or children receiving adoptive services and/or have significant medical conditions.

Care Select Historical Timeline:

- **November 2007** - Start of Care Select program in the Central Region
- **February 2008** - Auto-assignment began in the Central Region
- **March 2008** – Rollout of Care Select program in other regions
- **June 2008** - Auto-assignment of remaining members
- **July 2008** - Inclusion of wards and fosters in Care Select
- **January 2009** - Auto-assignment of wards and fosters in Care Select
- **January 2010** – Auto-assignment of remaining HCBS waiver members into Care Select
- **October 2010** – Redesign of Care Select
- **February 2014** – Redesign of Care Select, added COPD as a disease state

The Indiana Care Select program is a primary care case management program including disease management, care management and complex case management designed to individually tailor healthcare benefits to people more effectively, improve the quality of care and health outcomes, and provide a more holistic approach to member's chronic conditions. The Care Select program is designed to focus on members with asthma, diabetes, congestive heart failure or coronary heart disease, chronic obstructive pulmonary disease, hypertension, chronic kidney disease, severe mental illness, serious emotional disturbance, and depression. Chronic obstructive pulmonary disease was added in 2014 to address the large number of individuals with pulmonary related emergency department and inpatient hospitalization visits.

The Care Select program contracts with two care management organizations (CMOs), ADVANTAGE Health Solutions and MDwise, Inc.

Care Select Strategic Objectives for Quality Improvement, 2014

Table 3 demonstrates the objectives specific to the Care Select program. Some of these objectives have been monitored and maintained while other measures are new for the 2014 quality strategy. New measures are intended to evaluate the health outcomes and positive impact on members' lives achieved in the Care Select program through an analysis of trend data for calendar years 2012 and 2013.

TABLE 3	**2014 Care Select Initiatives**	
GOAL/OBJECTIVE	**METHODOLOGY**	**MEASURE**
1. Outpatient Visits (HEDIS AMB) Percentage of outpatient visits	Administrative reporting using HEDIS specifications.	More than 55% of members will have one outpatient visit.
2. Inpatient Bounce Back (30 days) (≤16%): (HEDIS). **ED Visits (< 12%)(HEDIS AMB)** Percentage of members who experience an ED visit	Administrative reporting using HEDIS specifications	Less than 12% of members will experience an ED visit

3. Improvement in Behavioral Health: * Number of follow-ups within 7 days of discharge from hospitalization for mental health disorder. * Number of members readmitted within 30 days who had a follow-up within 7 days of initial discharge. * Number of members with bridge appointments following initial discharge.	Administrative reporting using HEDIS specifications.	Less than 16% of members will be readmitted to inpatient hospitalization 30 days for the same complaint.
4. Ambulatory and Preventive Care (HEDIS AAP)	Administrative reporting	Percentage of members who receive ambulatory and preventive care above the 50th percentile of NCQA Medicaid (2013).
5. **Completion of Health Risk Assessments (≤73%)**	Administrative reporting	Percentage of newly enrolled MCE members, net of terminated members that have had a health screen assessment completed within 120 days.
6.Pharmacotherapy Management of COPD Exacerbation(HEDIS PCE)	Administrative reporting	At or above the 25th percentile of NCQA Medicaid.
7. Care Select members – to provide more effective and ongoing health promotion and disease prevention activities	Administrative reporting	Number of members identified by stratification level, program participation length and average contacts per member per month.
8. Complex Case Management - to effectively tailor benefits to member need.	Administrative reporting	Number of CCM members by disease state, total contacts and average contacts per reporting period.
9. Provider involvement - to effectively tailor benefits to member need.	Administrative reporting	Number of providers involved in care plan development and reviews.
10. Cost Savings – to manage the growth of health care costs for Care Select members	Administrative reporting	Number of members by aid category, paid claims, total expenditures, average expenditure per service.

Overview of Traditional Medicaid Populations

The Indiana Traditional Medicaid Population is comprised of those groups of members not currently enrolled in Hoosier Healthwise, Healthy Indiana Plan or Care Select. Individuals either may be waiting for primary care provider assignment, or are being served through other programs such as Medicare or special aid categories such as the breast and cervical cancer programs.

OMPP has identified those individuals in traditional Medicaid due to the following reasons:

- Receiving Medicare and Medicaid benefits,
- Spend-down status,

- Receiving Home and Community Based Services Waiver benefits,
- Awaiting an assignment with Hoosier Healthwise or Care Select,
- Receiving care in a nursing facility or other state operated facility, or
- On a specific Medicaid aid category, such as Refugee or the Breast and Cervical Cancer aid Category.

On June 1, 2014 Indiana Medicaid members will no longer have spend-down and will be eligible based on another aid category.

Traditional Medicaid Strategic Objectives for Quality Improvement 2014

In 2014, the OMPP will continue efforts to involve the traditional Medicaid population into the overall quality improvement efforts. OMPP will look at baseline data for two questions regarding the Traditional Medicaid population:

- How healthy are they?
- What type of care are they receiving?

Table 4 shows the initiatives for which baseline data will be analyzed.

TABLE 4	2014 Traditional Medicaid Initiatives	
GOAL/OBJECTIVE	**METHODOLOGY**	**MEASURE**
1. Preventive Care (HEDIS AAP-like)	Administrative reporting through EDW using HEDIS specifications.	Establish baseline data
2. Outpatient Ambulatory Visits (HEDIS AMB-like for outpatient)	Administrative reporting through EDW using HEDIS specifications	Establish baseline data

Development and Review of Quality Strategy

The OMPP constantly monitors the trends across healthcare in the state of Indiana. Quality measures monitor the determination of the contracted health plans to improve the landscape. External stakeholders bring issues to light, and the OMPP thoughtfully considers the impact facing the state. Regular meetings are reserved for the OMPP executive staff and the contracted health plan participants. The quarterly meetings typically have included information specific to all care programs. A review of each program's accomplishments, paired with a fiscal analysis concerning program expenditures, allows the OMPP to continue to progress through the strategic initiatives, making adjustments as necessary. Efforts moving forward will continue to focus on improving the delivery of healthcare to increase the quality and longevity of life for Hoosiers enrolled in Medicaid, with an additional consideration of the fiscal health of the State.

Individual initiative reports are presented to the Quality Strategy Committee. The role of the Committee is to assist in development and monitoring of identified goals and strategic objectives of the written Quality Strategy and to advise and make recommendations to the OMPP. The Quality Unit reports to the OMPP Quality Director, who reports directly to the OMPP Deputy Medicaid Director. The Quality Director is the

sponsor of the Quality Strategy Committee and chairs the meetings. Currently, the members of the Quality Strategy Committee include representatives from:

- Office of Medicaid Policy and Planning (OMPP)
- Division of Mental Health and Addiction (DMHA)
- Indiana State Department of Health (ISDH)
- Providers (pediatrician, adult health, behavioral health)
- Health Plan Quality Managers
- Advocacy groups
- Consumers
- Providers
- Academia
- Each of the 2014 quality initiative subcommittees:
    - Neonatal Quality, and
    - Health Services Utilization Management Quality.

The state will continue to hold Quality Strategy meetings quarterly with these representatives to discuss progress of quality improvement projects, quality subcommittee activities, and reports of outcomes measures. The health plans must submit updated quality improvement projects to the OMPP for review each quarter. Hoosier Healthwise/HIP MCEs and Care Select CMOs submit quarterly clinical quality measures reports in various areas, such as the following:

- Preventative Health
- Prenatal and Postpartum Health Outcomes
- Children and Adolescents Preventative Care, and
- Behavioral Health.

The contracted health plans continue to include the OMPP in monthly collaboration meetings to review and discuss their on-going Performance Improvement Projects (PIPs) and Quality Management and Improvement Program (QMIP) Work Plans. The contracted health plans use the group for focused problem-solving, clarification, and joint partnership in quality reporting. These collaboration meetings will continue in 2014.

OMPP continues to schedule subcommittee meetings that are comprised of the individuals from within the stakeholder groups. The subcommittees continue to support, advise, and inform the OMPP on the performance and progress toward the initiatives identified throughout this Quality Strategy.

Table 5 provides the annual schedule of Quality Committee meetings for 2014.

TABLE 5: Annual Schedule of the Quality Strategy Committee and Subcommittees

Meeting	Description	Frequency	2014 Dates
Quality Strategy	Oversight of other focus groups, providing input for overarching Quality Strategy.	Quarterly, 1-3 pm	3/12, 6/11, 9/10 and 12/10

Neonatal Quality	Focus: Improve birth outcomes. Members of the group will continue to discuss and analyze data from the Presumptive Eligibility for Pregnant Women and Notification of Pregnancy projects.	Quarterly, 2-4 pm	3/18, 6/17, 9/2 and 12/2
Health Services Utilization Management	Focus: Utilization issues related to behavioral health, Right Choices Program, prior authorization issues.	Quarterly, 9-11 am	4/3, 6/26, 9/18, and 12/11
Dental Advisory Panel	Focus: The Dental Advisory Panel is to improve oral health. The Panel will provide input on dental policy and provide clinical recommendations to improve oral health and overall health of our members.	Quarterly, to be determined	7/10, 9/11, 12/11

As a result of this shared information, the stakeholders' participation and cooperation to improve performance has remained steadfast. Committee members embrace their obligation to the State of Indiana and the many Hoosiers reliant on quality healthcare. The OMPP strives to continue to raise the bar for healthcare, and improve the quality of life for thousands of infant, children, adolescent and adult Hoosiers across the State of Indiana.

The OMPP maintains an on-going review of movement within the strategic objectives through these quality committees. An annual update is performed on the progress of the Quality Strategy document, as a whole.

SECTION II. ASSESSMENT

QUALITY AND APPROPRIATENESS OF CARE

The contracted health plans must maintain an administrative and organizational structure that supports effective and efficient delivery of services to members. Furthermore, the State is continually evaluating ways to increase cost-effectiveness. The overarching goal to improve access to care prevails throughout the quality improvement efforts of the OMPP, and is embedded into the expectation of the contracted health plans.

NATIONAL PERFORMANCE MEASURES

The contracted health plans must monitor, evaluate and take effective action to identify and address needed improvements in the quality of care delivered to members in the Hoosier Healthwise, HIP, and Care Select programs. This includes necessary improvements by all providers in all types of settings. In compliance with state and federal regulations, the contracted health plans submit quality improvement data, including data that meets HEDIS standards for reporting and measuring outcomes, to OMPP. This includes data on the status and results of performance improvement projects. Additionally, the contracted health plans submit information requested by OMPP to complete the State's Annual Quality Assessment and Improvement Strategies Report to CMS.

MONITORING AND COMPLIANCE

The State conducts multiple monitoring activities to maintain oversight and allegiance to stated goals within this Quality Strategy. Monitoring activities include:

- QMIP Work Plans
- Data Analysis
- Enrollee hotlines operated by the State's Enrollment Broker
- Geographic mapping for provider network
- External Quality Review (EQR)
- Network adequacy assurance submitted by plan
- On-site Monitoring Reviews
- Recognized performance measures reporting
- Surveys

The FSSA Operations oversees contract compliance by enforcing reporting requirements mandated within the contracted health plans' contracts. Each contracted health plan is required to document outcomes and performance results, as instructed within each program reporting manual, to demonstrate data reliability, accuracy, and validity. The contracted health plans' Reporting Manual provides guidance by OMPP on required performance reporting for the contracted health plans contracted to deliver services for Hoosier Healthwise, HIP and Care Select. The Reporting Manual describes the reporting process, submission requirements, and descriptions and templates of all reports with a required format.

Reports are submitted monthly and quarterly, to monitor and compare clinical outcomes against targets, standards and benchmarks as set by OMPP. The FSSA Operations staff directly manages all contracted health plans report submissions. This direct management supports and deepens the OMPP's capacity to align and increase oversight processes across the contracted health plans and the programs. Through the course of this alignment, a full comparative review of the report submissions by the contracted health plans takes place to ensure that key performance indicators, both operational and clinical, are effectively being identified, collected, validated and analyzed.

FSSA Operations sends a confirmation report to the plans confirming the receipt of required data along with any inquiries related to questionable data points. An analysis memo that reviews the finalized performance results, as well as the metrics which fail to meet specified targets is returned to the plans. The alignment of program processes has continued; both the HIP and the Care Select programs have similar processes in place. These actions have been undertaken to improve accountability, compliance, and reliance on the operations and health outcome achievements of the State's contracted health plans.

While the contracted health plans are required to submit annual HEDIS data, the OMPP also collects quarterly reports on a variety of quality indicators for preventive health; children and adolescents; and mothers and newborns. This increased access to data has allowed the OMPP to continually track and monitor performance on key quality indicators and steer the focus toward improvement activities.

Additionally, OMPP and FSSA Operations staff reviews and updates the reporting manuals annually, based on current needs of the programs, and in conjunction with the contracted health plans.

This annual review triggers the following:

(1) Changes to reporting requirements
(2) Improvement of submission processes, templates and retention
(3) Manual revisions which clarify and document specification changes
(4) Increases consistency in reporting across contracted health plans

The OMPP incorporated multiple steps within the Hoosier Healthwise, HIP, and Care Select report review process to reinforce its commitment to receive quality data in a complete, timely, and accurate manner. Validation of submitted data is crucial to ensure that performance analysis is based on sound information.

EXTERNAL QUALITY REVIEW (EQR)

The OMPP contracts with Burns & Associates, Inc. (B&A) to conduct the required External Quality Reviews (EQR) for Hoosier Healthwise, the Healthy Indiana Plan (HIP) and the Indiana's Children's Health Insurance Program (CHIP). The Hoosier Healthwise and HIP EQR usually takes place during the summer months, and the results are reported in the fall each year. The CHIP EQR is conducted in the winter months and reported in the spring of each year.

In Calendar Year (CY) 2014 B&A met with the OMPP and agreed to conduct the following:

- Validation of Performance Improvement Projects via meetings with OMPP and the Contracted health plans
- Validation of Performance Measures from quarterly report submissions to OMPP from the contracted health plans
- Conduct a focus study on transportation services
- Examination of new member activities; specifically contracted health plan assignment and completion of the new member health risk screenings/assessments
- A review of experience requirements and training protocols for each contracted health plan's provider-facing staff (provider relations field staff and customer service staff).
- Conduct a focus study on claim denials

SECTION III. STATE STANDARDS

Many of the OMPP's monitoring and oversight activities address compliance with access to care and quality of services. The Care Programs unit has contracts with the contracted health plans to ensure adequate access and availability of healthcare services to Medicaid members. Contracts are written based on state and federal regulations. The following sections are extracted from the OMPP-contracted health plans' contracts.

ACCESS STANDARDS

AVAILABILITY OF SERVICES

The FSSA requires that contracted health plans must ensure that its provider network is supported by written provider agreements, is available and geographically accessible, and provides adequate numbers of facilities, physicians, ancillary providers, service locations and personnel for the provision of high-quality covered services for its members. The contracted health plans must also ensure that all of its contracted providers are registered Indiana Health Coverage Program (IHCP) providers and can respond to the cultural,

racial and linguistic needs of its member populations. The network must be able to handle the unique needs of its members, particularly those with special health care needs. The contracted health plans are required to participate in any state efforts to promote the delivery of covered services in a culturally competent manner. In some cases, members may receive out-of-network services. In order to receive reimbursement from the contracted health plans, out-of-network providers must be IHCP providers. The contracted health plans shall encourage out-of-network providers, particularly emergency services providers, to enroll in the IHCP. An out-of-network provider must be enrolled in the IHCP in order to receive payment from the contracted health plans.

The FSSA requires the contracted health plans to develop and maintain a comprehensive network to provide services to its Hoosier Healthwise and HIP members. The network must include providers serving special needs populations. For its Hoosier Healthwise population, the network must include providers serving children with special health care needs.

Maintains and Monitors Network of Appropriate Providers:

The FSSA obligates each contracted health plan to consider the following elements when developing and maintaining its provider network:

- The anticipated enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of Hoosier Healthwise and HIP members;
- The numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted services;
- The numbers of network providers who are not accepting new members; and
- The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members and whether the location provides physical access for members with disabilities.

The FSSA will assess liquidated damages and impose other authorized remedies for contracted health plan's non-compliance with the network development and network composition requirements.

Each contracted health plan must contract its specialist and ancillary provider network prior to receiving enrollment. The FSSA reserves the right to implement corrective actions and will assess liquidated damages if the contracted health plan fails to meet and maintain the specialist and ancillary provider network access standards. The FSSA's corrective actions may include, but are not limited to, withholding or suspending new member enrollment from the contracted health plan until the contracted health plan's specialist and ancillary provider network is in place. The FSSA will monitor the contracted health plan's specialist and ancillary provider network to confirm that the contracted health plan is maintaining the required level of access to specialty care. The FSSA reserves the right to increase the number or types of required specialty providers at any time.

Female Enrollee Direct Access to Women's Health Specialist

The contracted health plans must provide female members 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 female member's designated source of primary care if that source is not a woman's health specialist. The contracted health plans must have an established mechanism to permit a female member direct access such as a standing referral from the member's PMP or an approved

number of visits. The contracted health plans may also establish claims processing procedures that allow payment for certain women's health codes without prior authorization or referral.

Second Opinions:

The contracted health plans must comply with all member requests for a second opinion from a qualified professional. If the provider network does not include a provider who is qualified to give a second opinion, the contracted health plans must arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.

Adequately and Timely Coverage of Services Not Available in Network:

With the exception of certain self-referral service providers and emergency medical care, each contracted health plan may limit its coverage to services provided by in-network providers once the contracted health plan has met the network access standards. The contracted health plan must authorize and pay for out-of-network care if the contracted health plan is unable to provide necessary covered medical services within sixty (60)-miles of the member's residence by the contracted health plan's provider network. The contracted health plan must authorize these out-of-network services in the timeframes established in the contracted health plan's contract and must adequately cover the services for as long as the contracted health plan is unable to provide the covered services in-network. The contracted health plan must require out-of-network providers to coordinate with the contracted health plan with respect to payment and ensure that the cost to the member is no greater than it would be if the services were furnished in-network.

The contracted health plan may require providers not contracted in the contracted health plan's network to obtain prior authorization from the contracted health plan to render any non-self-referral or non-emergent services to Contractor members. If the out-of-network provider has not obtained such prior authorization, the contracted health plan may deny payment to that out-of-network provider. The contracted health plan must cover and reimburse for all authorized, routine care provided to its members by out-of-network providers.

The contracted health plan must make nurse practitioner services available to members. Members must be allowed to use the services of nurse practitioners out-of-network if no nurse practitioner is available in the member's service area within the contracted health plan's network. If nurse practitioner services are available through the contracted health plan, the contracted health plan must inform the member that nurse practitioner services are available.

In HIP, the contracted health plan must make covered services provided by Federally Qualified Healthcare Centers (FQHCs) and Rural Health Clinics (RHCs) available to members out-of-network if an FQHC or RHC is not available in the member's service area within the contracted health plan's network.

The contracted health plan may not require an out-of-network provider to acquire a Contractor-assigned provider number for reimbursement. An NPI number shall be sufficient for out-of-network provider reimbursement.

Out-of-Network Providers Coordinate with the contracted health plan with Respect to Payment:

Out-of-Network Provider Reimbursement – Hoosier Healthwise

The contracted health plan must reimburse any out-of-network provider's claim for authorized services provided to Hoosier Healthwise members at a rate it negotiates with the out-of-network provider, or the lesser of the following:

The usual and customary charge made to the general public by the provider; or

The established Indiana Medicaid Fee-for-Service (FFS) reimbursement rates that exist for participating IHCP providers at the time the service was rendered.

Out-of-Network Provider Reimbursement – HIP

The contracted health plan must reimburse any out-of-network provider's claim for authorized services provided to HIP members at the Medicare rate or, if the service does not have a Medicare rate, 130% of the Medicaid rate for that service.

Provider Credentialing:

All contracted health plans must have written credentialing and re-credentialing policies and procedures for ensuring quality of care is maintained or improved and assuring that all contracted providers hold current state licensure and enrollment in the IHCP. The contracted health plans' credentialing and re-credentialing process for all contracted providers must meet the National Committee for Quality Assurance (NCQA) guidelines. The same provider credentialing standards must apply across both the Hoosier Healthwise and HIP programs.

The contracted health plans shall use the FSSA's standard provider credentialing form during the credentialing process. The contracted health plans must ensure that providers agree to meet all of FSSA's and the contracted health plans' standards for credentialing PMPs and specialists, and maintain IHCP manual standards, including:

- Compliance with state record keeping requirements
- FSSA's access and availability standards
- Other quality improvement program standards

The contracted health plans' provider credentialing and selection policies must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The contracted health plan must not employ or contract with providers that have been excluded from participating in federal health care programs under Section 1128 or Section 1128A of the Social Security Act.

The contracted health plan must ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members, if the contracted health plan also serve commercial members. The contracted health plan must also make covered services available twenty four (24)-hours-a-day, seven (7)-days-a-week, when medically necessary. In meeting these requirements, the contracted health plan must:

- Establish mechanisms to ensure compliance by providers
- Monitor providers regularly to determine compliance
- Take corrective action if there is a failure to comply

Each contracted health plan must provide the FSSA written notice at least ninety (90) calendar days in advance of the contracted health plan's inability to maintain a sufficient network in any county.

Provider Incentive Program

By contract each contracted health plans must comply with Section 1876(i)(8) of the Social Security Act and federal regulations 42 CFR 438.6(h), 42 CFR 422.208 and 42 CFR 422.210 and supply to FSSA information on its plan as required in the regulations and with sufficient detail to permit FSSA to determine whether the incentive plan complies with the federal requirements provide information regarding physician incentive plans. The contracted health plan must provide information concerning its physician incentive plan, upon request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in the federal regulations. Similar requirements apply to subcontracting arrangement with physician groups and intermediate entities. Physician incentive plans must comply with the federal requirement to refrain from making any specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member. The contracted health plans must also meet requirements for stop-loss protection, member survey and disclosure requirements under 42 CFR 438.6(h).

Cultural Competency

Data on race, ethnicity, and primary language is sent to the contracted health plan via the Enrollment Roster. The OMPP expects that this information be utilized by the contracted health plan to communicate effectively and appropriately with their population. The contracted health plan must make all written information available in English and Spanish, and other prevalent non-English languages identified by the OMPP, upon the member's request. In addition, the contracted health plan must identify additional languages that are prevalent among the contracted health plan's membership. The contracted health plan must inform members that information is available upon request in alternative formats and how to obtain them. The OMPP defines alternative formats as Braille, large-font letters, audiotape, prevalent languages, and verbal explanation of written materials. All materials must be approved by the FSSA and must be culturally appropriate. Verbal interpretation services must also be available and provided by the contracted health plan upon request. The contracted health plan must also ensure that all of its contracted providers can respond to the cultural, racial, and linguistic needs of the populations that they serve.

ASSURANCES OF ADEQUATE CAPACITY AND SERVICES

The FSSA obligates all contracted health plans to:

- Serve the expected enrollment
- Offer an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled
- Maintain a sufficient number, mix and geographic distribution of providers as specified below

At the beginning of its contract with the State, the FSSA Operations requires each contracted health plans to submit regular network access reports. Once the contracted health plan demonstrates compliance with FSSA's access standards, the contracted health plan is required to submit network access reports on an annual basis and at any time there is a significant change to the provider network (i.e., the contracted health plan no longer meets the network access standards). The OMPP reserves the right to expand or revise the network requirements, as it deems appropriate. The FSSA also requires that each contracted health plan must not discriminate with respect to participation, reimbursement or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. However, the contracted health plans are not

prohibited from including providers only to the extent necessary to meet the needs of the contracted health plan's members or from establishing any measure designed to maintain quality and control costs consistent with the contracted health plan's responsibilities.

Acute Care Hospital Facilities

The FSSA requires that all contracted health plans provide a sufficient number and geographic distribution of acute care hospital facilities to serve the expected enrollment. Inpatient services are covered when such services are prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.

Primary Medical Provider (PMP) Requirements

The FSSA's managed care contracts enforce the following contractual requirements:

- PMPs are allowed to contract with one or multiple contracted health plans. A PMP may also participate as a specialist in another contracted health plans. The PMP may maintain a patient base of non-Hoosier Healthwise and HIP members (e.g., commercial, traditional Medicaid or Care Select members).
- The contracted health plans may not prevent the PMP from contracting with other contracted health plans.
- The contracted health plans must assure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. PMPs must coordinate each member's physical and behavioral health care and make any referrals necessary. In Hoosier Healthwise a referral from the member's PMP is required when the member receives physician services from any provider other than his or her PMP, unless the service is a self-referral service.
- The contracted health plans must provide access to PMPs within at least thirty (30) miles of the member's residence. Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians (Hoosier Healthwise only), gynecologists and endocrinologists (if primarily engaged in internal medicine).
- The contracted health plan's PMP contract must state the PMP panel size limits, and the contracted health plans must assess the PMP's non-Hoosier Healthwise and HIP practice when assessing the PMP's capacity to serve the contracted health plan's members. The fiscal agent will maintain a separate panel for PMPs contracted with more than one contracted health plans. The FSSA operations will monitor the contracted health plan's PMP network to evaluate its member-to-PMP ratio.
- Each contracted health plans must have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services twenty four (24)-hours-a day, seven (7)-days-a-week and that PMPs have a mechanism in place to offer members direct contact with their PMP, or the PMP's qualified clinical staff person, through a toll-free telephone number twenty four (24)-hours-a-day, seven (7)-days-a-week. Each PMP must be available to see members at least three (3) days per week for a minimum of twenty (20) hours per week at any combination of no more than two (2) locations. Each contracted health plans must also assess the PMP's non-Hoosier Healthwise and HIP practice to ensure that the PMP's Hoosier Healthwise and HIP population is receiving accessible services on an equal basis with the PMP's non-Hoosier Healthwise and HIP population.
- The contracted health plans must ensure that the PMP provide "live voice" coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The contracted health plans must also ensure that members have

telephone access to their PMP (or appropriate designate such as a covering physician) in English and Spanish twenty four (24)-hours-a-day, seven (7)-days-a-week.

- The contracted health plans must ensure that PMPs are maintaining the PMP medical care standards and practice guidelines detailed in the IHCP Provider Manual. The contracted health plans must monitor medical care standards to evaluate access to care and quality of services provided to members and to evaluate providers regarding their practice patterns.

Specialist and Ancillary Provider Network Requirements

In addition to maintaining a network of PMPs, the contracted health plans must provide and maintain a comprehensive network of IHCP provider specialists and ancillary providers.

As with PMPs, specialist and ancillary providers may serve in all contracted health plan networks. In addition, physicians contracted as a PMP with one contracted health plan may contract as a specialist with other contracted health plans.

The contracted health plans must ensure that specialists are maintaining the medical care standards and practice guidelines detailed in the IHCP Provider Manual. The FSSA requires the contracted health plans to monitor medical care standards to evaluate access to care and quality of services provided to members and to evaluate providers regarding their practice patterns.

The FSSA requires the contracted health plans to develop and maintain a comprehensive network of specialty providers, listed in Table 6 below. For providers identified with an asterisk (*), the contracted health plans must provide, at a minimum, two specialty providers within sixty (60) miles of the member's residence. For providers identified with two asterisks (**), the contracted health plans must provide, at a minimum, one specialty provider within ninety (90) miles of the member's residence.

Table 6: Specialty providers

Table 6 Network Specialties	
Specialties	**Ancillary Providers**
➢ Anesthesiologists* ➢ Cardiologists* ➢ Cardiothoracic surgeons** ➢ Dentists/Oral Surgeons (HIP only)** ➢ Dermatologists** ➢ Endocrinologists* ➢ Gastroenterologists* ➢ General surgeons* ➢ Hematologists ➢ Infectious disease specialists** ➢ Interventional radiologists** ➢ Nephrologists* ➢ Neurologists* ➢ Neurosurgeons** ➢ Non-hospital based anesthesiologist (e.g., pain medicine)**	➢ Diagnostic testing* ➢ Durable Medical Equipment providers ➢ Home Health ➢ Prosthetic suppliers**

Table 6 Network Specialties	
Specialties	**Ancillary Providers**
➢ OB/GYNs* ➢ Occupational therapists* ➢ Oncologists* ➢ Ophthalmologists* ➢ Optometrists* ➢ Orthopedic surgeons* ➢ Orthopedists ➢ Otolaryngologists ➢ Pathologists** ➢ Physical therapists* ➢ Psychiatrists* ➢ Pulmonologists* ➢ Radiation oncologists** ➢ Rheumatologists** ➢ Speech therapists* ➢ Urologists*	

The FSSA requires that the contracted health plans maintain different network access standards for the listed ancillary providers as follows:

- Two durable medical equipment providers must be available to provide services to the contracted health plan's members in each county or contiguous county
- Two home health providers must be available to provide services to each contracted health plan's members in each county or contiguous county

In addition, the contracted health plans must demonstrate the availability of providers with training, expertise and experience in providing smoking cessation services, especially to pregnant women. Evidence that providers are trained to provide smoking cessation services must be available during FSSA's monthly onsite visits. The contracted health plans must contract with the Indiana Hemophilia and Thrombosis Center or a similar FSSA-approved, federally recognized treatment center. This requirement is based on the findings of the Centers for Disease Control and Prevention (CDC) which illustrate that persons affected by a bleeding disorder receiving treatment from a federally recognized treatment center require fewer hospitalizations, experience less bleeding episodes and experience a forty percent (40%) reduction in morbidity and mortality. The contracted health plans must also arrange for laboratory services only through those IHCP enrolled laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.

Non-psychiatrist Behavioral Health Providers

The FSSA requires that the contracted health plans include psychiatrists in their networks as required above. In addition to the regular oversight that the contracted health plans provide for contracted community mental health centers (CMHCs), the contracted health plans must utilize the results of state oversight reviews to inform contracting decisions, to monitor contracted CMHCs and to develop improvement plans with contracted CMHCs.

The contracted health plans must meet the following network composition requirements for non-psychiatrist behavioral health providers:

- In urban areas, the contracted health plans must provide at least one behavioral health provider within thirty (30) minutes or thirty (30) miles;
- In rural areas, one within forty-five (45) minutes or forty-five (45) miles. The availability of professionals will vary, but access problems may be especially acute in rural areas. The contracted health plans must provide assertive outreach to members in rural areas where behavioral health services may be less available than in more urban areas.
- The contracted health plans also must monitor utilization in rural and urban areas to assure equality of service access and availability. The following list represents behavioral health providers that should be available in each contracted health plan's network:
    - Outpatient mental health clinics
    - Community mental health centers
    - Psychologists
    - Certified psychologists
    - Health services providers in psychology (HSPPs)
    - Certified social workers
    - Certified clinical social workers
    - Psychiatric nurses
    - Independent practice school psychologists
    - Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
    - Persons holding a master's degree in social work, marital and family therapy or mental health counseling (under the Clinic Option)

COORDINATION AND CONTINUITY OF CARE

If a member is also enrolled in or covered by another insurer, the contracted health plan is fully responsible for coordinating benefits so as to maximize the utilization of third party coverage. The contracted health plan must share information regarding its members, especially those with special health care needs, with other payers as specified by the FSSA and in accordance with 42 CFR 438.208(b), which relates to coordination of care. In the process of coordinating care, the contracted health plan must protect each member's privacy in accordance with the confidentiality requirements stated in 45 CFR 160 and 164, which address security and privacy of individually identifiable health information. The contracted health plan is responsible for payment of the member's coinsurance, deductibles, co-payments and other cost-sharing expenses, but the contracted health plan's total liability must not exceed what the contracted health plan would have paid in the absence of TPL, after subtracting the amount paid by the primary payer.

The FSSA requires that each contracted health plan coordinate benefits and payments with the other insurer for services authorized by the contracted health plan, but provided outside the contracted health plan's plan. Such authorization may occur prior to provision of service, but any authorization requirements imposed on the member or provider of service by the contracted health plan must not prevent or unduly delay a member from receiving medically necessary services. Each contracted health plan remains responsible for the costs incurred by the member with respect to care and services which are included in the contracted health plan's capitation rate, but which are not covered or payable under the other insurer's plan.

In accordance with IC 12-15-8 and 405 IAC 1-1-15, the FSSA has a lien upon any money payable by any third party who is or may be liable for the medical expenses of a Medicaid recipient when Medicaid provides medical assistance. The contracted health plans may exercise any independent subrogation rights it may have under Indiana law in pursuit or collection of payments it has made when a legal cause of action for damages is instituted by the member or on behalf of the member.

Coordination of Benefits – Hoosier Healthwise, Package A, B and P

If the Hoosier Healthwise member primary insurer is a commercial HMO and the contracted health plan cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the contracted health plan's rules, the contracted health plan may submit to the Enrollment Broker a written request for disenrollment. The request must provide the specific description of the conflicts and explain why benefits cannot be coordinated. The Enrollment Broker will consult with the FSSA and the request for disenrollment will be considered and acted upon accordingly.

Coordination of Benefits – HIP and Hoosier Healthwise, Package C (CHIP)

An individual is not eligible for HIP or Hoosier Healthwise Package C if they have other health insurance coverage. If the contracted health plan discovers that a HIP or Hoosier Healthwise Package C member has other health insurance coverage, they are not required to coordinate benefits but must report the member's coverage to the State. The FSSA requires each contracted health plan to assist the State in its efforts to terminate the member from HIP or Hoosier Healthwise Package C due to the existence of other health insurance.

The types of other insurance coverage the contracted health plan should coordinate with include insurance such as worker's compensation insurance and automobile insurance.

Special Needs**:**

In accordance with 42 CFR 438.208(c), the FSSA requires each contracted health plan to allow members with special needs, who are determined to need a course of treatment or regular care monitoring, to directly access a specialist for treatment via an established mechanism such as a standing referral from the member's PMP or an approved number of visits. Treatment provided by the specialist must be appropriate for the member's condition and identified needs.

In accordance with 42 CFR 438.208(c)(2), which specifies allowable staff, the FSSA requires each contracted health plan to have a health care professional assess the member through a detailed health assessment if the health screening identifies the member as potentially having a special health care need. When the further assessment confirms the special health care need, the member must be placed in care management. Each contracted health plan must offer continued coordinated care services to any special health care needs members transferring into the contracted health plan's membership from another contracted health plan. For example, Contractor activities supporting special health care needs populations must include, but are not limited to:

- Conducting the initial screening and more detailed health assessment to identify members who may have special needs
- Scoring the initial screening and more detailed health assessment results

- Distributing findings from the health assessment to the member's PMP, FSSA and other appropriate parties in accordance with state and federal confidentiality regulations
- Coordinating care through a Special Needs unit or comparable program services in accordance with the member's care plan
- Analyzing, tracking and reporting to OMPP the issues related to children with special health care needs, including grievances and appeals data
- Participating in clinical studies of special health care needs as directed by the State

COVERAGE AND AUTHORIZATION OF SERVICES

The OMPP requires all contracted health plans to operate and maintain a utilization management program. The contracted health plans may place appropriate limits on coverage on the basis of medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve their purpose. The contracted health plans are prohibited from arbitrarily denying or reducing the amount, duration or scope of required services solely because of diagnosis, type of illness or condition.

The contracted health plans must establish and maintain medical management criteria and practice guidelines in accordance with state and federal regulations that are based on valid and reliable clinical evidence or consensus among clinical professionals and consider the needs of the contracted health plans' members. Pursuant to 42 CFR 438.210(b), relating to authorization of services, the contracted health plans must:

- Consult with contracting health care professionals in developing practice guidelines and must have mechanisms in place to ensure consistent application of review criteria for authorization decisions and consult with the provider that requested the services when appropriate.
- Have sufficient staff with clinical expertise and training to interpret and apply the utilization management criteria and practice guidelines to providers' requests for health care or service authorizations for the contracted health plans 'members.
- Periodically review and update the guidelines, distribute the guidelines to providers and make the guidelines available to members upon request. Utilization management staff must receive ongoing training regarding interpretation and application of the utilization management guidelines.
- Be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by the FSSA.

The State reserves the right to standardize certain parts of the prior authorization reporting process across the contracted health plans, such as requiring the contracted health plans to adopt and apply the same definitions regarding pended, denied, suspended claims, etc.

Each contracted health plan's utilization management program policies and procedures must meet all NCQA standards and must include appropriate timeframes for:

- Completing initial requests for prior authorization of services
- Completing initial determinations of medical necessity
- Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity, per state law
- Notifying providers and members in writing of the contracted health plan's decisions on initial prior authorization requests and determinations of medical necessity

- Notifying providers and members of the contracted health plan's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity

The FSSA requires each contracted health plan to report its medical necessity determination decisions, and must describe its prior authorization and emergency room utilization management processes. When the contracted health plan conducts a prudent layperson review to determine whether an emergency medical condition exists, the reviewer must not have more than a high school education and must not have training in a medical, nursing or social work-related field.

The OMPP requires that each contracted health plan's utilization management program:

- Not be limited to traditional utilization management activities, such as prior authorization.
- Integrate with other functional units as appropriate and supports the Quality Management and Improvement Program.
- Have policies, procedures and systems in place to assist utilization management staff to identify instances of over- and under-utilization of emergency room services and other health care services, identify aberrant provider practice patterns (especially related to emergency room, inpatient services, transportation (for Hoosier Healthwise only), drug utilization, preventive care and screening exams), ensure active participation of a utilization review committee, evaluate efficiency and appropriateness of service delivery, incorporate subcontractor's performance data, facilitate program management and long-term quality and identify critical quality of care issues.
- Links members to disease management, case management and care management.
- Encourage health literacy and informed, responsible medical decision making. For example, the contracted health plan should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and obtain services in the appropriate treatment setting. Each contracted health plan is also responsible for identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care.

The OMPP requires that each contracted health plan monitors utilization through retrospective reviews and will identify areas of high and low utilization and identify key reasons for the utilization patterns. Each contracted health plan must identify those members that are high utilizers of emergency room services and/or other services and perform the necessary outreach and screening to assure the member's services are coordinated and that the member is aware of and participating in the appropriate disease management, case management or care management services. The contracted health plan must also use this data to identify additional disease management programs that are needed. Any member with emergency room utilization at least three (3) standard deviations outside of the mean for the population group must be referred to case management or care management. The contracted health plan may use the Right Choices Program (RCP) in identifying members to refer to case management or care management.

Although the contracted health plans are not responsible for paying or reimbursing most pharmacy services, the contracted health plans must monitor pharmacy utilization as identified.

As part of its utilization review, the contracted health plans should monitor access to preventive care, specifically to identify members who are not accessing preventive care services in accordance with accepted preventive care standards such as those published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. The contracted health plans must develop education, incentives and outreach plans tailored to its member population to increase member compliance with preventive care standards.

In order to monitor potential under- or over-utilization of behavioral health services, the OMPP requires contracted health plans to provide separate utilization reports for behavioral health services. The contracted health plans must particularly monitor use of services for its members with special needs and members with a diagnosis of severe mental illness or substance abuse.

STRUCTURE AND OPERATIONS STANDARD

PROVIDER SELECTION

Provider Enrollment and Disenrollment

The contracted health plans must follow established procedures to enroll and disenroll providers, including PMPs. In enrolling and disenrolling providers, the contracted health plans must distinguish whether the provider participates in Hoosier Healthwise, HIP or Care Select programs. The Managed Care Policies and Procedures Manual provides detailed information on PMP and provider enrollment and disenrollment procedures.

To process provider enrollments and disenrollments with each contracted health plan, the contracted health plan must submit the required information to the State fiscal agent through Web Interchange.

The contracted health plans must notify the State fiscal agent of the intent to disenroll a PMP within five (5) business days of the receipt/issuance of the PMP's disenrollment by the contracted health plans. The fiscal agent must receive all enrollment and disenrollment requests at least five (5) business days prior to the 24th day of the month before the date the enrollment or disenrollment becomes effective. The OMPP reserves the right to take corrective actions if the State fiscal agent is not notified in a timely manner; and to immediately disenroll any provider if the provider becomes ineligible to participate in IHCP.

If a PMP disenrolls from the Hoosier Healthwise or HIP program, but remains an IHCP provider, the contracted health plan must assure that the PMP provides continuation of care for his/her Hoosier Healthwise and/or HIP members for a minimum of thirty (30) calendar days or until the member's link to another PMP becomes effective.

When a PMP disenrolls from Hoosier Healthwise or HIP, the contracted health plan is responsible for assisting members assigned to that PMP in selecting a new PMP within the network. If the member does not select another PMP, the contracted health plan assigns the member to another PMP in network before the original PMP's disenrollment is effective.

The contracted health plan must make a good faith effort to provide written notice of a provider's disenrollment to any member that has received primary care services from that provider or otherwise sees the provider on a regular basis. Such notice must be provided within fifteen (15) calendar days of the contracted health plan's receipt or issuance of the provider termination notice.

ENROLLEE INFORMATION

Member Enrollment

Applicants for both the Hoosier Healthwise and HIP programs have an opportunity to select a contracted health plan on their application. Contracted health plans are expected to conduct marketing and outreach efforts to raise awareness of both the programs and their product. The Enrollment Broker is available to assist members in choosing a contracted health plan. Applicants who do not select a contracted health plan on their application will be auto-assigned to a contracted health plan according to the State's auto-assignment methodology.

New Member Materials

Within five (5) calendar days of a new member's enrollment, the contracted health plan sends the new member a Welcome Packet. The Welcome Packet includes a minimum of a new member letter, explanation of where to find information about the contracted health plan's provider network and a copy of the member handbook. For HIP members, the Welcome Packet also includes a member ID card and POWER Account debit card. The same card may serve as both the member ID card and POWER Account debit card. The member ID card includes the member's RID number and the applicable emergency services co-payment amount.

The Welcome Packet also includes information about selecting a PMP, completing a health screening and any unique features of the contracted health plan. For example, if the contracted health plan incentivizes members to complete a health screening, a description of the member incentive is included in the Welcome Packet. For HIP members, the Welcome Packet includes educational materials about the POWER Account and POWER Account roll over, as well as the recommended preventive care services for the member's benefit year.

PMP Selection

The FSSA requires each contracted health plan to assure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. Following a member's enrollment, the contracted health plan must assist the member in choosing a PMP. Unless the member elects otherwise, the member must be assigned to a PMP within thirty (30) miles of the member's residence.

The contracted health plan must document at least three (3) telephone contact attempts made to assist the member in choosing a PMP. If the member has not selected a PMP within thirty (30) calendar days of the member's enrollment, the contracted health plan assigns the member to a PMP. The member must be assigned to a PMP within thirty (30) miles of the member's residence, and the contracted health plan considers any prior provider relationships when making the assignment. The FSSA approves the contracted health plan's PMP auto-assignment process prior to implementation, and the process must comply with any guidelines set forth by the state.

Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians (Hoosier Healthwise only), gynecologists and endocrinologists (if primarily engaged in internal medicine).

Health Screening

Since February 2011, each contracted health plan has been required to conduct a health screening for new members. The health screening is used to identify the member's physical and/or behavioral health care

needs, special health care needs, as well as the need for disease management, case management and/or care management services. The health screening may be conducted in person, by phone, online or by mail. The FSSA requires that each contracted health plan uses the standard health screening tool developed by the state, i.e., the Health Risk Screener (HRS), but allows supplementing the health screening tool with additional questions developed by the contracted health plan. Any additions to the health screening tool must be approved by the FSSA Operations. For pregnant Hoosier Healthwise members, a completed Notification of Pregnancy (NOP) form fulfills the health screening requirement.

The health screening must be conducted within ninety (90) calendar days of a new member's enrollment in the plan. The contracted health plan is encouraged to conduct the health screening at the same time it assists the member in making a PMP selection. The FSSA requires each contracted health plan to conduct a subsequent health screening if a member's health care status is determined to have changed since the original screening, such as evidence of overutilization of health care services as identified through such methods as claims review. Non-clinical staff may conduct the health screening. The results of this health screening are transferred to the FSSA. Data from the health screening or NOP assessment form, current medications and self-reported medical conditions will be used to meet the needs of individual members. Each contracted health plan may use its own proprietary stratification methodology to determine which members should be referred to specific disease management programs, ranging from member detailing to care management. In the Care Select program, members are stratified based on their health risk assessment needs and linked to the per-member-per-month capitation rate.

The initial health screening is followed by a detailed Health Assessment by a health care professional when a member is identified through the screening as having a special health care need or when there is a need to follow up on problem areas found in the initial health screening. The detailed Health Assessment may include, but is not limited to, discussion with the member, a review of the member's claims history and/or contact with the member's family or health care providers. These interactions must be documented and shall be available for review by the OMPP. The contracted health plan must keep up-to-date records of those members found to have special health care needs based on the initial screening, including documentation of the follow-up detailed Health Assessment and contacts with the member, their family or health care providers.

Children with Special Health Care Needs

The FSSA requires each contracted health plan to have plans for provision of care for the special needs populations and for provision of medically necessary, specialty care through direct access to specialists. The Hoosier Healthwise managed care program uses the definition and reference for children with special health care needs as adopted by the Maternal and Child Health Bureau (MCHB) and published by the American Academy of Pediatrics (AAP):

> "Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

The health screening tool will assign children to one of the Living with Illness Measures (LWIM) screener health domains based on the National Committee on Quality Assurance study design. The scoring for the LWIM screener identifies a child as potentially having a special health care need if the screening identifies needs in one or more of seven (7) different health domains:

- Functional limitations only
- Dependency on devices only

- Service use or need only
- Functional limitations and a dependency on devices
- Functional limitations and a service use or need
- Dependency on devices and a service use or need
- Functional limitations, a dependency on devices and a service use or need

Member Disenrollment from contracted health plans

In accordance with 42 CFR 438.6(k), which addresses enrollment and disenrollment, each contracted health plan may neither terminate enrollment nor encourage a member to disenroll because of a member's health care needs or a change in a member's health care status. A member's health care utilization patterns may not serve as the basis for disenrollment from the contracted health plan.

The contracted health plan must notify the local county DFR office, in the manner outlined in the Managed Care Policies and Procedures Manual, within thirty (30) calendar days of the date it becomes aware of the death of one of its members, giving the member's full name, address, Social Security Number, member identification number and date of death. The contracted health plan will have no authority to pursue recovery against the estate of a deceased Medicaid member.

CONFIDENTIALITY

The contracted health plan must ensure that member medical records, as well as any other health and enrollment information that contains individually identifiable health information, is used and disclosed in accordance with the privacy requirements set forth in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (see 45 CFR parts 160 and 164, subparts A and E, which address security and privacy of individually identifiable health information). The FSSA requires that each contracted health plan comply with all other applicable state and federal privacy and confidentiality requirements and have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements.

The FSSA requires that each contracted health plan's Information Systems (IS) support HIPAA Transaction and Code Set requirements for electronic health information data exchange, National Provider Identifier requirements and Privacy and Security Rule standards. Each contracted health plan's electronic mail encryption software for HIPAA security purposes must be the same as the State's. The contracted health plan's IS plans for privacy and security shall include, but not be limited to:

- Administrative procedures and safeguards (45 CFR 164.308)
- Physical safeguards (45 CFR 164.310)
- Technical safeguards (45 CFR 164.312)

GRIEVANCE SYSTEMS

The FSSA requires each contracted health plan to establish written policies and procedures governing the resolution of grievances and appeals. At a minimum, the grievance system must include a grievance process, an appeal process, expedited review procedures, external review procedures and access to the State's fair hearing system. The contracted health plans' grievances and appeals system, including the policies for recordkeeping and reporting of grievances and appeals, must comply with state and federal regulations.

The contracted health plans' appeals process encompasses the following:

- Allow members, or providers acting on the member's behalf, thirty (30) days from the date of action notice within which to file an appeal.
- Ensure that oral requests seeking to appeal an action are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.
- Maintain an expedited review process for appeals when the contracted health plan or the member's provider determines that pursuing the standard appeals process could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

In accordance with IC 27-13-10.1-1 and IC 27-8-29-1, each contracted health plan must maintain an external grievance procedure for the resolution of decisions related to an adverse utilization review determination, an adverse determination of medical necessity or a determination that a proposed service is experimental or investigational. An external review does not inhibit or replace the member's right to appeal a contractor decision to a state fair hearing.

Member Notice of Grievance, Appeal and Fair Hearing Procedures

The contracted health plan must provide specific information regarding member grievance, appeal and state fair hearing procedures and timeframes to members, as well as providers and subcontractors at the time they enter a contract with the contracted health plan.

SUB-CONTRACTUAL RELATIONSHIPS AND DELEGATION

According to IC 12-15-30-5, subcontracts, including provider agreements, cannot extend beyond the term of the Contract between the contracted health plan and the State. A reference to this provision and its requirements must be included in all provider agreements and subcontracts.

The contracted health plan is responsible for the performance of any obligations that may result from the Contract. Subcontractor agreements do not terminate the legal responsibility of the contracted health plan to the State to ensure that all activities under the Contract are carried out. The contracted health plan must oversee subcontractor activities and submit an annual report on its subcontractors' compliance, corrective actions and outcomes of the contracted health plan's monitoring activities. The contracted health plan will be held accountable for any functions and responsibilities that it delegates.

The contracted health plan must comply with 42 CFR 438.230, which contains federal subcontracting requirements, and the following subcontracting requirements:

- The contracted health plan must obtain the approval of FSSA before subcontracting any portion of the project's requirements. Subcontractors may include, but are not limited to a transportation broker, behavioral health organizations (BHOs) and Physician Hospital Organizations (PHOs).
- All subcontractors must fulfill all state and federal requirements appropriate to the services or activities delegated under the subcontract.
- The contracted health plans must have policies and procedures addressing auditing and monitoring subcontractors' data, data submissions and performance. The Contracted health plans must integrate subcontractors' financial and performance data (as appropriate) into the contracted health plans' information system to accurately and completely report Contractor performance and confirm contract compliance.

The FSSA reserves the right to audit the contracted health plans' subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. The OMPP may require corrective actions and will assess liquidated damages, as specified in Contract Exhibit 2, for non-compliance with reporting requirements and performance standards.
If the contracted health plan uses subcontractors to provide direct services to members, such as behavioral health services, the subcontractors must meet the same requirements as the contracted health plan, and the contracted health plan must demonstrate its oversight and monitoring of the subcontractor's compliance with these requirements. The contracted health plan must require subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors.

MEASUREMENT AND IMPROVEMENT STANDARDS

Table 7 indicates the 2014 OMPP Care Programs Quality Measures which apply to Hoosier Healthwise, the Healthy Indiana Plan and Care Select. The OMPP continues a commitment to quality improvement and closely monitors the health care program goals and works closely with the contracted health plans to ensure quality improvement.

Table 7:	**OMPP Quality Measures For 2014**			
Program	**HEDIS Code**	**CAHPS**	**State Reports**	**Description**
Hoosier Healthwise P4O Goals				
	AMB		QR-GSU1	Ambulatory Care
	W15		QR-CA1	Well-Child Annual in the First 15 Months - Six or More Visits
	W34		QR-CA2	Well-Child Annual Visits in the Third, Fourth, Fifth and Sixth Years of Life
	AWC		QR-CA3	Adolescent Well Child Visits
	FUH		QR-BH2	Follow-up After Hospitalization for Mental Illness - 7-Day Follow-Up
	PPC		QR-MN3	Postpartum Care - Percentage of Deliveries with Post-Partum Visit
	FPC		QR-MN3	Frequency of Ongoing Prenatal Care
		CAHPS		Medical Assistance with Smoking and Tobacco Use Cessation
HIP P4O Goals				
	AMB		QR-GSU8	ER Admissions per 1000 Members per Month
			QR-PCC2	Roll-Over Measure – Preventative Exams
		CAHPS		Medical Assistance with Smoking and Tobacco Use Cessation
Care Select P4O Goals				
	FUH		QR-BH2	Follow-up After Hospitalization for Mental Illness - 7-Day Follow-Up

	AMB		QR-DPS1, QR-DPS2, QR-CDS	Ambulatory care
	AMB		QR-CDS	Frequency of emergency room utilization
	AAP		QR-DPS1, QR-DPS2	Adult Ambulatory and Preventive Care
			EDW/FSSA data management	Health Risk Assessments
	PCE			Pharmacotherapy Management of COPD Exacerbation*

*Calendar year 2014 is the first year for this measure.

PRACTICE GUIDELINES

Contracted health plans develop or adopt practice guidelines based on valid and reliable clinical evidence and/or through consensus of health care professionals in the field. These practice guidelines are evaluated according to the needs of Indiana Medicaid members and are periodically reviewed and updated. Periodically, the contracted health plans meet to consult on best practices and effective interventions. Practice guidelines are distributed to providers through the plans' provider relations representative visits, and/or mailings and may be available on plans' websites.

QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT

The State places great emphasis on the delivery of quality health care to Hoosier Healthwise, HIP and Care Select members. Performance monitoring and data analysis are critical components in assessing how the contracted health plans maintain and improve quality of care delivered across the State. Each reportable measure monitored by the OMPP reflects either HEDIS specification or are reflective of state initiatives. The OMPP works with the contracted health plans to establish common definitions and understanding across plans for consistency in meeting HEDIS specifications and/or meeting state needs. Contracted health plan reporting is monitored monthly, quarterly and annually. Data is compared to contract specifications, HEDIS measures and between plans. The confirmation report process allows the OMPP to provide feedback periodically to the contracted health plans on individual values.

Evaluation of reporting standards and templates is a continuous practice. As HEDIS revisions occur, the OMPP makes reporting adjustment to reflect current national benchmarking practices. As Indiana initiatives evolve, reporting changes are made to analyze the data and contract compliance. Concurrently, the development and implementation of overarching quality strategy initiatives reflects HEDIS measures and State data reporting. It is the expectation that the accuracy and comparative populations are consistent across all Medicaid programs.

The OMPP identified Pay-for-Outcomes measures by program. As illustrated in Table 1, a performance measure may apply to one or more health care programs. Annually, drafts of the following year's QMIP Work Plans and PIPs are submitted to OMPP for review and approval. By October 31 of each year, the Care Select QMIP Work Plans and PIPs are due to the OMPP. Likewise, by December 1 of each year the Hoosier Healthwise and Healthy Indiana Plan QMIP Work Plans and PIPs are due to the OMPP.

To assess quality strategy effectiveness and to determine strategies for the following year, the contracted health plans review and monitor current member utilization. Monitoring is conducted through data mining at the contracted health plan level as well as a review of data reports from state contractor Hewlett Packard (HP) and referrals from providers. Individuals with extensive utilization are further assessed for appropriateness in Indiana's restricted card program (known as the Right Choices Program) or for case/care/disease management programs. Individuals with underutilization are encouraged to participate in preventive care services.

Health risk assessments are used to identify individuals with special health care needs. The Indiana Care Select program provides disease management for individuals with diabetes, congestive heart failure, coronary artery disease, chronic kidney disease, severe mental illness, COPD, severe emotional disturbance, depression and/or the co-morbidities of diabetes and hypertension as well as the co-morbidities of any combination of these disease states. Hoosier Healthwise and HIP provide case management and care management programs targeting individuals with special health care needs.

The OMPP has outlined eleven (11) quality-related incentives measures in 2014. The outcome measures are composed of eight withhold measures and three bonus measures divided as follows: seven Healthcare Effectiveness Data and Information Set (HEDIS) withhold measures; one CAHPS withhold measure; and three bonus measures. Targets for HEDIS measures are reviewed annually and updated when new NCQA benchmarks become available. The State recognizes that performance improvement is an ongoing process and intends to retain targets for at least two years. This allows for a longer timeframe for initiatives to take shape. At the end of 2013, performance measures were reviewed and certain targets were dropped or added to create targets more apt to meet the needs of the Medicaid population. Contract amendments occur on an annual basis, or more frequently as needed if program changes occur. The Pay-for-Outcomes program is reviewed and updated as needed during the annual contract process.

Table 9 reflects the performance measures established by the OMPP for the Pay-for-Outcomes program – CY14.

Table 9: Pay-for-Outcomes Contracting – CY14		
Hoosier Healthwise	**Healthy Indiana Plan**	**Care Select**
P4O Measures Aligned Across Programs		
Ambulatory Care	Ambulatory Care	Ambulatory Care
Follow-up After Hospitalization for Mental Illness– 7 Day Follow-up		Follow-up After Hospitalization for Mental Illness 7 day Follow-up
Medical Assistance with Smoking and Tobacco Use Cessation	Medical Assistance with Smoking and Tobacco Use, Cessation, and Physicians Advising Smokers to Quit	Pharmacotherapy Management of COPD Exacerbation
Additional P4OMeasures		
Well-Child Visits in the First 15 months - Six or more visits	Roll-Over Measure – Preventative Exams	Preventive Care

Well Child Visits in the third, Fourth, Fifth and Sixth Years of Life	ER Admissions per 1000 member months	Completion of Health Risk Assessments
Postpartum Care - Percentage of Deliveries with Post-Partum Visit		
Frequency of Ongoing Prenatal Care		

The contracted health plans may receive additional compensation for attaining specific established levels. Such additional compensation is subject to the contracted health plans' complete and timely satisfaction of its obligations under the state fiscal year 2014 contract. This includes timely submission of the contracted health plans' HEDIS Report for the measurement year, the Certified HEDIS Compliance Auditor's attestation, the Consumer Assessment of Healthcare Providers and Systems report as well as timely submission of the Priority Reports.

Consumer self-report surveys allow the OMPP to gather data from the unique perspective of the Medicaid consumer. Like many other state Medicaid agencies, the OMPP has elected to use the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) to assess member satisfaction. The OMPP has required the use of the CAHPS® since measurement year 2004. Each of the MCOs is required to submit a final report from the survey vendor to the OMPP on July 31st of each calendar year. Each MCO contacted survey participants during the months of January – May. Members are required to be enrolled in the MCO at the time of the survey and for at least five of the six prior months.

A contracted health plan may, at the discretion of the FSSA, lose eligibility for compensation under the Pay-for-Outcomes program if:

- The FSSA has suspended capitation payments or enrollment to the contracted health plan;
- The FSSA has assigned the membership and responsibilities of the contracted health plan to another participating managed care organization;
- The FSSA has assumed or appointed temporary management with respect to the contracted health plan;
- The contracted health plan's contract has been terminated;
- The contracted health plan has, in the determination of the Director of the Office of Medicaid
- Policy and Planning, failed to execute a smooth transition at the end of the contract term, including failure to comply with the contracted health plan's responsibilities set forth in the Scope of Work; or
- Pursuant to the Contract, the FSSA has required a corrective action plan or assessed liquidated damages against a contracted health plan in relation to its performance under the contract during the measurement year.

The FSSA may, at its option, reinstate a contracted health plan's eligibility for participation in the Pay-for-Outcomes program once the contracted health plan has properly remediated all prior instances of non-compliance and the OMPP has satisfactory assurances of acceptable future performance.

To provide an incentive to the contracted health plans for submitting encounter claims, Pay-for-Outcomes results are verified by the FSSA Data Management and Analysis unit. Data must reconcile to a variance no greater than 2 percent for both Hoosier Healthwise and HIP.

The OMPP works diligently to organize monitoring and reporting systems. One aspect of the OMPP quality improvement program is the monthly onsite monitoring visit with each contracted health plan. The OMPP completes an in-depth review of various operational, reporting, and quality topics at the onsite visit. A Monthly Onsite Monitoring Tool is prepared by FSSA based on a selected topic of focus and sent to each contracted health plan at the first of the month. The purpose of the Monthly Onsite Monitoring Tool is to gain practical insight into the daily operational practices, reporting results, and internal quality assurance programs currently being performed by the contracted health plans based on the current month's chosen topic. The contracted health plan returns the Monthly Onsite Monitoring Tool to the FSSA with written responses to topic inquiries and other detailed quality and operational documentation for review by the FSSA. Requested data for review often consists of policies and procedures, trending and collection data, member/topic examples and other specific information. The FSSA completes a detailed review of the supporting documentation submitted by the contracted health plan. Based on this detailed review, the FSSA prepares the agenda and a set of drill-down questions that is sent to the contracted health plan in advance of the onsite visit. At the onsite visit, the FSSA discusses the contracted health plan's performance as it relates to the operational, reporting, and quality expectations. The contracted health plans have an opportunity to provide additional topic information and ask questions to gain a better understanding of the state's expectations and suggestions for improvement.

The onsite visit offers an opportunity for the contracted health plans and FSSA to discuss other issues not included on the agenda. Upon conclusion of the monthly onsite monitoring visits, the FSSA prepares and sends a Feedback Tool to each contracted health plan that summarizes specific onsite visit information, action items and discussion of other high-level issues. The Onsite Visit is an integral part of the process to ensure that the contracted health plans are operating according to their contractual obligations.

State Defined Performance Improvement Projects

The OMPP requires standard processes for submission of QMIP Work Plans and PIPs from the contracted health plans.

1) QMIP Work Plan template: contracted health plans are required to use a standard template for submission of QMIP Work Plans. This standardized template is a helpful tool for reviewing the draft work plans as well as the quarterly progress updates submitted by the contracted health plans.

2) PIPs: contracted health plans are required to submit PIPs prospectively using the NCQA Quality Improvement Project form. The use of a standard form was a recommendation from the External Quality Review (EQR), performed by Burns and Associates.

Table 10 exhibits identified Performance/Quality Improvement Project topics of focus for 2014, for Care Select and Hoosier Healthwise.

TABLE 10:	**Performance/Quality Improvement Projects for 2014 Hoosier Healthwise, HIP, and Care Select.**			
Care Select		**Hoosier Healthwise/HIP**		
Advantage	**MDwise**	**Anthem**	**MDwise**	**MHS**

Utilization of ambulatory care in the categories of outpatient visits and ED visits.	Utilization of ambulatory care in the categories of outpatient visits and ED visits.	Well-Child Visits: 0-15 months, 3-6 years of age, and Adolescent Well Care Visits (HHW only)	Well-Child Visits: 0-15 months, 3-6 years of age, and Adolescent Well Care Visits (HHW only)	Well-Child Visits: 0-15 months, 3-6 years of age, and Adolescent Well Care Visits (HHW only)
Adult ambulatory and preventive care.	Adult ambulatory and preventive care	Diabetes: LDL-C Screening, HbA1c testing, and Retinol Eye Exam	Comprehensive Diabetes Care – LDL-C Screening	Diabetes: LDL-C Screening,
Health risk screenings	Health risk screenings			
Treatment of COPD	Treatment of COPD			
Follow-up After Behavioral Health Inpatient Stay	Follow-up After Behavioral Health Inpatient Stay	Follow-up After Behavioral Health Inpatient Stay	Follow-up After Behavioral Health Inpatient Stay	Follow-up After Behavioral Health Inpatient Stay

HEALTH INFORMATION SYSTEMS

The FSSA requires all contracted health plans to operate and maintain an Information System (IS) sufficient to support the Hoosier Healthwise and HIP program requirements and capable of collecting and transmitting required data and reports to the FSSA in the format specified by the FSSA. Each contracted health plan maintains an Information System that collects, analyzes, integrates and reports data. Contracted health plans report data to FSSA on:

- utilization management – health risk assessments, health screenings, prior authorization, care management, complex case management, disease management, services utilization, pregnancy identification
- member services - member helpline, grievances, hearings and appeals, Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- provider reports – claims disputes, credentialing, enrollments and disenrollments, geographic access, compliance
- quality management and improvement – quality management and improvement work plan, program integrity report, quality improvement projects, HEDIS
- financial reports – TPL, Benefit limits, spending by source and service, Stop Loss, physician incentive plan
- clinical reports – newborns, well child visits, preventive exams, health screenings ambulatory care, ER and inpatient utilization, follow up after hospitalization, inpatient readmissions

The contracted health plans are obligated to maintain an IS with capabilities to perform the data receipt, transmission, integration, management, assessment and system analysis tasks. Data from the Plans is used to complete monthly and quarterly reports as required by FSSA. Also, data is utilized internally to assess member's service utilization and prioritize for engagement with case/care/disease management programs. Periodically, OMPP requests member level data from the plans to monitor quality initiatives.

The FSSA requires that all contracted health plans develop Information system contingency plan in accordance with 45 CFR 164.308, which relates to administrative safeguards and to comply with 42 CFR 438.242 relative to data.

SECTION IV. IMPROVEMENT AND INTERVENTIONS

IMPROVEMENTS

OMPP's strategic plan for 2014 builds upon the plans from 2012 and 2013. There is a continued focus on ensuring that quality health care is provided to Indiana Medicaid members. The OMPP has determined that while each individual managed care entity has identified quality improvements for 2014, there are several interventions in place that encompass all Medicaid Programs. The interventions listed in Table 9 will be at the forefront of planning and implementation of this Quality Strategy. On-going monitoring will provide the OMPP with quality-related data for future reporting.

Some of the interventions that encompass all Medicaid programs are tracked through the Pay-for-Outcomes measures described by the OMPP within this document. The Hoosier Healthwise performance contracting is based on HEDIS results submitted by the contracted health plans to the OMPP.

Table 11 displays all cross-cutting interventions for the managed care programs.

TABLE 11:	Cross-Cutting Interventions for all Managed Care Programs	
Intervention	**Process**	**Stakeholders**
Outcome-Based Contracting	• Pay-for-Outcomes (P4O) • Maintain and improve current metrics with slight modifications • Require reporting that matches State's goals • Monitor enrollment in the Right Choices program	OMPP Contracted Health Plans
Prenatal/Post-Natal Care Initiatives	• Monitor Presumptive Eligibility for Pregnant Women; further review of provider participation • Modify the Notification of Pregnancy at the provider level • Develop a smoking cessation initiative for pregnant women • Monitoring women's access to care	OMPP Contracted Health Plans ISDH IPN Providers
Improve Healthcare for Indiana's Children/EPSDT	• Increase % of children and adolescents receiving well-care • Develop protocol for provider adherence to in-depth physical and mental health screenings • On-going provider education, monitoring, and outreach • Monitor collaboration efforts between mental health services, PRTF and Money Follows the Person services. • Develop a CDC/CMS data linkage	OMPP Contracted Health Plans HP DMHA EPSDT
Behavioral Health	• Collaborative project focused on follow-up after mental health hospitalization	OMPP DMHA Contracted Health Plans

Improving Access to Prenatal Care & Case Management of High-Risk Pregnancies by improving the process for Presumptive Eligibility for Pregnant Women (PE) and Notification of Pregnancy (NOP) Programs.	• Improvements in the PE and NOP process will be implemented during 2014. • Monitor with OMPP Data Management Analysis teams monthly and quarterly reports to assess the effectiveness of PE and NOP improvements.	OMPP IPN CKF Contracted Health Plans ISDH Providers

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Table 12 describes contracted health plans performance results in which payout percentages are based upon.

y-for-Outcomes" Measures Overview [Measurement Year 2011]										
em			MHS			MDwise			Contract 2011 performance rates	Contract 2012 performance rates
	2011	2012	2010	2011	2012	2010	2011	2012		
%	18.83%	19.40%	18.00%	18.20%	18.63%	17.67%	17.70%	17.88%	<= 19.0% <= 18.0% <= 17.0%	<= 19.0% <= 18.0% <= 17.0%
%	63.02%	70.31%	56.57%	61.18%	65.12%	61.80%	62.77%	65.21%	61.3% 68.9% 77.1%	62.9% 70.70% 77.31%
%	68.88%	73.33%	69.92%	65.05%	67.55%	72.02%	69.10%	69.34%	72.3% 77.6% 82.9%	72.26% 79.32% 83.0%

Adolescent Well Care Visits (12-21 years). Percentage of members 12-21 years who had at least one comprehensive well child exam with a PCP or OB/GYN practitioner. HEDIS measure (HEDIS AWC) using hybrid data.	56.69%	57.91%	55.09%	61.34%	55.10%	54.30%	65.45%	58.88%	50.88%	46.1% 57.2% 64.1%	49.65% 57.61% 69.57%
Follow-up after Hospitalization for Mental Illness. Percentage of members who received follow-up within 7 days or discharge from hospitalization for mental health disorders. HEDIS measure (HEDIS FUH) using administrative data.		75.84%	74.24%		59.54%	61.06%		50.85%	51.40%	45.1% 53.9% 68.3%	46.06% 57.68% 69.57%

Post-Partum Visits. Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery (Includes deliveries between Nov 6th of the year prior to the measurement year and Nov 5th of the measurement year). HEDIS measure using hybrid data.	75.22%	76.36%	76.39%	70.66%	70.66%	73.78%	77.86%	71.53%	73.24%	N/A N/A 75.2%	N/A N/A 74.73%
Comprehensive Diabetes Care– Cholesterol Screening. Percentage of diabetic members that received a LDL-C screening during the measurement year. HEDIS measure (HEDIS CDC using hybrid data).	62.04%	63.32%	66.42%	60.70%	56.58%	61.01%	63.87%	66.97%	66.24%	70.4% 75.4% 80.3%	70.34% 73.0% 80.88%
Percentage of Smokers Advised to Quit (CAHPS survey)	63.70%	72.30%	74.91%	75.00%	72.30%	72.00%	67.90%	68.60%	72.80	70.0% 73.0% 76.0%	70.0% 73.0% 76.0%

Indiana health plan contracts include provisions for failure to perform remedies. Non-compliance remedies include written warning, formal corrective actions, withholding payments, suspending enrollments, immediate sanctions and contract termination. These remedies provide FSSA with an administrative procedure to address issues. To assure quality care for members, OMPP monitors quality and performance standards through several means including reporting and monthly onsite monitoring visits. OMPP works collaboratively with the contracted health plans and holds them accountable for maintaining and improving Medicaid programs. The disposition of any corrective action depends upon the nature, severity and duration of a deficiency or non-compliance.

HEALTH INFORMATION TECHNOLOGY

The FSSA requires all contracted health plans to operate and maintain an Information System (IS) sufficient to support the Hoosier Healthwise, HIP, and Care Select program requirements. IS must be capable of collecting and transmitting required data and reports to the OMPP in the format specified by the OMPP. Data from the contracted health plans is used to complete monthly, quarterly, and annual reports to monitor and compare clinical outcomes against targets, standards and benchmarks as set forth by FSSA. The state staff directly manages all contracted health plan report submissions. This direct management supports and deepens the OMPP's capacity to align and increase oversight processes across the contracted health plans and the programs. Through the course of this alignment, a full comparative review of the report submissions by the contracted health plans takes place to ensure that key performance indicators, both operational and clinical, are effectively being identified, collected, validated and analyzed. Reports are presented to the Quality Strategy Committee. The role of the Committee is to assist in the developing and monitoring of the identified goals and strategic objectives of the written Quality Strategy and to advise and make recommendations to the OMPP.

While the contracted health plans are required to submit annual HEDIS data, the OMPP also collects quarterly reports on a variety of quality indicators for preventive health; children and adolescents; and mothers and newborns. This increased access to data has allowed the OMPP to continually track and monitor performance on key quality indicators and steer the focus toward improvement activities. The OMPP incorporated multiple steps within the Hoosier Healthwise report review process to reinforce its commitment to receive quality data in a complete, timely, and accurate manner.

SECTION VI. INIATIATIVES AND CONCLUSIONS

THE OMPP INITIATIVES FOR 2014

Hoosier Healthwise and Healthy Indiana Plan

Hoosier Healthwise and the Healthy Indiana Plan are aligned under a family-focused approach to create a "family contracted health plan" that results in a seamless experience for Hoosier families. Together, these programs aim to provide comprehensive health care coverage for uninsured Hoosiers to improve overall health, promote prevention and encourage healthy lifestyles. Families will have access to health care through the same PMP for each member when possible. Continuity of care for family members will provide enhanced opportunities for health care to all members of the household.

Right Choices Program

The Right Choices Program (RCP) is designed to enhance the contracted health plan's ability to assist members in obtaining the right care at the right time. Within this new model, RCP members are restricted to one PMP, one hospital, and one pharmacy. This allows all care to be managed by the member's PMP to

ensure the member is receiving appropriate care. The contracted health plans evaluate members for potential enrollment in the program when members are identified as not utilizing health care services appropriately, such as multiple Emergency Room visits, pharmacy visits, and physician visits that are not medically necessary. The program's design is to assist RCP enrollees by creating a medical home to support the member in obtaining the appropriate care at the right time in the right place.

Policy Governance

The OMPP Policy Consideration unit continues to facilitate the structured policy consideration process in order to advance a value-driven program, focusing on cost effective improvements to the health of the Indiana Medicaid population. The Medicaid policy decision-making process defines how requests enter the system and are sorted through the Medicaid office. A policy library was created to store information pertaining to policy requests that "funnel" through the system, including background information on the request, research, dates of use, and policy decisions.

Monitoring and Reporting Quality

The OMPP Quality staff works collaboratively with the contracted health plans to improve the oversight and reporting processes by ensuring that all contracted health plans are measuring, calculating, and reporting in the same manner. Quality team staff reviewed the contracted health plans' proposed 2014 QMIP Work Plans and PIPs. QMIP Work Plans progress will be monitored during contracted health plan Onsite Monitoring Visits.

Under the alignment of programming described in this quality strategy, the OMPP team will continue to collaborate to identify areas needing improvement and determine a collaborative approach to monitoring and reporting.

Improving Birth Outcomes

Issues were raised in the 2011 Birth Outcomes Report. In 2012 the OMPP requested that MMAC revisit PE and NOP to identify factors that might affect program penetration and, ultimately, the success of the initiatives. OMPP first requested that MMAC look to scholarly literature on PE and NOP and descriptions of other states' PE and NOP practices to make recommendations for improving Indiana's own programs. The scope of work was later expanded to incorporate additional exploration of the PE and NOP processes in Indiana to identify potential barriers to the programs' success. In 2014 OMPP will be monitoring PE and NOP changes. Moving forward, the OMPP will continue improving the PE process to improve penetration of the program. Additionally, through the recommendations made by MMAC and collaboration of the OMPP, contracted health plans, and other stakeholders Indiana will continue to improve data reporting of PE program.

As part of OMPP's commitment to healthy babies and healthy moms, OMPP is requiring MCEs to develop a detailed marketing/strategy plan targeted at smoking cessation in pregnant women to be approved by OMPP. The plan must include 8 components such as counseling, Quitline, incentives, pharmacology, rural outreach and involvement, early identification and increased identification of pregnant members and data collection.

Adult Quality Initial Core Set Measures Grant:

The Affordable Care Act, made $300 million available the "Adult Medicaid Quality Core Set Measures Grant" over a 2-year period (December 21, 2012 to December 21, 2014). Indiana was awarded $1 million for each year of the two-year project period. In adherence to the grant's requirements, OMPP will use the grant funds for (1) testing and evaluating methods for collection and reporting of the Initial Core Set Measures in varying delivery care settings (e.g. managed care, fee-for-service, long term care settings such as nursing homes and intermediate care facilities); (2) developing staff capacity to report the data, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid; and (3) conducting two Medicaid quality improvement projects in St Joseph, LaPorte, Marshall, Elkhart, and Starke counties (northern Indiana region).

Care Select and COPD

In the 2013 Care Select redesign, OMPP identified a care management gap related to persons with pulmonary disease. Beginning in 2014, the Care Select health plans began an initiative to develop disease management, care management, and complex case management for these individuals. OMPP will monitor the effectiveness of interventions, ER utilization, and inpatient utilization for persons with pulmonary illnesses.

Table 13 illustrates how the contracted health plans' QMIPs, CAHPS scores, HEDIS scores, contract requirements, and External Quality Review all contribute to the Quality Strategy Plan.

Table 13:

CONCLUSION

There are ongoing initiatives which describe the State's monitoring, measuring, and reporting process, in a transparent fashion. The State of Indiana strives to demonstrate the overall commitment to quality of services available to our Medicaid recipients.

Collaboration among contracted health plans, state agencies, providers, advocacy groups and the OMPP is a representation of dedication to performance and quality. Throughout the process of developing and narrowing the focus for improvements in 2014, the OMPP gathered input for this Quality Strategy from a variety of staff and stakeholders. Additionally, the quality sub-committees will drill down further to sculpt the focus of the strategic objectives described in this quality strategy, monitor outcomes, and plan for future endeavors.

The State of Indiana 2014 Quality Strategy will be presented to the Quality Strategy Committee and will be made available through a public posting on the State website.