Indiana Health Coverage Programs 2024 Quality Strategy Plan

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Office of Medicaid Planning and Policy

Submitted to CMS: [insert date]

Revised Effective: June 1, 2024

The previous version of the Quality Strategy Plan was published on [June 1, 2022]

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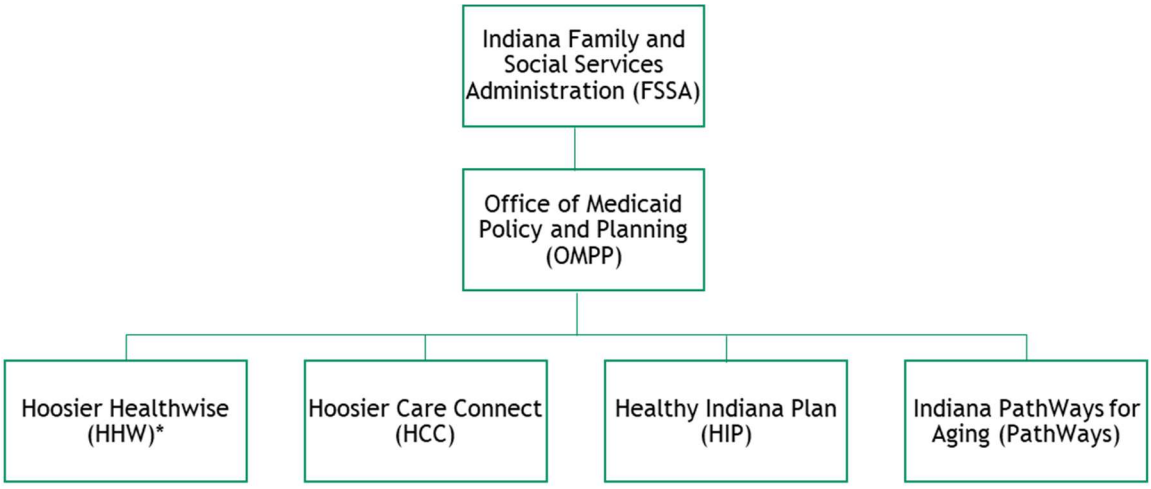
SECTION I. Introduction and Overview

Introduction

The Indiana Family and Social Services Administration (FSSA) is the state agency responsible for administering the Indiana Health Coverage Programs (IHCP) under Medicaid. The vision of the agency is to ensure that "*All Hoosiers live in fully engaged communities and reach their greatest emotional, mental and physical well-being,"* while adhering to the agency's mission "*To compassionately serve our diverse community of Hoosiers by dismantling long-standing, persistent inequity through deliberate human services system improvement."*

Under the direction of FSSA, the Office of Medicaid Policy and Planning (OMPP) is responsible for administering the Medicaid programs for the State of Indiana. OMPP partners with managed care entities (MCEs) to provide administrative services for the Indiana Health Coverage Programs including Hoosier Healthwise (HHW), Hoosier Care Connect (HCC), Healthy Indiana Plan (HIP), and, effective July 1, 2024, Indiana PathWays for Aging (PathWays). The structure of the managed care programs offered by OMPP are outlined in Figure 1 below. Indiana provides Children's Health Insurance Program (CHIP) benefits through managed care under the HHW program as a combination Medicaid expansion and separate CHIP program, which is addressed in this quality strategy plan (QSP).

Figure 1. FSSA IHCP Organizational Structure



**Hoosier Healthwise program includes CHIP coverage*

In accordance with 42 Code of Federal Regulations (CFR) 438.340~~(a)~~ and 42 CFR 457.1240(e), the state implements and maintains a QSP that establishes the methods for improving the delivery of Medicaid services throughout the state. The QSP aligns with the agency's objective to enhance the emotional, mental, and physical wellness of Hoosiers. It outlines the state's managed care quality priorities, goals, and objectives to improve the health outcomes of Hoosiers and make Indiana a healthier state. The QSP serves as guidance for the Managed Care Entities on which to base their quality improvement program including their program goals and objectives. This quality strategy will also help to guide the state's Performance Improvement Projects (PIPs), as part of Quality Assessment and Performance Improvement (QAPI)

programs; state directed payments; annual External Quality Reviews; approach to using core measure sets and other quality indicators, and other aspects of the state's quality management activities.

This QSP is the start of a three-year strategy plan that outlines the state's quality improvement goals and objectives for the Indiana Health Coverage Programs. The QSP takes into consideration the needs of the population through multiple avenues such as partner engagement (including MCEs), community, public comment, state agencies, advocacy groups, and data collection. The QSP establishes top priorities, areas for improvement, and performance metrics to evaluate effectiveness. The QSP is being revised as part of the federal requirement 42 CFR 438.340 (b)(10) to address significant changes in the quality strategy plan. The implementation of the Indiana PathWays for Aging program effective July 1, 2024, as well as various updates including revised quality metrics (pay for outcomes, performance measures, and performance improvement projects) initiated the significant changes necessary to revise the QSP.

Overview of Indiana Health Coverage Programs

Indiana is actively enhancing the lives of its Medicaid managed care members by strategically focusing on timely healthcare access, quality improvement, and cost management. This is of particular importance given the large proportion of Hoosiers who are served by Indiana Medicaid. According to the U.S. Census Bureau, the population of Indiana in 2023 was estimated at 6,862,199 million.[1] As of December 2023, 2,012,389 individuals were enrolled in Indiana Medicaid (including CHIP), meaning almost 1 in 3 Hoosiers are enrolled in Medicaid.[2] Of those Medicaid enrollees, 1,660,942 individuals (82.5%) are enrolled under an MCE.[3]

As of July 1, 2024, the State of Indiana will contract with six risk-based managed care entities (referred to as MCEs in Indiana) to administer the various Indiana Health Coverage programs. The MCEs contracted with the state include:

- Anthem Insurance Companies, Inc., d/b/a Anthem Blue Cross and Blue Shield (Anthem)
- Arcadian Health Plan, d/b/a Humana Healthy Horizons in Indiana (Humana)
- CareSource
- Coordinated Care Corporation, Inc., d/b/a Managed Health Services
- MDwise, Inc., and
- UnitedHealthcare Insurance Company, d/b/a United Healthcare Community Plan (United).

The MCEs are expected to achieve the goals and objectives set forth by OMPP and manage the care of members enrolled in the IHCP programs they administer. Effective July 1, 2024, the state will begin delivering long-term services and support (LTSS) through managed care under the Indiana PathWays for Aging program. Indiana PathWays for Aging MCEs are required to cover the full range of Medicaid services to their members, and to operate a companion dual-eligible special needs plan (D-SNP) exclusively aligned to their Medicaid plan in calendar year 2026 to provide services to members dually eligible for Medicaid and Medicare. Until then MCEs and D-SNP plans will be aligned.

[1] https://www.census.gov/quickfacts/fact/table/IN
[2] https://www.in.gov/fssa/ompp/forms-documents-and-tools2/medicaid-monthly-enrollment-reports/
[3] Ibid.

Table 1 shows the different types of MCEs available in Indiana Medicaid, the programs they administer, the populations they serve, and the authority under which they operate.

Table 1. Indiana Medicaid Health Coverage Programs

Program Name	Populations Served[4]	Managed Care Authority	Managed Care Entity	Services Covered
Children's Health Insurance Program (CHIP)	Children up to age 19	1115(a) 1932(a)	Anthem Managed Health Services MDwise CareSource	Physical Health Behavioral Health Vision Dental Pharmacy
Hoosier Healthwise	Children up to age 19 and pregnant individuals	1115(a) 1932(a)	Anthem Managed Health Services MDwise CareSource	Physical Health Behavioral Health Vision Dental Pharmacy Non-Emergent Transportation
Healthy Indiana Plan	Individuals ages 19 to 64 who meet specific income levels	1115(a)	Anthem Managed Health Services MDwise CareSource	Physical Health Behavioral Health Vision Dental Pharmacy Non-Emergent Transportation
Hoosier Care Connect	Individuals aged 65 years or older, blind, or disabled who are not eligible for Medicare, do not reside in an institution, and do not receive home- and community-based services through a waiver[5] Some foster care children	1915(b)(1), (b)(4)	Anthem Managed Health Services UnitedHealthcare	Physical Health Behavioral Health Vision Dental Pharmacy Non-Emergent Transportation
Indiana PathWays for Aging	Individuals aged 60 years or older, blind, or disabled with or without Medicare	1915(b)(1), (b)(4) 1915(c)	Anthem Humana UnitedHealthcare	Physical Health Behavioral Health Vision Dental Pharmacy Long Term Support Services

[4] There is one federally-recognized tribe in Indiana, the Pokagon band of Potawatomi, and individuals who are American Indian/Alaksa Native (AI/AN) may elect to enroll into managed care (voluntary enrollment).
[5] Effective July 1, 2024, members who meet the eligibility criteria for the PathWays for Aging program will transition from Hoosier Care Connect to PathWays.

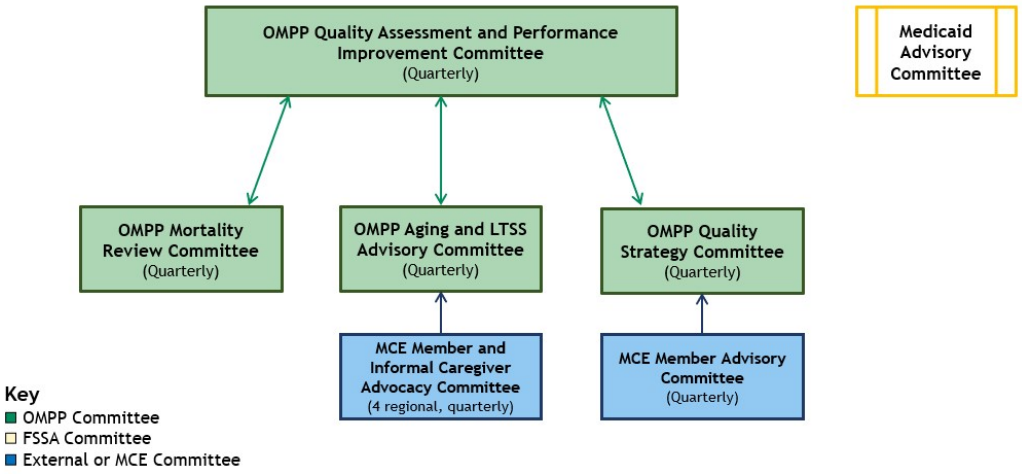
SECTION II. OMPP Quality Management

Quality Management Structure

OMPP is ultimately responsible for the development and review of the state's QSP. An interdisciplinary team formed within OMPP, led by the Clinical Operations Unit, assists in the development of the QSP. The Clinical Operations Unit provides oversight and ongoing monitoring of the quality activities and performance metrics associated with the QSP. OMPP's quality committee governance structure is outlined in Figure 2 below, and additional information including a description of each of the quality committees can be found in Appendix IV.

Figure 2. OMPP Quality Committee Governance Structure*

Figure 2

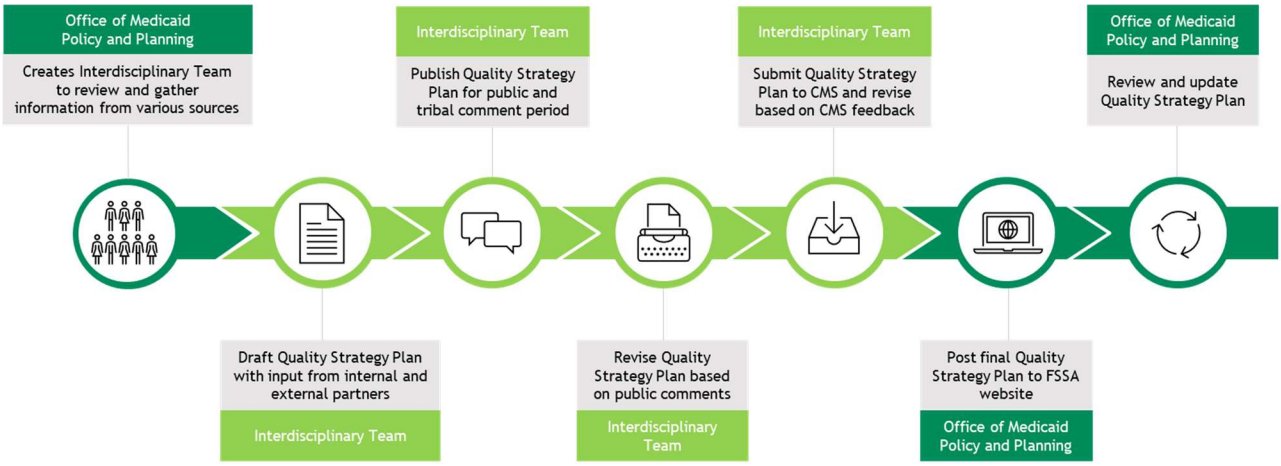


**This structure contains current and proposed elements that may evolve over time to address the needs of the Medicaid program and implementation of the Indiana PathWays for Aging Care Program.*

Development and Review of Quality Strategy Plan

The QSP must be reviewed and updated every three years. The steps that OMPP follows to review and update the QSP are outlined in Figure 3 below.

Figure 3. Process Flow for Quality Strategy Plan Renewal Development



As part of OMPP's continuous quality improvement efforts related to updating the quality strategy, the state established a set of overarching goals that apply across all the managed care programs. Performance targets are then refined based on examination of historical performance. This approach recognizes that contracted MCEs and providers serve in multiple healthcare programs and that by aligning priorities across programs, OMPP can increase the likelihood of achieving the desired performance because the state, the MCEs, and the providers can concentrate their efforts around these priority areas.

Resources from the following may be taken into consideration as part of the renewal development process [See Figure 3]:

- Advisory committees
- Community/Advocacy Groups
- Data collection and trends
- External Quality Review technical reports
- Federal regulations
- Financial/Budget
- Health Equity Plan
- State and Federal legislation
- Medicaid managed care contracts
- National quality metrics (HEDIS®, Child Core Set, Adult Core Set. etc.)

- Pay for outcomes
- Performance metrics
- Public
- Quality program descriptions, evaluations, and work plans
- State agencies
- State initiatives
- Statutory reporting

The final version of the QSP is posted to the FSSA Medicaid Policy website in the Quality and Outcomes Reporting Section:

https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/

Public Comment Process

The state provides the QSP for public comment prior to submitting it to the Centers for Medicare and Medicaid Services (CMS) for review. The public comment process includes obtaining input from the Medicaid Advisory Committee, members, and other community partners. The QSP is also provided to the recognized Tribe in Indiana, the Pokagon band of Potawatomi, as part of the public comment period in accordance with the state's tribal consultation policy. OMPP posted the draft QSP for public comment on [04/15/2024]. Following the public comment and tribal consultation period, comments are taken into consideration and updates are made to the QSP at the discretion of OMPP. A summary of the comments received during the public comment and tribal consultation periods, as well as information on how the QSP was refined based on input, is included in Appendix V. OMPP then submits the revised QSP to CMS for review and revises the quality strategy based on CMS feedback as necessary prior to the QSP being finalized and posted on the FSSA website.

Updating the Quality Strategy

Significant Changes

OMPP conducts an annual review of the QSP to determine if updates are necessary. Based on the annual review, if there are significant changes to the QSP, OMPP follows the process for submission to CMS. The only exception is if it occurs in a renewal year.

OMPP defines a significant change as:

- A modification that occurs to an Indiana Medicaid program goal, objective, or priority (other than modifications done for clarity);
- Implementation of new managed care authorities
    - State plan authority [Section 1932(a)]
    - Waiver authority [Section 1915 (a) and (b)]
    - Waiver authority [Section 1115].
- Procurement of a new MCE or change in MCEs; or

- Adding new population(s) to the managed care program.

The following are not considered significant change:

- Modifications to performance measures, quality metrics, performance improvement projects, or targets based on annual evaluation; or
- Adjustments made to quality measures due to changes in technical specifications, retirement, or implementation of new measures.

Review and Evaluation of the Quality Strategy

In accordance with 42 CFR 438.340, OMPP will review and update the quality strategy no less than every three years. Indiana has historically evaluated its quality strategy plan every year and adjusted performance measures and targets according to the needs of Indiana Medicaid members. This includes an annual evaluation of the pay for outcome (P4O) measures. This annual evaluation ensures that there is a continuous improvement process on the efforts made by the Medicaid MCEs to improve year over year quality performance.

Lastly, evaluation of and updates to the quality strategy take into consideration the recommendations provided by an External Quality Review Organization (EQRO). The EQRO evaluates the performance measures, performance improvement projects (PIPs), and other focus areas on an annual basis. They provide their recommendations for improvement and share their results with the Managed Care Entities. In addition, it is the intention that OMPP Clinical Operations Quality Department will facilitate a full program evaluation. Part of the evaluation consists of an annual review of the MCEs quality program evaluations. Program evaluations are taken into consideration as part of the oversight of the MCEs Quality Assessment and Performance Improvement programs. Recommendations for quality improvement based on evaluation are shared with the MCEs as part of the oversight process.

Summary of External Quality Review Organization Recommendations

OMPP updates the quality strategy taking into consideration the recommendations provided by the EQRO pursuant to 42 CFR 438.364. In 2022, OMPP contracted with Qsource to conduct the required External Quality Reviews for HHW, HCC, HIP and CHIP. A summary of their findings and recommendations can be found in Table 2 below.

Table 2. External Quality Review Recommendations

Topic	EQRO Recommendation	OMPP Response
Quality Improvement Project Validation	Improvements are needed in the submission of QIP data and progress measurement; OMPP should continue to monitor QIPs to ensure quality, timeliness, and access to care for members.	OMPP has adjusted the quarterly templates for the QIPs for better monitoring and to provide timely feedback to the MCEs.
Performance Measure Validation	No deficiencies were noted in the MCE's processes for data collection and performance measure reporting.	OMPP will continue to monitor the performance measure evaluation and address any deficiencies as identified.

Topic	EQRO Recommendation	OMPP Response
Annual Network Adequacy	MCEs should be proactive in monitoring and adding providers to their network to ensure a robust provider network, ensure provider lists in member materials are correct, and ensure PMP network adequacy by targeting counties identified with additional assessments.	OMPP will continue to monitor MCEs for an issue related to network adequacy through routine reporting as outlined in the MCE Reporting Manual.

In addition to the overall recommendations outlined above, Qsource identified specific recommendations for individual MCEs in their 2022 External Quality Review (EQR) Technical Report. These recommendations can be found in the EQR posted publicly at https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/.

SECTION III. Managed Care Goals and Objectives

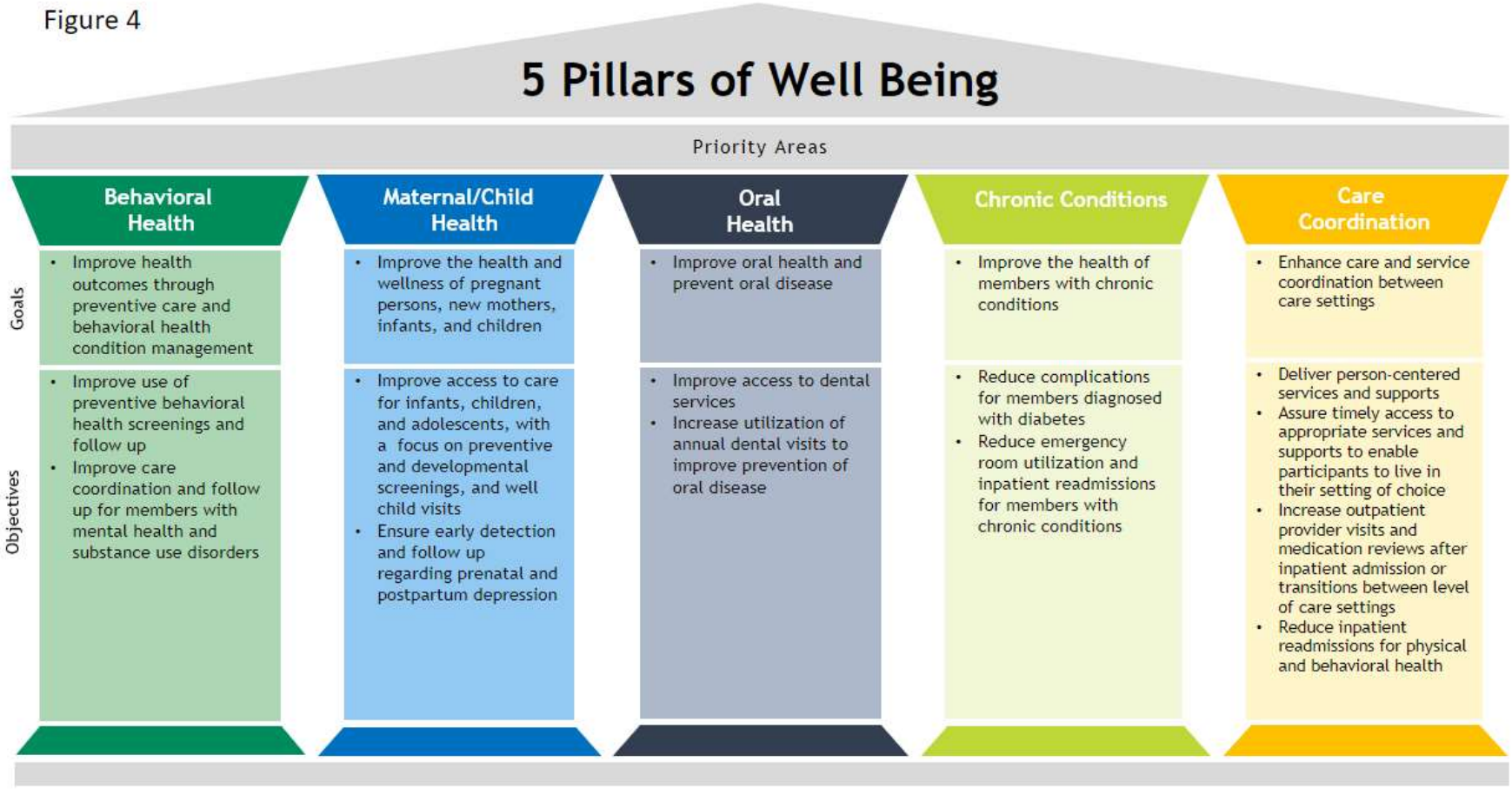
Quality Metrics and Performance Targets

FSSA is committed to improving the lives of Hoosiers to reach their greatest emotional, mental, and physical well-being. To achieve this vision, OMPP has established Five Pillars of Well Being (Five Pillars) each with its own goal and objectives. The expectations are that the MCEs will begin to incorporate the Five Pillars into their quality improvement program from the date of the QSP posting. The Five Pillars will remain in effect for the 3-year length of this current QSP.

The Five Pillars were developed based on review of state and national data, state health initiatives, input from external partners, and needs of the population. The goals and objectives for each pillar are measurable, take into consideration the health status of all populations in the state served by the MCEs, and were determined based on review of quality metrics (e.g., HEDIS®), P4Os, external quality review, consumer surveys (e.g., CAHPS), and trends in health care data within the state. To support the program goals and objectives, OMPP also aligns with the Medicaid and Child and Adult Core Sets.

Figure 4 outlines the Five Pillars, goals, and objective

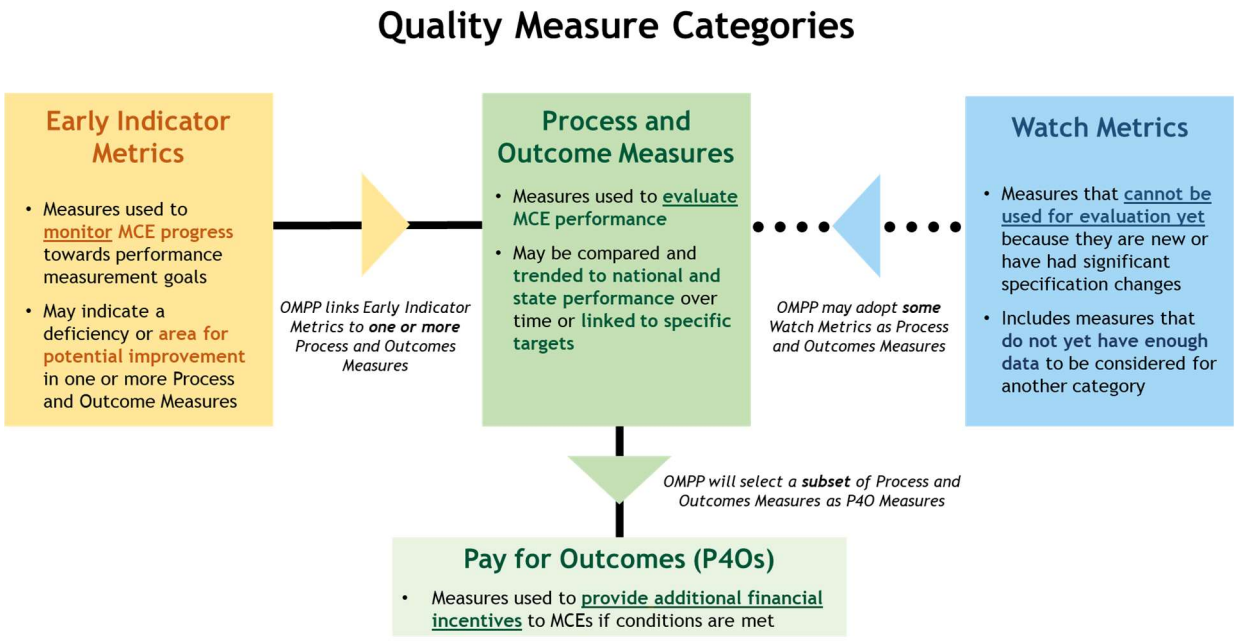
Figure 4. Five Pillars of Well Being



As part of the QSP, OMPP has identified categories of quality measures each with its own targets that will be used to evaluate the Indiana Health Coverage Programs on an annual basis. The quality measure categories OMPP has identified are as follows [see Figure 5]:

- **Watch Metrics** are defined as quality measures with significant changes in the measure specifications or that have been newly developed. Baseline measures where data may not be available will also be included in this category. These measures will be placed under the watch metric category until enough data is obtained for consideration into other categories. For example:
    - Controlling Blood Pressure (CBP): There are proposed changes to the 2025 HEDIS® Blood Pressure Measure include broadening the criteria for hypertension diagnosis and introducing a new blood pressure target (<130/80 mm Hg). Due to significant changes this measure would fall under a watch metric in 2025.
    - Breast Cancer Screening- (BCS-E): NCQA is considering adding individuals 40–49 years of age to the measure, and stratifying performance rates by 40–49 and 50–74 years for all product lines, for HEDIS MY 2025. Due to proposed changes this measure would be considered for watch metric.
- **Early Indicator Metrics** are defined as quality measures that will be used to monitor potential progress towards performance measurement goals. These measures may indicate a deficiency or area for potential improvement. For example:
    - Prenatal Depression Screening and Follow Up (PND-E) and Postpartum Depression Screening and Follow-Up (PDS-E) are NCQA depression care quality measures included in HEDIS. These measures identify potential risks for depression for early intervention.
- **Process and Outcomes Measures** are defined as quality measures that may be measured, compared, and trended to national and state performance over time or linked to specific targets. MCE performance will be evaluated using Process and Outcomes measures.
- **Pay for outcomes (P4O)** are a subset of process and outcomes measures. They are defined as quality measures that OMPP has determined MCEs may receive additional compensation if certain conditions are met. MCE performance will be evaluated using P4Os.

Figure 5. Quality Measure Categories



Goals and Objectives

Table 3 outlines the specific goals and objectives that OMPP has identified for continuous quality improvement, the process and outcomes quality measures that will be monitored, the measure source, and which managed care program the specific measure is applicable to are outlined below. The goals, objectives, and measures outlined below take into consideration the health status of all populations served by the MCEs.

Table 3.1 reflects the early indicator metrics, baseline performance, targets, and managed care program that are specific to the early indicators. These metrics will be used to monitor progress towards the process and outcome quality measures.

Table 3.2

Statewide baseline performance and performance target information for each measure can be found in Appendix III.

Table 3. Quality Strategy Goals and Objectives

Objective	Objective Description	Process and Outcomes Quality Measures	Measure Source	Managed Care Program			
				HHW	HIP	HCC	Indiana PathWays for Aging
Goal 1: Improve health outcomes through preventive care and behavioral health condition management							
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	HEDIS	X	X	X	X
		Follow-Up after Hospitalization for Mental Illness (FUH)	HEDIS	X	X	X	X
		Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS	X	X	X	X
		Initiation and Engagement of Alcohol and other Drug (IET)	HEDIS	X	X	X	X
		Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	HEDIS	X	X	X	X
1.2	Improve the use of preventive behavioral health screenings and follow up to screenings	Metabolic Monitoring for Children and Adolescents on Antipsychotic (APM)	HEDIS	X	X	X	
		Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD)	HEDIS	X	X	X	X
		Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC)	HEDIS	X	X	X	X
		Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD)	HEDIS	X	X	X	X
Goal 2: Improve the health and wellness of pregnant persons, new mothers, infants, and children							
2.1	Ensure early detection and follow up regarding prenatal and postpartum depression	PPC: Timeliness of Prenatal Care	HEDIS	X	X		
		PPC: Postpartum Care	HEDIS	X	X		
2.2	Improve access to care for infants, children, and adolescents, with a focus on preventive and	Well-Child Visits in the First 30 Months of Life (W30)◊	HEDIS	X			
		Child and Adolescent Well-Care Visits (WCV)◊	HEDIS	X			
		Childhood Immunization Status (CIS)◊	HEDIS	X			

Objective	Objective Description	Process and Outcomes Quality Measures	Measure Source	Managed Care Program			
				HHW	HIP	HCC	Indiana PathWays for Aging
	developmental screenings, and well child visits	Immunizations for Adolescents (IMA)◊	HEDIS	X			
Goal 3: Improve oral health and prevent oral disease							
3.1	Prevent oral disease	Oral Evaluation, Dental Services (OED)	HEDIS	X	X	X	X
3.2	Improve access to dental services	Dentists and Oral Surgeons Network Adequacy	OMPP	X	X	X	X
Goal 4: Improve the health of members with chronic conditions							
4.1	Improve the health and reduce complications for members diagnosed with diabetes	CDC: HbA1c Testing	HEDIS	X	X	X	X
		HBD: Hemoglobin A1c Control for Patients with Diabetes - Poor HbA1c Control	HEDIS	X	X	X	X
		HBD: Hemoglobin A1c Control for Patients with Diabetes*	HEDIS	X	X	X	X
4.2	Reduce emergency room utilization and inpatient readmissions for members with chronic conditions	Adults' Access to Preventive/Ambulatory Health Services (AAP)	HEDIS	X	X	X	X
		Acute Hospital Utilization (AHU)	HEDIS	X	X	X	X
		Emergency Department Utilization (EDU)	HEDIS	X	X	X	X
Goal 5: Improve care coordination across the entire service continuum							
5.1	Reduce the number of inpatient readmissions for physical and behavioral health	Plan All-Cause Readmissions (PCR)*	HEDIS	X	X	X	X
		MLTSS-4: Medicaid Managed Long-Term Services and Supports Reassessment/Care Plan Update after Inpatient Discharge▲	CMS				X
		MLTSS-5: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls▲	CMS				X
5.2	Ensure smooth transitions between level of care settings	Completion of Initial Health Needs Screening within 30 days or 90 Days of MCE Enrollment based on care program	OMPP	X	X	X	X
		Participants who Report Knowing who Their MCE Care Manager is	CAHPS				X
		MLTSS-3: Medicaid Managed Long-Term Services and Supports Shared Care Plan with Primary Care Provider▲	CMS				X

Objective	Objective Description	Process and Outcomes Quality Measures	Measure Source	Managed Care Program			
				HHW	HIP	HCC	Indiana PathWays for Aging
		MLTSS-8: Medicaid Managed Long-Term Services and Supports Successful Transition after Long-Term Facility Stay▲	CMS				X
5.3	Deliver person-centered services and supports	Service Coordinators who Have Successfully Completed Person-centered Planning Competency Training within 90 days of Hire	OMPP				X
		Participants who, in the Last 3 Months, Reported that Their Service Plan Included Most or all of the Things that are Important to Them	CAHPS				X
5.4	Assure timely access to appropriate services and supports to enable participants to live in their setting of choice	Care Management Individualized Care Plan Developed and Implemented within 90 Days of MCE Effective Date for Members with Care Management Level of Service	OMPP				X
		Care Management Individualized Care Plan Developed and Implemented within 60 Days of MCE Effective Date for Members with Complex Care Management Level of Service	OMPP				X
		MLTSS-1: Medicaid Managed Long-Term Services and Supports Comprehensive Assessment and Update▲	CMS				X
		MLTSS-2: Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update▲	CMS				X
		MLTSS-6: Medicaid Managed Long-Term Services and Supports Admission to a Facility from the Community▲	CMS				X
		MLTSS-7: Medicaid Managed Long-Term Services and Supports Minimizing Facility Length of Stay▲	CMS				X

Note: Performance measures specific to the LTSS population are included in the performance objectives listed above.
**Measure included in 2024 Core Set of Adult Health Care Quality Measures for Medicaid*[6]
◊*Measure included in 2024 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP*[7]
▲*Measure included in the 2022 HCBS Quality Measure Set* [8]

[6] https://www.medicaid.gov/sites/default/files/2024-01/2024-adult-core-set.pdf
[7] https://www.medicaid.gov/sites/default/files/2024-01/2024-child-core-set.pdf
[8] https://www.medicaid.gov/sites/default/files/2022-07/smd22003.pdf

Table 3.1 Early Indicator Metrics, Baseline, and Target

Early Indicator Metrics, Baseline, and Target						
Goal 1: Improve health outcomes through preventive care and behavioral health condition management						
Early Indicator Metric	**Baseline Performance Calendar Year 2022**	**Performance Target (Calendar Year 2025)**	**Program**			
			HHW	**HCC**	**HIP**	**Indiana PathWays for Aging**
Grievances related to Behavioral Health	Not reported	HHW/HIP: 100%) of member grievances within thirty (30) calendar days of receipt of the grievance	X	X	X	X
Care and Complex Case Management Report – Physical and ***Behavioral Health*** Conditions of Interest	Average Days HCC: 64.5 HHW: 41.7 HIP: 45.3		X	X	X	
Member Access to Providers (BH)	100%	100%	X	X	X	
Inpatient Utilization Report: Mental Health Discharges and Substance Use Discharges	Avg. Length of Stay (Days) HCC: 7 HHW: 6 HIP: 6		X	X	X	
Quality of Care & Quality of Services related to Behavioral Health			X	X	X	

Early Indicator Metrics, Baseline, and Target						
Goal 2: Improve the health and wellness of pregnant persons, new mothers, infants, and children						
Early Indicator Metric	**Baseline Performance (Calendar Year 2021)**	**Performance Target (Calendar Year 2025)**	**Program**			
			HHW	**HCC**	**HIP**	**Indiana PathWays for Aging**
Prenatal Depression Screening and Follow-Up (PND-E)- HEDIS ®	HHW: 2.69% HIP: 4.79%	HHW: 66%, 75%, 75% HIP: 50%, 50%, 66% HCC: 50%, 66%, 66%		X	X	
Postpartum Depression Screening and Follow-Up (PDS-E) - HEDIS ®	HHW: 5.26% HIP: 5.04%	HHW: 50%, 75%, 75% HIP: 50%, 66%, 66% HCC: 50%, 50%, 50%		X	X	
Care and Complex Case Management Report – Physical and Behavioral Health Conditions of Interest: Pregnancy & Specific to Children and Adolescents	Enrolled: HCC: 2 HHW: 29 HIP: 105	TBD	X	X	X	
Member Access to Providers (OB/GYN, PMP)	100%	100%	X	X	X	

Inpatient Utilization Report: Vaginal and Cesarean Delivery Discharges	Avg LOS Vaginal Delivery: HCC: 3 Days HHW: 2 Days HIP: 2 Days Avg LOS Cesarian Delivery: HCC: 5 Days HHW: 3 Days HIP: 3 Days	TBD	X	X	X	
Tobacco Cessation	TBD			X	X	

Early Indicator Metrics, Baseline, and Target						
Goal 3: Improve oral health and prevent oral disease						
Early Indicator Metric	**Baseline Performance (Calendar Year 2023)**	**Performance Target (Calendar Year 2025)**	**Program**			
			HHW	**HCC**	**HIP**	**Indiana PathWays for Aging**
Oral Evaluation, Dental Services- HEDIS ®	HCC: 49.13% HIP: 28.6% HWW: 48.13%	HHW: 50%, 50%, 50% HIP: 33%, 50%, 50% HCC: 50%, 50%, 50%	X	X	X	X
Member Access to Providers (Dental/Oral Surgeon)	100%		X	X	X	X
CWS WITH OPTIMUM LEVELS OF FLUORIDE- ISDH (Indiana State Department of Health) (Existing State Report)			X	X	X	

Early Indicator Metrics, Baseline, and Target						
Goal 4: Reduce complications and improve health of members with chronic conditions						
Early Indicator Metric	**Baseline Performance (Calendar Year 2023)**	**Performance Target (Calendar Year 2025)**	**Program**			
			HHW	**HCC**	**HIP**	**Indiana PathWays for Aging**
Care and Complex Case Management Report – Physical and Behavioral Health Conditions of Interest: Chronic Condition	Total Enrolled: HHC: 1652 HHW: 606 HIP: 1522 Avg. Participation Days HCC: 53.3 HHW: 41 HIP: 40		X	X	X	
Disease Management Report- ***Physical*** and Behavioral Health Conditions of Interest	Total Enrolled HCC: 8,834 HHW: 8,640 HIP: 54,643		X	X	X	X
Member Access to Providers (Specialists)	100%		X	X	X	X
Inpatient Admission for Chronic Conditions of Interest: Asthma, COPD, CHF, CAD, and Diabetes			X	X	X	X
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions with allowable adjustments (FMC)- HEDIS ®			X	X	X	X

Early Indicator Metrics, Baseline, and Target						
Goal 5: Reduce the number of inpatient readmissions for physical and behavioral health & ensure smooth transitions between level of care settings						
Early Indicator Metric	**Baseline Performance (Calendar Year 2025)**	**Performance Target (Calendar Year 2026)**	**Program**			
			HHW	**HCC**	**HIP**	**Indiana PathWays for Aging**
Transitions of Care (TRC) with allowable adjustments- HEDIS ®	TBD		X	X	X	X

Table 3.2 List of Watch Metrics

Watch Metric	HHW	HIP	HCC	Indiana PathWays for Aging
Social Need Screening and Intervention- *HEDIS* ®	✓	✓	✓	
Controlling Blood Pressure- *HEDIS* ®	✓	✓	✓	✓
Breast Cancer Screening- *HEDIS* ®	✓	✓	✓	✓
Getting Care- CAHPS				
Getting Needed Care (Usually + Always)	✓	✓	✓	✓
Getting Care Quickly (Usually + Always)	✓	✓	✓	✓
Satisfaction With Plan Physicians- CAHPS				
Rating of Personal Doctor (9 + 10),	✓	✓	✓	✓
Rating of Specialist Seen Most Often (9 + 10)	✓	✓	✓	✓
Coordination of Care (Usually + Always)	✓	✓	✓	✓

SECTION IV. Quality of Care

Measurement and Improvement Standards

The State prioritizes delivering high quality healthcare to all Medicaid members. Effective performance monitoring and data analysis play crucial roles in evaluating how MCEs uphold and enhance the quality of care provided throughout Indiana. OMPP monitors reportable measures, which may include HEDIS®, Adult and Child Core Sets, HCBS Quality metrics, state initiatives, and national quality standards. Collaborating with MCEs, OMPP establishes common definitions and ensures consistent adherence to specifications and/or state requirements for uniformity across MCEs.

MCE statutory reporting is monitored by OMPP on a monthly, quarterly, and annual basis. Data is analyzed for trends, variances, and consistency. OMPP Clinical Operations Quality Team routinely meets with the MCEs to address quality performance.

OMPP determines how MCEs quality performance will be evaluated and identifies which metrics will be reported on the Quality and Outcomes Reporting website, such as HEDIS®. The posted reports are meant to be an equal comparison of quality across all MCEs and care programs.

MCEs will be providing Long Term Support Services (LTSS) through the Indiana PathWays for Aging ~~care~~ program. Quality related assurances and sub assurances will be monitored to ensure that the quality of services being provided meet expectations. An example of how a health and welfare sub assurances will be monitored is provided below.

Example of LTSS Monitoring of Health and Welfare

Health and Welfare Sub Assurance	Monitoring
The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect, and exploitation.	The state utilizes a single critical incident reporting system to monitor and address critical incidents and identify potential cases of abuse, neglect, and exploitation.

OMPP categorizes P4Os by program, as shown in Tables 4-7. A performance measure can be applicable to multiple health care programs. Each year, OMPP reviews and approves drafts of the upcoming year's Quality Assessment and Performance Improvement (QAPI) Work Plans, along with performance improvement projects (PIPs). OMPP continues to work with the MCEs to identify sources of input to the QAPI. Figure 6 below illustrates a minimum of six sources used for input into the QAPI: the External Quality Review, HEDIS® outcomes, CAHPS® outcomes, P4O results, and other identified areas for improvement. Gaps in any of these sources should be addressed in the MCE's QAPI as well as any additional areas identified by OMPP.

Figure 6. Sources of Input to the Quality Management Improvement Workplan

MCEs must evaluate the effectiveness of their quality strategy and plan for the next year by investigating current member service utilization. This monitoring involves data mining at the MCE level, reviewing data reports from the state fiscal agent, and referrals from providers. Individuals with extensive utilization undergo additional assessment for suitability in Indiana's restricted card program, the Right Choices Program. Alternatively, they may be considered for enrollment in their MCE's disease management, care management, or complex case management programs. Individuals who underutilize appropriate health care services are encouraged to participate in preventive care services, and their primary medical providers (PMPs) are provided gaps in care reports to increase the utilization of preventive care.

Health need screening tools are used to identify individuals early with special healthcare needs, and MCEs must offer tailored programs for disease management, care management, and complex case management to address these specific needs.

Each year, OMPP outlines performance quality measures including HEDIS®. Targets for HEDIS® measures are reviewed annually as well as considered for update whenever new NCQA benchmarks become available. The state recognizes that performance improvement is an ongoing process and evaluates quality targets on an annual basis including any changes to NCQA benchmarks.

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. Pay for outcome measures may be adjusted based on national benchmarks or changes with technical specifications.

The contracted MCEs may be eligible for supplementary compensation upon achieving or surpassing the predetermined metrics outlined for pay for outcome measures. Such additional compensation is subject to the MCEs' complete and timely satisfaction of its obligations under the applicable state fiscal year contract. This includes timely submission of the contracted MCEs' HEDIS® Report for the measurement year, the Certified HEDIS® Compliance Auditor's attestation, the Consumer Assessment of Healthcare Providers

and Systems (CAHPS) report, as well as timely submission of other reports detailed in the MCE Reporting Manual.

Consumer self-reported surveys enable OMPP to collect data from the distinctive viewpoint of Medicaid members, providing valuable insights into their experiences and perspectives. Like many other state Medicaid agencies, OMPP has elected to use various forms of CAHPS® to assess member experience. Each MCE is required to submit a final report from its survey vendor to OMPP each calendar year.

Performance Improvement Projects

Each MCE must implement and maintain a minimum of two performance improvement projects (PIPs); one clinical and one non-clinical in nature. The PIP topics, goals, and objectives may be mandated by the state. Each PIP will remain in effect for three years unless OMPP decides otherwise. The MCEs must develop and submit draft PIPs by October 31 for the prospective year. OMPP offers feedback to MCEs as necessary regarding PIPs. OMPP may provide technical assistance and feedback to plans, specifically addressing the measurability of identified interventions. It is expected that PIPs will receive a minimum of 80% compliance rate from the annual EQR review. If MCEs fail to meet this expectation corrective action plans may be implemented.

OMPP requires standard processes for submission Performance Improvement Projects (PIPs) from the contracted MCEs.

- **PIP template**: Contracted MCEs are required to use a standard template for submission of PIPs. This includes both quarterly and annual submissions.
- **PIPs**: Contracted MCEs must use the OMPP developed standard template for quarterly submissions of their PIPs. Annual submission to the EQR is provided in a format provided by the external quality review organization.

Tables 4-7 outline the PIPs that each MCE plans to implement in the calendar year 2024. In 2024 prior year PIP topics were retired. MCEs were provided three topics for PIPs: Maternal/Child Health, Diabetes, and Member Satisfaction. The MCEs could choose which clinical topic they wanted to address but were required to have member satisfaction as their non-clinical PIP. The PIPs for the HHW, HIP, and HCC managed care programs were submitted by the MCEs and are unique to each plan. For the first year of the program, the PIPs for the Indiana PathWays for Aging program were determined by the state. Additional information about performance improvement projects can be found in the annual EQR Technical Reports posted publicly at https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/.

Table 4. Hoosier Healthwise 2024 Performance Improvement Projects

Hoosier Healthwise		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
MDwise		
Goal: Improve the health of members with chronic conditions		
Diabetes	Increase the enrollment of members with diabetes in the following MDwise programs: Disease Management, Care Management, and Case Management, to ensure proper monitoring of glycemic index. Enrollment is classified as a member who has received an assessment and a care plan.	Members identified through the Health Needs Screen will receive a referral to our care management team to offer and engage in disease, care, or complex case management services. By completing a direct referral, engagement will be streamlined to CM services to assist with appointment adherence. This data is a part of what is reported, due to multiple referral sources for identification and engagement of members with diabetes. This referral process allows MDwise to use the John Hopkins Predictive Modeling program to prioritize members based on acuity. Referrals are automatically generated when a member has an inpatient hospital stay. Our prior authorization team will also create Care Management referrals for when members have been identified with diabetes, requesting services be reviewed for prior authorization. As a part of this outreach will be gathering member demographics, type of prior authorization and if those members had successful outreach and engagement in Disease, Care or Complex Case Management. While not a direct correlation to GSD, it does have an impact on early identification of members who would need to have a glycemic screening completed. The MDwise Care Management team will conduct outreach to members who have been identified as being seen in the emergency room and have a diabetic related diagnosis code associated with the

Hoosier Healthwise		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
		visit. These members will receive at least (2) calls and a letter to engage them with DM, CM or CCM services. Members with diabetes will be contacted by care outreach and connected with a Community Health Worker if they reside in Allen, Marion, Monroe, or Lake counties. Eligible members will receive telephone and in-person visits to connect them to providers and resources, if needed, to manage their diabetes care.
Goal: Improve the health and wellness of pregnant persons, new mothers, infants, and children		
Infant and maternal health	Improve access to obstetric and gynecological care for pregnant members during and within 84 days of giving birth.	Members identified through the HNS will receive a warm transfer to our care management team to offer and engage in case management services. By doing a warm transfer, it will help streamline engagement into CM services to assist with appointment adherence. This data will only be one piece of what is reported due to multiple referral sources to identify and engage pregnant members. Members identified through the NOP daily reporting will receive outreach from our care management team to offer and engage in case management services. This report allows us to identify members who have already completed their first OB visit and are established with a pregnancy provider. This data will only be one piece of what is reported due to multiple referral sources to identify and engage pregnant members. Members identified through the My Healthy Baby weekly reporting will receive outreach from our care management team to offer and

Hoosier Healthwise		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
		engage in case management services. This report allows us to identify members who have confirmed their pregnancy with a support service. This data will only be one piece of what is reported due to multiple referral sources to identify and engage pregnant members.
Goal: Improve member satisfaction		
Member satisfaction	Increase member satisfaction, as measured by the number of member complaints, member grievances, and aggregation of self-reported member surveys, e.g. CAHPS, in relation to their access to services.	Utilize MDwise Quality Outreach Representatives to engage members with MDwise via telephone. Utilize mailers and postcards to engage members with MDwise. Utilize text message campaigns to engage members with MDwise.
Anthem		
Goal: Improve the health of members with chronic conditions		
Improving member outcomes	• Improve quality of SDOH and member whole health data in MY 2024 through the use of Azara with rural FQHCs • Improve outcomes for members in rural providers' panels with an asthma, diabetes, or cardiovascular disease diagnosis in MY 2024 through regular ongoing engagement with a provider quality consultant	• Contract with Azara (data aggregator) for FQHCs and implement analytic and data-sharing processes to identify members and their SDOH needs • Match identified provider groups with provider quality consultant with expertise to address areas of opportunity • Provide providers with best practice strategies to increase member compliance for targeted metrics
Goal: Improve the health of members with chronic conditions		

Hoosier Healthwise		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
Improving diabetes control	• Increase HbA1c control in previously non-compliant members in MY 2024 through the distribution of home HbA1c test kits and telephonic support • Increase HbA1c control in previously non-compliant members in MY 2024 through distribution of home HbA1c test kits in tandem with support from a CHW trained in diabetes management • Increase HbA1c control in eligible members in MY 2024 through member incentives and increased access to fresh fruits and vegetables • Decrease diabetes related emergency department visits and inpatient visits for identified and participating members compared to a control group through diabetes management tools, coaching, and incentives	• Secure home based A1c test kit vendor • Finesse CHW diabetes education protocol • Disease management program • Fruit and vegetable enhanced benefit
MHS		
Goal: Improve the health of members with chronic conditions		
Diabetes	• Increase the proportion of adults with diabetes who have an annual eye exam • Increase the proportion of adults with successful management of blood pressure/hypertension	
Goal: Improve the health and wellness of pregnant persons, new mothers, infants, and children		
Reduction in maternal and infant mortality	• Increase proportion of pregnant women who are enrolled in SSFB (Start Smart for Baby) • Reduce hospital admissions for high-risk OB members	
Goal: Improving Member Satisfaction		

Hoosier Healthwise		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
Improving member satisfaction	• Increase proportion of positive responses from MCD members who contact MHS with question/issue/concern • Improve rate for MHS Health Plan Rating	
CareSource		
Goal: Improving Member Satisfaction		
Improve member satisfaction with health plan	Improve member reported satisfaction in the health plan through increased member engagement in and utilization of enhanced benefits	Implement a new Member Services matrix to proactively offer available benefits to members and improve the process for informing and linking members to enhanced benefits during inbound and outbound member calls
Goal: Improve the health of members with chronic conditions		
Improve access to annual kidney health evaluations for members diagnosed with diabetes	Improve the compliance rate for annual kidney evaluation for members ages 18-85 years diagnosed with type 1 or type 2 diabetes through targeted provider education and decision support tools	Deliver a targeted provider education campaign to improve the rate of adoption and member access to the recommended annual kidney health evaluation
Goal: Improve the health and wellness of pregnant persons, new mothers, infants, and children		
Improve outcomes for pregnant members who are at-risk for preeclampsia	Reduce the rate of preterm births for pregnant members at-risk for preeclampsia through implementation of a proactive prenatal interdisciplinary systematic case review	Form a Prenatal Interdisciplinary Review Team (PIRT) to act as a surveillance hub to perform a systematic case review for pregnant members at-risk for preeclampsia

Table 5. Healthy Indiana Plan 2024 Performance Improvement Projects

Healthy Indiana Plan		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
MDwise		
Goal: Improve the health of members with chronic conditions		
Diabetes	Increase the enrollment of members with diabetes in the following MDwise programs: Disease Management, Care Management, and Case Management, to ensure proper monitoring of glycemic index. Enrollment is classified as a member who has received an assessment and a care plan.	Identification and outreach for new members responding "Yes" on their initial Health Needs Screening (HNS), indicating a diabetes diagnosis. Members identified through the HNS will receive a referral to our care management team to offer and engage in disease, care, or complex case management services. By completing a direct referral, engagement will be streamlined to CM services to assist with appointment adherence. This data is a part of what is reported, due to multiple referral sources for identification and engagement of members with diabetes. This referral process, allow MDwise to use the John Hopkins Predictive Modeling program to prioritize members based on acuity. Care/Case Management outreach for prior authorization for diabetes management services (IP or OP). Referrals are automatically generated when a member has an inpatient hospital stay. Our prior authorization team will also create Care Management referrals for when members have been identified with diabetes, requesting services be reviewed for prior authorization. As a part of this outreach will be gathering member demographics, type of prior authorization and if those members had successful outreach and engagement in Disease, Care or Complex Case Management. While not a direct correlation to GSD, it does have an impact on early identification of members who would need to have a glycemic screening completed.

Healthy Indiana Plan		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
		Care Management team will outreach to members that have been seen in the emergency room due to diabetes complications. The MDwise Care Management team will conduct outreach to members who have been identified as being seen in the emergency room and have a diabetic related diagnosis code associated with the visit. These members will receive at least (2) calls and a letter to engage them with DM, CM or CCM services. Identify members that would benefit from CHW outreach and connection through our Better Together Program. Members with diabetes will be contacted by care outreach and connected with a Community Health Worker if they reside in Allen, Marion, Monroe, or Lake counties. Eligible members will receive telephone and in-person visits to connect them to providers and resources, if needed, to manage their diabetes care.
Goal: Improve the health and wellness of pregnant persons, new mothers, infants, and children		
Infant and maternal health	Improve access to obstetric and gynecological care for pregnant members during and within 84 days of giving birth.	
Goal: Improving member satisfaction		
Member satisfaction	Increase member satisfaction, as measured by the number of member complaints, member grievances, and aggregation of self-reported member surveys, e.g. CAHPS, in relation to their access to services.	
Anthem		
Goal: Improve the health of members with chronic conditions		

Healthy Indiana Plan		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
Improving member outcomes	• Improve quality of SDOH and member whole health data in MY 2024 through the use of Azara with rural FQHCs • Improve outcomes for members in rural providers' panels with an asthma, diabetes, or cardiovascular disease diagnosis in MY 2024 through regular ongoing engagement with a provider quality consultant	• Contract with Azara (data aggregator) for FQHCs and implement analytic and data-sharing processes to identify members and their SDOH needs • Match identified provider groups with provider quality consultant with expertise to address areas of opportunity • Provide providers with best practice strategies to increase member compliance for targeted metrics
Goal: Improve the health of members with chronic conditions		
Improving diabetes control	• Increase HbA1c control in previously non-compliant members in MY 2024 through the distribution of home HbA1c test kits and telephonic support • Increase HbA1c control in previously non-compliant members in MY 2024 through distribution of home HbA1c test kits in tandem with support from a CHW trained in diabetes management • Increase HbA1c control in eligible members in MY 2024 through member incentives and increased access to fresh fruits and vegetables • Decrease diabetes related emergency department visits and inpatient visits for identified and participating members compared to a control group through diabetes management tools, coaching, and incentives	• Secure home based A1c test kit vendor • Finesse CHW diabetes education protocol • Disease management program • Fruit and vegetable enhanced benefit
MHS		
Goal: Improve the health of members with chronic conditions		

Healthy Indiana Plan		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
Diabetes	• Increase the proportion of adults with diabetes who have an annual eye exam • Increase the proportion of adults with successful management of blood pressure/hypertension	This is the first year of the PIP and interventions have not been fully established.
Goal: Improve the health and wellness of pregnant persons, new mothers, infants, and children		
Reduction in maternal and infant mortality	• Increase proportion of pregnant women who are enrolled in SSFB (Start Smart for Baby) • Reduce hospital admissions for high-risk OB members	This is the first year of the PIP and interventions have not been fully established.
Goal: Improving member satisfaction		
Improving member satisfaction	• Increase proportion of positive responses from MCD members who contact MHS with question/issue/concern • Improve rate for MHS Health Plan Rating	This is the first year of the PIP and interventions have not been fully established.
CareSource		
Goal: Improving member satisfaction		
Improve member satisfaction with health plan	Improve member reported satisfaction in the health plan through increased member engagement in and utilization of enhanced benefits	Implement a new Member Services matrix to proactively offer available benefits to members and improve the process for informing and linking members to enhanced benefits during inbound and outbound member calls
Goal: Improve the health of members with chronic conditions		
Improve access to annual kidney health evaluations for members diagnosed with diabetes	Improve the compliance rate for annual kidney evaluation for members ages 18-85 years diagnosed with type 1 or type 2 diabetes through targeted provider education and decision support tools	Deliver a targeted provider education campaign to improve the rate of adoption and member access to the recommended annual kidney health evaluation
Goal: Improve the health and wellness of pregnant persons, new mothers, infants, and children		

Healthy Indiana Plan		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
Improve outcomes for pregnant members who are at-risk for preeclampsia	Reduce the rate of preterm births for pregnant members at-risk for preeclampsia through implementation of a proactive prenatal interdisciplinary systematic case review	Form a Prenatal Interdisciplinary Review Team (PIRT) to act as a surveillance hub to perform a systematic case review for pregnant members at-risk for preeclampsia

Table 6. Hoosier Care Connect 2024 Performance Improvement Projects

Hoosier Care Connect		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
Anthem		
Goal: Improve the health of members with chronic conditions		
Improving member outcomes	• Improve quality of SDOH and member whole health data in MY 2024 through the use of Azara with rural FQHCs • Improve outcomes for members in rural providers' panels with an asthma, diabetes, or cardiovascular disease diagnosis in MY 2024 through regular ongoing engagement with a provider quality consultant	• Contract with Azara (data aggregator) for FQHCs and implement analytic and data-sharing processes to identify members and their SDOH needs • Match identified provider groups with provider quality consultant with expertise to address areas of opportunity • Provide providers with best practice strategies to increase member compliance for targeted metrics
Goal: Improve the health of members with chronic conditions		
Improving diabetes control	• Increase HbA1c control in previously non-compliant members in MY 2024 through the distribution of home HbA1c test kits and telephonic support • Increase HbA1c control in previously non-compliant members in MY 2024 through distribution of home HbA1c test kits in tandem with support from a CHW trained in diabetes management • Increase HbA1c control in eligible members in MY 2024 through member incentives and increased access to fresh fruits and vegetables • Decrease diabetes related emergency department visits and inpatient visits for identified and participating members compared to a control group through diabetes management tools, coaching, and incentives	• Secure home based A1c test kit vendor • Finesse CHW diabetes education protocol • Disease management program • Fruit and vegetable enhanced benefit

Hoosier Care Connect		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
MHS		
Goal: Improve the health of members with chronic conditions		
Diabetes	• Increase the proportion of adults with diabetes who have an annual eye exam • Increase the proportion of adults with successful management of blood pressure/hypertension	This is the first year of the PIP therefore, interventions have not been established.
Goal: Improve the health and wellness of pregnant persons, new mothers, infants, and children		
Reduction in maternal and infant mortality	• Increase proportion of pregnant women who are enrolled in SSFB (Start Smart for Baby) • Reduce hospital admissions for high-risk OB members	This is the first year of the PIP therefore, interventions have not been established.
Goal: Improving member satisfaction		
Improving member satisfaction	• Increase proportion of positive responses from MCD members who contact MHS with question/issue/concern • Improve rate for MHS Health Plan Rating	This is the first year of the PIP therefore, interventions have not been established.
UnitedHealthcare		
Goal: Improving member satisfaction		
Member satisfaction	Determine member satisfaction with customer service and identify opportunities for improvement using Adults CAHPS questions 24 and 25	• Analyze grievances and complaints to determine opportunities for improvement including interventions to impact results • Retro actively review monthly grievance data to identify trends and process improvement opportunities • Track grievance types for a reduction in specific grievance types based on tailored interventions
Goal: Improve the health of members with chronic conditions		

Hoosier Care Connect		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
Diabetes	Improve HbA1c control in our diabetic members	• Leverage data for diabetic outcomes overall to include interventions for measures such as member utilization (ED visits for diabetics), diabetic eye exams, etc. • Utilize Livongo as a pilot to assess for increase in adherence rates • Conduct targeted provider and member outreach to include mailings, telephonic communications, etc. in attempts to increase adherence for those members not involved in the Livongo pilot • Opportunities around diabetes and minority health as well as diabetes medication adherence impact • Care management services and distribute materials for diabetics

Table 7. Indiana PathWays for Aging 2024 Performance Improvement Projects

Indiana PathWays for Aging		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
Goal: Enhance care and service coordination between care settings		
HCBS Service Planning	Improve member involvement in HCBS service planning. The PIP aims to increase the percentage of members reporting that their service plan included most or all of the things that are important to them.	• Service Coordinator training on person-centered service planning and practices • Coordinator training on service planning documentation requirements • Plan audits and provision of technical assistance based on audit findings • Tracking of service plan content and timeliness and delivery of technical assistance, heightened scrutiny, corrective action plans, etc. based on timeliness
	Improve timeliness of HCBS service plans. The PIP aims to increase the percentage of service plans completed within established timeframes.	
	Improve the rate of completed care plans. The PIP aims to increase the number of members who had a comprehensive assessment documented within 90 days of enrollment (new members) or during the measurement year (current members).	
HCBS Service Delivery	Improve the timeliness of HCBS service delivery. This PIP would aim to increase the percent of new HCBS members whose first HCBS service is delivered within 5 days of Service Plan completion.	• Mandatory MCE reporting of service delivery timeliness
	Improve the state's capacity to collect service delivery data. This PIP would aim to increase the number of HCBS providers who have established information system capacity to enable them to meet the state's EVV reporting specifications as well as the percent of providers who exceed 90% reporting levels.	• Tracking of HCBS provider EVV connectivity and reporting • Technical assistance to providers who have not yet established connectivity or achieved targeted reporting levels.
Care Coordination	Increase the percentage of care plans shared with primary care providers (PCPs) and other documented medical care practitioners identified in the member's care plan within 30 days of the care plan development	• Care Manager training and related supports to facilitate the sharing of care plans • PCP outreach and education about what to do with care plan • Mandatory MCE reporting of care plans shared with PCPs • Tracking of service plan content and timeliness and delivery of technical assistance, heightened scrutiny, corrective action plans, etc. based on timeliness

Indiana PathWays for Aging		
PIP Topic	**PIP Aim**	**PIP Intervention(s)**
Goal: Enhance care and service coordination between care settings		
	Establish services and supports to enable at-risk individuals to avoid unnecessary NF admissions. This PIP would aim to increase the number of days that individuals identified by D-SNPs as being at risk for LTSS or nursing facility placement continue to live in the community.	• MCE policies and procedures for receiving and processing these referrals timely • Require MCEs to develop interventions to support these individuals and to assess and address risks for NF placement such as toolkits for members living in their own homes, education on dementia screening benefits, or use of telephonic post-discharge assessments

Pay for Outcomes Performance Measures

Table 8 provides information on the 2024 pay for outcomes measures for each managed care program. OMPP continues a commitment to quality improvement and closely monitors the health care program measures, working closely with the contracted MCEs to ensure quality improvement. Tables 9-11 provide MCE performance results upon which payout percentages are based.

Table 8. 2024 P4O Measures by Program

Abbreviation	Description
Hoosier Healthwise	
512	Health Needs Screening
W30	Well-Child Visits in the First 30 Months of Life (W30)
W30	Well-Child Visits in the First 30 Months of Life (First 15 Months)
WCV	Child and Adolescent Well-Care Visits (WCV)
CIS	Childhood Immunization Status (CIS) - Combo 10
LSC	Lead Screening in Children (LSC)
-	Pregnant Members Receiving Care Coordination (30 days or more)
OED	Oral Evaluation, Dental Services (OED)
PND-E	Prenatal Depression Screening and Follow-Up (PND-E)
Healthy Indiana Plan	
AAP	Adults' Access to Preventive/Ambulatory Health Services (AAP)
512	Health Needs Screening
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care
PPC	Prenatal and Postpartum Care - Postpartum Care
PND-E	Prenatal Depression Screening and Follow-Up (PND-E)
FUH	Follow-Up After Hospitalization for Mental Illness (7 days)
FUH	Follow-Up After Hospitalization for Mental Illness (30 days)
-	Pregnant Members Receiving Care Coordination
HBD	Hemoglobin A1c Control for Patients With Diabetes HbA1c Control (<8.0%), (age 18-75)
Hoosier Care Connect	
512	Health Needs Screening
-	Completion of Comprehensive Health Assessment
OED	Oral Evaluation, Dental Services (OED)
AAP	Adults' Access to Preventive/Ambulatory Health Services (AAP)
IMA	Immunizations for Adolescents (IMA) - Combo 1
WCV	Child and Adolescent Well-Care Visits (WCV)
HBD	Hemoglobin A1c Control for Patients With Diabetes HbA1c Control (<8.0%), (age 18-75)
FUH	Follow-Up After Hospitalization for Mental Illness (7 days)
FUH	Follow-Up After Hospitalization for Mental Illness (30 days)
Indiana PathWays for Aging	
-	Service Coordinator Person-Centered Planning Competency
512	Health Needs Screening

Abbreviation	Description
-	Participant Experience Accessing Care (number of grievances related to access to care/services from plan or provider)

Table 9. Hoosier Healthwise P4O Measure Overview

Anthem			MHS			MDwise			CareSource		
2020	2021	2022	2020	2021	2022	2020	2021	2022	2020	2021	2022
Well-Child Visits in the First 30 months of Life (W30) Target Threshold: NCQA 50th, 75th, 90th											
59.95	61.92	65.52	54.88	56.16	60.3	56.4	54.41	61.12	56.41	56.24	60.86
50th Percentile	75th Percentile	90th Percentile	<50th Percentile	50th Percentile	50th Percentile	50th Percentile	<50th Percentile	50th Percentile	50th Percentile	50th Percentile	50th Percentile
Child and Adolescent Well-Care Visits (WCV) Target Threshold: [NCQA 50th, 75th, 90th											
50.27	52.39	50.59	48.51	50.50	48.75	46.36	48.12	46.05	46.46	50.69	48.22
50th Percentile	50th Percentile	50th Percentile	50th Percentile	50th Percentile	50th Percentile	50th Percentile	<50th Percentile	<50th Percentile	50th Percentile	50th Percentile	50th Percentile
Lead Screening in Children Target Threshold: NCQA 50th, 75th, 90th											
65.45	64.23	56.82	66.84	60.58	57.66	65.36	56.69	54.26	67.64	66.18	61.66
50th Percentile	50th Percentile	25th Percentile	50th Percentile	25th Percentile	25th Percentile	50th Percentile	25th Percentile	25th Percentile	50th Percentile	50th Percentile	25th Percentile
Asthma Medication Ratio Target Threshold: NCQA 50th, 75th, 90th											
82.27	83.20	82.53	82.93	74.87	76.67	82.1	74.95	66.81	84.47	87.82	80.79
50th Percentile	75th Percentile	90th Percentile	75th Percentile	<50th Percentile	90th Percentile	50th Percentile	<50th Percentile	50th Percentile	75th Percentile	90th Percentile	90th Percentile

Anthem			MHS			MDwise			CareSource		
2020	2021	2022	2020	2021	2022	2020	2021	2022	2020	2021	2022
Annual Dental Visit **Target Threshold: NCQA 50th, 75th, 90th**											
48.62	49.88	49.36	*No data available*	50.50	49.95	48.28	50.99	50.09	40.63	44.34	45.09
50th Percentile	25th Percentile	<25th Percentile		50th Percentile	25th Percentile	50th Percentile	50th Percentile	25th Percentile	50th Percentile	25th Percentile	<25th Percentile
Childhood Immunization Status (CIS Combination 10) **Target Threshold: NCQA 50th, 75th, 90th**											
No data available	28.22	27.25	*No data available*	31.87	28.8	*No data available*	28.47	19.22	*No data available*	34.31	28.95
	10th Percentile	<10th Percentile		25th Percentile	<25th Percentile		10th Percentile	<10th Percentile		25th Percentile	<10th Percentile
Completion of Health Needs Screening for New Members **Target Threshold: NCQA 50th, 75th, 90th**											
No data available	24.70	27.98	*No data available*	51.48	55.18	*No data available*	36.37	57.42	*No data available*	61.84	68.61
	<60%	<60%		<60%	<60%		<60%	<60%		<60%	<60%
Prenatal Depression Screening and Follow-up (PND-E) **Target Threshold: NCQA 50th, 75th, 90th**											
No data available	*Screening* 1.59 *Follow-up* 50.00	*Screening* 1.39 *Follow-up* 66.67	*No data available*	*Screening* 2.95 *Follow-up* 33.33	*Screening* 0.91 *Follow-up* 60.00	*No data available*	Did not obtain P4O	Did not obtain P4O	*No data available*	*Screening* 6.13 *Follow-up* 44.44	*Screening* 16.52 *Follow-up* 37.1
	0% 100%	0% 100%		0% 100%	0% 100%		0% 100%	0% 100%		0% 100%	0% 100%

Table 10. Healthy Indiana Plan P4O Measure Overview

Anthem			MHS			MDwise			CareSource		
2020	2021	2022	2020	2021	2022	2020	2021	2022	2020	2021	2022
Adult Preventative Care (AAP) Target Threshold: NCQA 50th, 75th, 90th											
80.24	79.33	76.25	79.43	75.15	71.7	76.8	74.51	70.74	72.26	70.21	67.93
75th Percentile	50th Percentile	25th Percentile	50th Percentile	25th Percentile	<25th Percentile	25th Percentile	25th Percentile	<25th Percentile	<50th Percentile	<50th Percentile	<25th Percentile
Completion of Health Needs Screening for New Members Target Threshold: NCQA 50th, 75th, 90th											
46.6	39.16	38.5	70.36	62.98	66.35	0	50.82	57.42	35.01	60.94	65.56
<50th Percentile no payout	<60%	<60%	70%	60%	65%	<60%	<60%	<60%	<60%	60%	60%
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA) 7-days Target Threshold: NCQA 50th, 75th, 90th											
17.63	16.58	28.19	14.63	14.86	27.26	15.1	18.78	27.29	15.82	15.19	27.84
75th Percentile	50th Percentile	N/A	50th Percentile	50th Percentile	N/A	50th Percentile	75th Percentile	N/A	50th Percentile	50th Percentile	N/A
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA) 30-days Target Threshold: NCQA 50th, 75th, 90th											
26.23	24.66	40.02	19.99	22.04	38.19	23.21	25.50	38.50	21.74	22.30	40.33
75th Percentile	50th Percentile	N/A	25th Percentile	50th Percentile	N/A	50th Percentile	50th Percentile	N/A	50th Percentile	50th Percentile	N/A
Post-partum Visits (PPC) Target Threshold: NCQA 50th, 75th, 90th											
82.97	82.48	84.40		76.16	79.08	78.42	72.57	78.51	71.05	77.13	81.51

Anthem			MHS			MDwise			CareSource		
2020	2021	2022	2020	2021	2022	2020	2021	2022	2020	2021	2022
75th Percentile	75th Percentile	50th Percentile	*No data available*	25th Percentile	25th Percentile	50th Percentile	<50th Percentile	25th Percentile	<50th Percentile	25th Percentile	25th Percentile
Timeliness of Ongoing Prenatal Care (PPC) **Target Threshold: NCQA 50th, 75th, 90th**											
92.46	89.54	91.20	*No data available*	84.67	83.45	87.63	81.25	83.28	85.16	81.02	85.89
50th Percentile	50th Percentile	50th Percentile		75th Percentile	<25th Percentile	50th Percentile	10th Percentile	<25th Percentile	25th Percentile	10th Percentile	25th Percentile
Prenatal Depression Screening and Follow-up (PND-E) **Target Threshold: NCQA 50th, 75th, 90th**											
No data available	*Screening* 1.78 *Follow-up* 54.76	*Screening* 2.50 *Follow-up* 47.92	*No data available*	*Screening* 2.50 *Follow-up* 47.92	*Screening* 1.22 *Follow-up* 52.17	*No data available*	*No data available*	*No data available*	*No data available*	*Screening* 5.33 *Follow-up* 52.63	*Screening* 15.72 *Follow-up* 40.00
	0% 100%	0% 100%		0% 100%	0% 100%					0% 100%	0% 100%

Table 11. Hoosier Care Connect P4O Measure Overview

Anthem			MHS		
2020	2021	2022	2020	2021	2022
Completion of Health Needs Screening for New Members Target Threshold: NCQA 50th, 75th, 90th					
44.45	35.61	47.72	78.08	66.45	70.46
<50th Percentile	<60%	<60%	70%	65%	65%
Completion of Comprehensive Health Assessment Target Threshold: NCQA 50th, 75th, 90th					
77.6	74.02	73.45	87.53	90.46	90.11
76%	73%	73%	79%	79%	79%
Follow-up After Hospitalization for Mental Illness – 30 days Target Threshold: NCQA 25th, 50th, 75th					
No data available	64.04	42.16	*No data available*	58.63	*No data available*
	50th Percentile	N/A		25th Percentile	
Follow-up After Hospitalization for Mental Illness – 7 days Target Threshold: NCQA 25th, 50th, 75th					
44.73	45.93	28.54	36.54	33.89	23.08
50th Percentile	50th Percentile	N/A	25th Percentile	25th Percentile	N/A
Annual Dental Visit Target Threshold: NCQA 25th, 50th, 75th					
48.62	48.80	50.87	*No data available*	50.64	51.55
N/A	25th Percentile	N/A		50th Percentile	N/A

Anthem			MHS		
2020	2021	2022	2020	2021	2022
Adult Preventative Care **Target Threshold: NCQA 25th, 50th, 75th**					
84.32	84.25	82.52	79.43	79.5	78.05
75th Percentile	75th Percentile	75th Percentile	50th Percentile	50th Percentile	25th Percentile

Public Posting of Quality Measures and Performance

OMPP posts quality measures and performance outcomes annually to the Quality and Outcomes Reporting webpage found at: https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/, including HEDIS results for the following measure categories:

- Preventive care child measures
- Other physical health child measures
- Behavioral health child measures
- Preventive care adult measures
- Other physical health adult measures
- Behavioral health adult measures

OMPP monitors MCE compliance with contractual requirements. The MCEs submit reports to OMPP on a monthly and quarterly basis, which are reviewed by staff for compliance with the hundreds of service level agreements. Synopses of the MCE quarterly performance results can also be found on the Quality and Outcomes Reporting webpage. The synopses include data such as the following.

- Engaging in member and provider outreach
- Provider service authorization requests
- Processing provider service claims
- MCE provider network adequacy
- Measuring member experience with the MCEs

Transition of Care Policy

In accordance with 42 CFR 438.62, OMPP is committed to providing continuity of medical care during a member's transition period among the various Indiana Medicaid programs and the MCEs. The MCE must have mechanisms in place to ensure the continuity of care and coordination of medically necessary health care services for its members to ensure that members have access to services consistent with the access they previously had. The MCE is financially responsible for providing medically necessary care during the transition. Some examples of the need for special consideration include, but are not limited to, the following:

- Transitions for members receiving HIV, Hepatitis C, and/or behavioral health services, especially for those members who have received prior authorization from their previous MCE or through fee-for-service.
- Members transitioning into a managed care program from traditional fee-for-service.
- Members transitioning between MCEs, particularly during an inpatient stay.
- Members transitioning between Indiana Medicaid programs, particularly when a member becomes pregnant or disabled, or meets the annual or lifetime benefit maximum.
- Members exiting a managed care program to receive excluded services.
- Members transitioning to a new PMP.

- Members transitioning to private insurance or Marketplace coverage.
- Members transitioning to no coverage.
- Members transition between benefit packages.
- Any other necessary procedures, as specified by the state, to ensure continued access to services to 1) prevent serious detriment to the enrollee's health or 2) reduce the risk of hospitalization or institutionalization.
- Consistent with federal and state law, the enrollee's new providers are able to obtain copies of the enrollee's medical records, as appropriate.
- Members are referred to appropriate providers of services that are in the network.
- The process for the electronic exchange of beneficiary data.

In situations such as a member or PMP disenrollment, the MCE must facilitate care coordination with other MCEs or other PMPs. When receiving members from another MCE or fee-for-service, the MCE shall provide continuity of care for the authorization of services as well as choice of providers for ninety (90) days. For a member who meets HCBS Level of Care and has an existing care plan approved by FSSA or another MCE, that care plan will be honored for ninety (90) days from the date of enrollment. When receiving members from another MCE, fee-for-service, or commercial coverage, the MCE shall honor the previous care authorizations for one of the following durations, whichever comes first: ninety (90) calendar days from the member's date of enrollment with the contractor, or the remainder of the prior authorized dates or service, or until the approved units of service are exhausted. The MCE shall establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member's enrollment in their plan. Additionally, when a member transitions to another source of coverage, the MCE must be responsible for providing the receiving entity with information on any current service authorizations, utilization data, and other applicable clinical information such as disease management, case management, or care management notes. This process is overseen by the MCE Transition Coordination Manager.

The MCE will be responsible for care coordination after the member has disenrolled from the MCE whenever the member disenrollment occurs during an inpatient stay. In these cases, the MCE will remain financially responsible for the hospital DRG payment and any outlier payments (without a capitation payment) until the member is discharged from the hospital or the member's eligibility in Medicaid terminates. The MCE must coordinate discharge plans with the member's new MCE.

OMPP monitors the transition of care through member and provider grievance and appeals.

Disparities Plan

FSSA continues to develop comprehensive efforts to identify the causes of health disparities in Indiana and to create targeted strategies for reform. FSSA's Office of Healthy Opportunities prioritizes identifying and reducing the impact of social determinants of health on the populations we serve, recognizing that factors like access to food, stable housing, and education may limit someone from reaching their greatest wellbeing. The Office of Healthy Opportunities utilizes standards such as as Culturally and Linguistically Appropriate Services (CLAS) as a basis for activities. By serving our population holistically, FSSA can begin to remove barriers and positively impact health outcomes for vulnerable populations.

MCE Health Equity Monitoring

The MCEs are required to participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural, and ethnic backgrounds. OMPP requires that all MCEs develop a health equity plan that factor in race, ethnicity, language, disability[9], and social determinants of health. These plans are reviewed on an annual basis and approved by the state. Quality metrics, such as HEDIS®, that categorize data into race and ethnicity are reported to the State and reviewed for opportunities for quality improvement.

The MCEs must incorporate the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services (CLAS) into the provision of healthcare services for its members. Per 42 CFR 438.204, at the time of enrollment with the MCE, the state shall provide the race, ethnicity, and primary language of each member. This information is utilized by the MCE to ensure the delivery of culturally competent services. The MCEs must make all information available in English and Spanish and other prevalent languages, including American Sign Language, identified by OMPP, upon the member's request. Each MCE must identify additional languages that are prevalent among its membership. The MCE must also inform members that information is available upon request in alternate formats and how to obtain them. OMPP defines alternate formats as Braille, large-font letters, audio, prevalent languages, and verbal explanation of written materials. All materials must be approved by OMPP and be culturally appropriate. Verbal interpretation services must also be available and provided by the MCEs upon request. The MCEs must also ensure that all its contracted providers can respond to the cultural, racial, and linguistic needs of the populations that they serve.

The MCE must ensure all services are delivered through a health equity lens. The MCE maintains health equity representatives who are actively involved in improvement initiatives to reduce disparities by: obtaining input from Medicaid-insured individuals and from providers of direct services which are intended to reduce adverse health outcomes among Medicaid insured individuals, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts. OMPP provides oversight of MCE health equity activities as part of routine monitoring. OMPP would like to note that four of the five current MCEs have either NCQA Health Equity Accreditation or Multicultural Health Care distinction. This aligns with FSSA's vision to identify areas of opportunity to reduce health care disparities.

Identification of Persons who need Long-term Services and Supports or Persons with Special Health Care Needs

MCEs are required to conduct a health needs screen (HNS) for new members. The HNS is used to identify the member's potential physical and/or behavioral health care needs, special health care needs, long-term services and supports needs, as well as the need for disease management, care management, and/or complex case management services. The HNS may be conducted in person, by phone, online, or by mail. All MCEs use an OMPP-approved standard HNS, although the HNS may be supplemented with additional questions developed by the MCE or partnered with the MCE's comprehensive health assessment tool. Any additions to the HNS must be approved by OMPP.

[9] FSSA statutory definition of disability is defined in section 223(d) of the Social Security Act.

The plans be conducted within 90 calendar days of a new member's enrollment in the HIP, HHW, or HCC plans or within 30 calendar days of a new member's enrollment in the Indiana PathWays for Aging plan. The contracted MCE is encouraged to conduct the HNS at the same time it assists the member in making a PMP selection. Non-clinical staff may conduct the health needs screen. Data from the health

screening or notice of pregnancy (NOP) assessment form, current medications, and self-reported medical conditions will be used to meet the needs of individual members through disease management or care coordination. Each MCE may use its own proprietary stratification methodology to determine which members should be referred to specific care coordination programs, ranging from disease management involving member education and awareness efforts to care management or complex case management.

In accordance with 42 CFR 438.208(c)(2), which specifies allowable staff, OMPP requires each MCE to have a health care professional assess the member through a comprehensive health assessment tool if the health screening identifies the member as potentially having a special health care need or when there is a need to follow up on problem areas. OMPP also requires each MCE to conduct a subsequent comprehensive health assessment if a member's health care status is multifaceted or has changed since the original screening. Possible overutilization of health care services as identified through claims review may also trigger a comprehensive health assessment.

The comprehensive 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 OMPP. The MCE must maintain records of those members found to have special health care needs based on the HNS, including documentation of the follow-up comprehensive health assessment and contacts with the member, their family, or health care providers. The detailed comprehensive health assessment is utilized to identify a member's individualized needs and ultimately allows for stratification into the appropriate level of care coordination whether it be disease management, care management, or complex case management. Each MCE must offer continued coordinated care services to members with special health care needs transferring into the MCE from another MCE. MCE activities supporting the special health care needs population must include, but are not limited to:

- Conducting the initial screening and a comprehensive health assessment to identify members who may have special needs
- Scoring the initial screening and comprehensive health assessment results
- Distributing findings from the health assessment to the member's PMP, OMPP, 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

SECTION V. Assessment and Oversight

Monitoring and Compliance

The state conducts multiple monitoring activities to maintain oversight and allegiance to stated goals within this QSP. Monitoring activities include:

- Quality management and improvement program work plans
- Data analysis
- Monitoring of member hotlines operated by the state's enrollment broker
- Geographic mapping for provider network
- External quality review
- Network adequacy assurance submitted by plan
- On-site monitoring reviews
- Monitoring of national quality metrics

OMPP Quality and Outcomes staff oversees contract compliance by enforcing reporting requirements mandated within the MCEs' contracts. Each contracted MCE is required to document outcomes and performance results, as instructed within each program reporting manual, to demonstrate data reliability, accuracy, and validity. The MCE Reporting Manual provides guidance from OMPP on required performance reporting for the MCEs contracted to deliver services for HHW, HIP, and HCC. The MCE Reporting Manual is tailored to the goals of each program and describes the reporting process, submission requirements, report descriptions, definitions, and templates of all reports with an OMPP required format. The reports submitted in compliance with MCE Reporting Manual specifications are generally referred to as "periodic MCE reports."

In general, reports are submitted quarterly to monitor and compare clinical outcomes against targets, standards, and benchmarks as established by OMPP. The OMPP Quality and Outcomes staff directly manages all contracted MCE reporting to ensure timely submissions. This management supports OMPP's capacity to align and increase oversight processes across the MCEs and the programs. OMPP Quality and Outcomes staff conducts a comparative review of the report submissions by the MCEs to ensure that key performance indicators, both operational and clinical, are effectively being identified, collected, validated, and analyzed. Quality and Outcomes conducts quarterly Reporting Meetings to discuss the MCEs' data submissions. Representatives from OMPP pharmacy, program integrity, contract compliance, and operations meet to discuss the various reports submitted, analyze the data, identify discrepancies, and develop feedback for the MCEs. Anomalies that are identified may also be targeted for discussion at the Quality Strategy Committee and/or the monthly on-site visit.

OMPP Quality and Outcomes 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. Processes have been developed and implemented to improve accountability, compliance, and reliance on the operations and health outcome achievements of the state's contracted MCEs.

While the contracted MCEs are required to submit data annually from HEDIS, CAHPS®, and NCI-AD (for the Indiana PathWays for Aging program only), OMPP also collects quarterly reports on a variety of quality

indicators for preventive health, children and adolescents, and mothers and newborns. This access to data has allowed OMPP to continually track and monitor performance on key quality indicators and steer the focus toward improvement activities.

OMPP Quality and Outcomes staff review and update the reporting manuals annually based on the current needs of the programs and in conjunction with the contracted MCEs. OMPP has implemented streamlined reporting processes and increased consistency in reporting for both the MCEs and OMPP.

OMPP incorporated multiple steps within the MCE report review processes to reinforce OMPP's 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. OMPP Quality and Outcomes staff reviews data for contract compliance, adherence to established standards, and comparisons between MCEs as well as data for progress toward pay for outcomes measures and quality initiatives.

OMPP operates a Quality and Outcomes portal to provide a high-level description of key quality improvement processes and links to various resources to help interested parties see how Indiana's Medicaid program is performing. Quarterly and yearly reports from the MCEs are aggregated and synthesized on this site via a stoplight system to make performance easier to gauge. This portal can be accessed at: https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/.

Quality and Appropriateness of Care

The MCEs are contractually required to maintain an administrative and organizational structure that supports the effective and efficient delivery of services to members. Furthermore, Indiana is continually evaluating ways to increase cost-effectiveness. The overarching goal to improve access to care extends throughout the quality improvement efforts of OMPP and is embedded into the expectations of the contracted MCEs.

National Performance Measures

The MCEs monitor, evaluate, and take action to identify and address needed improvements in the quality of care delivered to members in the Indiana managed care programs. This includes necessary improvements by all providers in all types of settings. In compliance with state and federal regulations, the contracted MCEs 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 quality improvement projects. Additionally, the MCEs submit the information requested by OMPP to complete annual quality reports.

Network Adequacy and Availability of Services

Availability of Services

OMPP Quality and Outcomes requires the MCEs to develop and maintain a comprehensive network to provide services to its members. The network must include providers serving special needs populations such as people who are aged, blind, or disabled. In accordance with 42 CFR 438.68, OMPP has developed network adequacy standards for all MCEs. Access standards vary by program (e.g., HHW, HIP, HCC, and Indiana PathWays for Aging) to assure standards for the relevant types of providers needed for the populations served by each program. For example, for the HHW population, the network must include providers serving children with special health care needs. Managed care program specific network

adequacy standards are outlined within the MCE contracts that are publicly available on the FSSA website located at https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/.

The MCEs' contractual obligations with OMPP are aimed at ensuring that covered services are available to Indiana Medicaid members and delivered in a culturally competent manner. The MCEs must have written provider agreements with providers in their networks. The MCEs are responsible for ensuring covered services are available and geographically accessible. The networks must provide adequate numbers of facilities, physicians, ancillary providers, service locations, and personnel for the provision of high-quality covered services for all Indiana Medicaid members. The MCEs must ensure that all their contracted providers are registered IHCP providers and can respond to the cultural, racial, and linguistic needs of its member populations. Each MCE is contractually obligated to meet the unique needs of its members, particularly those with special health care needs, within their networks. For members who may require out-of-network services, the out-of-network providers must be IHCP providers to receive reimbursement from the MCEs.

The contracted MCEs encourage out-of-network providers, particularly emergency services providers, to enroll in the IHCP. Tribal Health providers are not required to participate with the MCE, and Native Americans enrolled in MCEs can choose their Tribal Health provider whether in- or out-of-network and those providers should be reimbursed the same as if they were in-network, under the same prior authorization requirements and at the same rate as in-network providers. The MCEs must offer Tribal Health providers contracts with their network that consider the Indian Health Addendum, but Tribal providers are not required to contract with MCEs for their Native American patients to be served.

Each MCE must develop and have under contract its specialist and ancillary provider network before receiving enrollment. HCC access requirements were changed as a part of the re-implementation of the program in 2021. New requirements for substance use disorder treatment and pediatric dentistry access were added as a result of community partner feedback.

Maintain and Monitor Network of Appropriate Providers

In accordance with 42 CFR 438.68, MCEs are required to consider the following elements when developing, maintaining, and monitoring their provider networks:

- Anticipated enrollment
- Expected utilization of services, taking into consideration the characteristics and health care needs of members
- Numbers and types of providers required, including training, experience, and specialization, to furnish the contracted services
- Numbers of network providers who are not accepting new members
- Geographic location of providers and members, considering the distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities

OMPP Quality and Outcomes reserves the right to implement corrective actions and will assess liquidated damages if the contracted MCE fails to meet and maintain the specialist and ancillary provider network access standards. OMPP monitors the MCEs' specialist and ancillary provider network to confirm that the MCE is maintaining the required level of access to specialty care. OMPP reserves the right to increase the number or types of required specialty providers at any time.

Female Member Direct Access to Women's Health Specialist

The MCEs are contractually required to 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 PMP if that provider is not a women's health specialist. The MCEs may also establish claims processing procedures that allow payment for certain women's health codes without prior authorization or referral.

Second Opinions

The managed care MCEs must comply with all member requests for a second opinion from a qualified professional. If the provider network does not include a qualified provider for a second opinion, the MCE must arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.

Adequate and Timely Coverage of Services not Available In-network

With the exception of certain self-referral service providers and emergency medical care, the MCE may limit its coverage to services provided by in-network providers once the contracted MCE has met the network access standards and has received state approval to close the network. The MCE must authorize and pay for out-of-network care if the MCE is unable to provide necessary covered medical services within contractually required mileage standards. The MCE must authorize these out-of-network services in the timeframes established in the MCE contract and must adequately cover the services for as long as the MCE is unable to provide the covered services in-network. The MCE must require out-of-network providers to coordinate with the MCE on payment and reimbursement to ensure that any cost to the member is no greater than it would be if the services were furnished in-network.

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

To ensure adequate and timely services are available to members, the MCE must make nurse practitioner services available to members. If nurse practitioner services are available through the contracted MCE, the contracted MCE must inform the member that nurse practitioner services are available. Members can use the services of out-of-network nurse practitioners if no nurse practitioner is available in the member's service area and within the MCE's network.

MCEs must make covered services provided by federally qualified health centers and rural health clinics available to members who are out-of-network. If an FQHC or RHC is not available in the member's service area within the contracted MCE's network.

Provider Credentialing

In accordance with 42 CFR 455, providers must first be enrolled as an IHCP provider before initiating credentialing with an MCE. All MCEs must have written credentialing and re-credentialing policies and procedures to ensure that quality of care is maintained or improved and to assure that all contracted providers hold current state licensure and enrollment in the IHCP. The MCEs' credentialing and recredentialing process for all contracted providers must meet the National Committee for Quality Assurance guidelines.

All new providers are required to follow the same provider enrollment process to ensure state and federal regulations are met. Federal regulations require state Medicaid agencies to screen providers and ensure they have not been excluded from participating in the Medicaid program. Once the enrollment process is completed, managed care entities receive a file from the fiscal agent with all the enrolled providers.

The contracted MCEs must ensure that providers agree to meet all OMPP's and the MCEs' standards for credentialing PMPs and specialists and maintain IHCP manual standards, including:

- Compliance with state record-keeping requirements
- OMPP's access and availability standards Quality improvement program standards

The MCEs' provider credentialing and selection policies must not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. The MCEs 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.

MCEs must ensure that the network providers offer hours of operation that are no less than the hours of operation offered to their commercial members if the MCE also serves commercial members. The MCE must also make covered services available 24/7 when medically necessary. In meeting these requirements, the MCE 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 MCE must provide OMPP written notice at least 90 calendar days in advance of the contracted MCE's inability to maintain a sufficient network in any county.

For the Indiana PathWays for Aging program, home and community-based services (HCBS) providers are not required to complete credentialing. However, these providers must continue to be IHCP-enrolled and be in good standing with their FSSA certification.

Physician Incentive Program

MCEs are contractually required to comply with Section 1876(i)(8) of the Social Security Act and federal regulations, including 42 CFR 438.3, 42 CFR 422.208, and 42 CFR 422.210. The MCEs must provide OMPP information on its physician incentive plan as required in the regulations and with sufficient detail for OMPP to determine whether incentive plans comply with federal requirements. The MCEs 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 arrangements 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 MCEs must also meet requirements for stop-loss protection, member survey, and disclosure requirements under 42 CFR 438.6.

Assurances of Adequate Capacity and Services

MCEs are contractually obligated to:

- Serve their 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

OMPP requires each of the contracted MCEs to submit network access reports. Network access reports are aligned between the managed care programs to ensure consistency by all MCEs in reporting the number of providers and member access. The reporting requires each MCE to provide the unique count of providers under contract by provider specialty and county location. The reports require the MCEs to utilize the IHCP Provider Type and Specialty that is assigned to the provider. For those specialties without a pre-defined IHCP Provider Type or Specialty, the MCEs are required to use the nationally recognized taxonomy code for the provider in assigning them to a specialty category. Each provider is to be counted once based on the county in which the rendering provider is located. The unique providers by county are then compared to the MCE's capitation payment file containing the total members enrolled with them in each line of business in September. Members are then segmented into one of the state's 92 counties. Each member is then tested to determine the distance that the member would need to travel to seek the services of each provider category listed on the report.

MCEs submit network access reports on an annual basis in October of each year and at any time there is a significant change to the provider network. OMPP reserves the right to expand or revise the network requirements due to changing provider or member enrollment, as it deems appropriate. OMPP stipulates that an MCE may not discriminate concerning participation, reimbursement, or indemnification of any provider, solely based on such license or certification, who is acting within the scope of the provider's license or certification under applicable state law. However, the MCEs may include providers only to the extent necessary to meet the needs of the MCE's members. The MCEs may also manage provider enrollment to establish and maintain quality measures and control costs consistent with the MCE's responsibilities.

OMPP strives to maintain access to care for all members via several managed care contractual requirements. The MCEs are required to develop and implement provider incentive programs to assure the provision of services for all Medicaid members. They are obligated to ensure that a full spectrum of medical services is accessible to all Medicaid members including those who reside in the rural areas of Indiana with emphasis on the specialty provider and hospital services. Another contractual requirement directs the MCEs to ensure that members have access to care via those physicians in academic medical centers. OMPP utilizes the network adequacy reports submitted by the MCEs regularly to assess member access to services.

Acute Care Hospital Facilities

OMPP requires that all MCEs provide a sufficient number and geographic distribution of acute care hospital facilities to serve the expected enrollment. The transport distance to a hospital from the member's home shall be usual and customary, not to exceed thirty (30) miles in urban areas and sixty (60) miles in rural areas. 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 Requirements

To assure the availability of PMPs for members around the state, OMPP's managed care contracts include provisions on PMPs:

- PMPs are allowed to contract with one or multiple MCEs. A PMP may also participate as a specialist in another MCE. The PMP may maintain a patient base of individuals who are not members of HHW, HIP, and/or HCC (e.g., commercial or traditional Medicaid members).
- The MCEs may not prevent the PMP from contracting with other MCEs.
- The MCEs must ensure 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 HHW 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 MCEs must provide access to PMPs within at least 30 miles of the member's residence. Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians, gynecologists, and endocrinologists (if primarily engaged in internal medicine). Due to the characteristics of needs for members who are aged, blind or disabled, in HCC any physician may be an individual's PMP.
- The MCE's PMP contract must state the PMP's panel size limits, and the MCE must assess the PMP's non-managed care practice size when assessing the PMP's capacity to serve the MCE's Medicaid members. Gainwell, OMPP's fiscal agent, maintains a separate panel for those PMPs contracted with more than one MCE.
- The MCEs must ensure that the PMP provides "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 MCEs must also ensure that members have telephone access to their PMP (or appropriate designee such as a covering physician) in English and Spanish 24/7.
- Each PMP shall 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.
- The MCEs must ensure that PMPs are maintaining the PMP medical care standards and practice guidelines detailed in the IHCP Provider Manual. The MCEs 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 MCEs 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 MCE networks. In addition, physicians contracted as a PMP with one MCE may contract as a specialist with other MCEs.

The MCEs must ensure that specialists are maintaining the medical care standards and practice guidelines detailed in the IHCP Provider Manual. OMPP requires the MCEs 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.

OMPP requires the MCEs to develop and maintain a comprehensive network of specialty providers. These requirements are outlined within the MCE contracts that are publicly available on the FSSA website located at https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/.

OMPP requires that the MCEs maintain additional network access standards for durable medical equipment and home health providers:

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

In addition, the MCEs must demonstrate the availability of certain specialty providers. The MCEs must also contract with the Indiana Hemophilia and Thrombosis Center or a similar OMPP approved federally recognized treatment center. This requirement is based on the findings of the Centers for Disease Control and Prevention which illustrate that persons affected by a bleeding disorder receiving treatment from a federally recognized treatment center require fewer hospitalizations, experience fewer bleeding episodes, and experience a 40% reduction in morbidity and mortality. The MCEs must also arrange for laboratory services only through those IHCP-enrolled laboratories with Clinical Laboratory Improvement Amendments certificates.

Non-psychiatrist Behavioral Health Providers

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

The MCEs must meet specific network composition requirements for non-psychiatrist behavioral health providers:

- In urban areas, the MCEs must provide at least one behavioral health provider within 30 minutes or 30 miles. Due to the availability of professionals, access problems may be especially acute in rural areas. In rural areas, the MCE must provide at least one behavioral health provider within 45 minutes or 45 miles. The MCE must provide assertive outreach to members in rural areas where behavioral health services may be less available than in urban areas.
- The MCEs 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 MCE's network:
    - Outpatient mental health clinics
    - Community mental health centers
    - Psychologists
    - Certified psychologists
    - Health services providers in psychology
    - Certified social workers
    - Licensed 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

Coordination of Benefits and Continuity of Care

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

OMPP requires that each MCE coordinates benefits and payments with the other insurer for services authorized by the MCE that were provided outside the MCE'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 MCE must not prevent or unduly delay a member from receiving medically necessary services. Each MCE remains responsible for the costs incurred by the member concerning care and services which are included in the MCE's capitation rate and not covered or payable under the other insurer's plan.

In accordance with Indiana Code (ID) 12-15-8 and 405 Indiana Administrative Code (IAC) 1-1-15, OMPP 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. An MCE may exercise 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

If an HHW member is enrolled in or covered by another insurer, the MCE is fully responsible for coordinating benefits. If an HHW Package A member's primary insurer is a commercial HMO and the contracted MCE cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the contracted MCE's rules, the MCE may submit to the enrollment broker a written request for disenrollment. The request must provide a specific description of the conflicts and explain why benefits cannot be coordinated. The enrollment broker will consult with OMPP and the request for disenrollment will be considered and acted upon accordingly.

Coordination of Benefits: Hoosier Healthwise, Package C

An individual is not eligible for HHW Package C if they have other health insurance coverage. If the MCE discovers that a HHW Package C member has other health insurance coverage, they must report the member's coverage to the state. OMPP requires the MCE to assist the state in its efforts to terminate the member from HHW Package C due to the existence of other health insurance.

The MCEs should coordinate with other insurance types such as worker's compensation insurance and automobile insurance.

Coordination of Benefits: HIP

An individual is not eligible for HIP if they have other health insurance coverage. If the MCE discovers that a HIP member has other health insurance coverage, they are required to coordinate benefits and must report the member's coverage to the state. OMPP requires each MCE to assist the state in its efforts to terminate the member from HIP due to the existence of other health insurance.

Coordination of Benefits: HCC

If an HCC member is enrolled in or covered by another insurer, the MCE is fully responsible for coordinating benefits. If an HCC member's primary insurer is a commercial HMO and the contracted MCE cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the contracted MCE's rules, the MCE may submit to the enrollment broker a written request for disenrollment. The request must provide a specific description of the conflicts and explain why benefits cannot be coordinated. The enrollment broker will consult with OMPP, and the request for disenrollment will be considered and acted upon accordingly.

Coordination of Benefits: Indiana PathWays for Aging

If a PathWays member is dually enrolled in Medicaid and Medicare, it is the MCEs responsibility to coordinate benefits between Medicaid and Medicare Clinical Practice Guidelines

MCEs develop or adopt practice guidelines based on valid and reliable clinical evidence and/or through the consensus of health care professionals in the field. The MCE must utilize a nationally recognized set of guidelines, including but not limited to non-company customized Milliman Care Guidelines (MCG) or InterQual, which must be approved by the state. These practice guidelines are evaluated according to the needs of Indiana Medicaid members and are periodically reviewed and updated. Periodically, the MCEs 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.

Coverage and Authorization of Services

OMPP requires all MCEs to operate and maintain a utilization management program. The MCEs 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 MCEs 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 MCEs 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 MCEs' members. Pursuant to 42 CFR 438.210, relating to authorization of services, the contracted MCEs 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 MCEs 'members
- Periodically review and update the guidelines, distribute the guidelines, or make them available to providers upon request 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 OMPP

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

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

OMPP requires each MCE to report its medical necessity determination decisions and must describe its prior authorization and emergency room utilization management processes. When the MCE 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.

OMPP requires that each MCE's utilization management program:

- Include activities above and beyond traditional utilization management activities, such as prior authorization
- Integrate with other functional units as appropriate and support 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.
- Have policies, procedures, and systems in place to identify aberrant provider practice patterns related to the emergency room, inpatient services, transportation, drug utilization, preventive care, and screening exams

- Utilize policies, procedures, and systems in place to ensure positive outcomes including active participation of a utilization review committee; evaluation of efficiency and appropriateness of service delivery; and incorporation subcontractor's performance data and facilitate program management and long-term quality and identify the critical quality of care issues
- Connect members to disease management, care management, and complex case management
- Encourage health literacy and informed responsible medical decision-making. For example, the MCE 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 MCE is also responsible for identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care.

OMPP requires that the MCE monitors utilization through retrospective reviews, identifies areas of high and low utilization, and identifies key reasons for the utilization patterns. Each MCE must identify those members that are high utilizers of emergency department services and/or other services and perform the necessary outreach and screening to ensure the member's services are coordinated and that the member is aware of and participating in the appropriate disease management, care management or complex case management services. The MCE must also use this data to identify additional disease management programs that are needed. Any member with emergency department utilization at least three standard deviations outside of the mean for the population group is to be referred to care management or complex case management. When identifying members who over-utilize services, the MCE may use Indiana's Right Choices Program, or they may refer members to care management or complex case management.

The MCEs must monitor pharmacy utilization as identified when stratifying a member for care. Pharmacy services for managed care members continue to be managed by the MCE through their own pharmacy benefits managers. As a part of the utilization review, the MCEs will assess a member's utilization as compliant with, contraindicated, or in conflict with their diagnoses and health care needs. The OMPP Pharmacy team is currently collaborating with Indiana's MCEs to align their pharmacy medical necessity criteria with the Medicaid fee for service program. This project will establish uniform prior authorization criteria and processes among the MCEs.

As part of its utilization review, the MCEs 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 MCEs should target education, incentives, and outreach plans tailored to its member population to increase member compliance with preventive care standards and to decrease inappropriate use of health care.

To monitor the potential under- or over-utilization of physical and behavioral health services, the MCEs submit a variety of utilization reports to OMPP. The MCEs monitor the volume, type, effectiveness, and timeliness of their prior authorization requirements. The MCEs also provide OMPP with the rates of assessment utilizing the state-approved health needs screen as well as their own comprehensive health assessments. OMPP also receives quarterly reporting on how members are stratified, upon completion of assessment(s), into the appropriate level of care coordination including disease management, care management, and complex case management. MCEs monitor the use of services for their members assessed with special needs as well as members with a diagnosis of serious emotional disturbance, severe mental illness, and/or substance abuse.

Intermediate sanctions

It is the state's primary goal to ensure that the MCE and its subcontractors/vendors deliver quality care to members while maintaining the program integrity of the State of Indiana's Medicaid programs. In accordance with 42 CFR 438 Subpart I, Indiana MCE contracts include provisions for failure to perform remedies. Non-compliance remedies include a written warning, formal corrective actions, withhold of payments, suspending enrollments, immediate sanctions, and contract termination. These remedies provide OMPP 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 on-site monitoring visits. OMPP works collaboratively with the contracted MCEs 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. If a formal correction action is put into place, OMPP and the MCE then negotiate the specific sanction.

OMPP may enforce any of the remedies listed if the MCE does the following:

- Fails substantially to provide medically necessary services that the MCE is required to provide, under law or its Contract with the state, to a member.
- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the HCC program.
- Acts to discriminate among members based on their health status or need for health care services, such as unlawful termination, refusal to re-enroll a member, or engaging in any practice that would reasonably be expected to discourage enrollment by a potential member whose medical condition or history indicates a probable need for substantial future medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to the state.
- Misrepresents or falsifies information that it furnishes to a member, potential member, or health care provider.
- Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210; or
- Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

Table 12. 2021-2023 Sanctions and/or Corrective Actions Imposed on MCEs

Type of Sanction	Number of Sanctions Applied		
	2021	2022	2023
Liquidated Damages	13	24	27
Corrective Action Plan	12	29	5
Warning Letter	0	0	3

Structure and Operations Standards

Provider Enrollment and Disenrollment

The contracted MCEs must follow established procedures to enroll and disenroll providers, including PMPs. In enrolling and disenrolling providers, the MCEs may distinguish whether the provider participates in HHW, HCC, HIP and/or Indiana PathWays for Aging programs. The Managed Care Policies and Procedures Manual provides detailed information on PMP and provider enrollment and disenrollment procedures. Once enrolled at the MCE, enrollment information is entered into CoreMMIS with the fiscal agent to complete the enrollment process.

If a PMP disenrolls from the HHW, HCC, or HIP program, but remains an IHCP provider, the MCE must ensure that the PMP provides a continuation of care for his/her HHW, HCC, and/or HIP members for a minimum of 30 calendar days or until the member's link to another PMP becomes effective.

When a PMP disenrolls from HHW, HCC, or HIP, the MCE 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 MCE assigns the member to another PMP in-network before the original PMP's disenrollment is effective.

The MCE must make a good faith effort to provide written notice of a provider's disenrollment to any member who has received primary care services from that provider or otherwise sees the provider regularly. Such notice must be provided within 15 calendar days of the MCE's receipt or issuance of the provider termination notice.

Member Information

Member Enrollment

Applicants for the HHW, HCC, HIP, and Indiana PathWays for Aging programs have an opportunity to select a MCE on their application. The MCEs 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 MCE. Applicants who do not select a MCE on their application will be auto-assigned to an MCE according to the state's auto-assignment methodology. For members enrolled in the Indiana PathWays for Aging program, the MCE's companion D-SNP must be exclusively aligned with its Indiana PathWays for Aging Medicaid plan and will only be allowed to enroll dual eligible members who are also enrolled in its Indiana PathWays for Aging Medicaid plan. Members enrolled in a Indiana PathWays for Aging Medicaid plan who later become Medicare-eligible for the first time will be default enrolled into the MCE's companion D-SNP.

New Member Materials

Within five (5) calendar days of a new member's enrollment date, the MCE sends the new member a welcome packet. The welcome packet includes a minimum of a new member letter, an explanation of where to find information about the MCE's provider network, and a copy of the member handbook or member quick start guide. HHW, HCC, and HIP members receive a member ID card within the same timeframe as the welcome packet. The member ID card includes the member's identification number and the applicable phone numbers for member assistance.

The welcome packet contains information about selecting a PMP, completing a health needs screening, and the MCE's educational programs and enhanced services. For example, if the MCE incentivizes members

to complete a health needs screen, 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.

Primary Medical Provider Selection

OMPP requires each MCE to ensure 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 MCE must assist the member in choosing a PMP. If the member has not selected a PMP within 30 calendar days of the member's enrollment, the MCE assigns the member to a PMP. Unless the member elects otherwise, the member must be assigned to a PMP within 30 miles of the member's residence and the MCE considers any prior provider relationships when making the assignment. OMPP approves the MCE's PMP auto-assignment process prior to implementation, and the process must comply with any guidelines set forth by the state.

The member may make PMP changes at any time. If the member was auto-assigned a PMP, the member may change to another provider which s/he prefers. The member may also work with the MCE to find a new PMP if he or she moves or otherwise desires a change.

Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians, gynecologists, and endocrinologists (if primarily engaged in internal medicine). HCC allows any treating specialist to be a member's PMP due to the unique health needs of members.

Children with Special Health Care Needs

OMPP requires each MCE to develop care plans to address the special needs populations and for the provision of medically necessary, specialty care through direct access to specialists. The HHW managed care program uses the definition and reference for children with special health care needs as adopted by the Maternal and Child Health Division of the Indiana Department of Health and published by the American Academy of Pediatrics:

> "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 needs screening tool will assign children to one of the Living with Illness Measures screen health domains based on the National Committee on Quality Assurance study design. The scoring for the LWIM screen identifies a child as potentially having a special health care need if the screening identifies needs in one or more of seven 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 Managed Care Entities

In accordance with 42 CFR 438.56 regarding enrollment and disenrollment, each MCE 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 pattern may not serve as the basis for disenrollment from the contracted MCE.

The MCE must notify the local county FSSA Division of Family Resources office within 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 MCE will have no authority to pursue recovery against the estate of a deceased Medicaid member.

Confidentiality

The MCE must ensure that member medical records and all other health and enrollment information that contain individually identifiable health information, is used and disclosed in accordance with the privacy requirements set forth in the Health Insurance Portability and Accountability Act Privacy Rule (see 45 CFR parts 160 and 164 , subparts A and E, which address security and privacy of individually identifiable health information). OMPP requires that each MCE 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.

OMPP requires that each MCE's information system is in compliance with the HIPAA Transaction and Code Set requirements for electronic health information data exchange, National Provider Identifier requirements, and Privacy and Security Rule standards. The MCEs' electronic mail encryption software for HIPAA security purposes must be as stringent as the state's security level. The MCEs' Information System 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

OMPP requires each MCE to establish written policies and procedures governing the resolution of grievances and appeals. 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 MCEs' grievances and appeals system, including the policies for record-keeping and reporting of grievances and appeals, must comply with state and federal regulations.

The MCEs' appeals process must:

- Allow members, or providers acting on the member's behalf, 60 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 MCE 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 MCE 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 MCE decision to a state fair hearing.

The MCE must provide specific information regarding member grievance, appeal, and state fair hearing procedures and timeframes to members. This information is included in the MCE welcome packet and is available upon request. The MCE must also supply providers and subcontractors' information on member grievance, appeal, and state fair hearing procedures and timeframes at the time they enter a contract with the MCE.

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 MCE and the state. A reference to this provision and its requirements must be included in all provider agreements and subcontracts.

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

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

- The MCE must obtain the approval of OMPP before subcontracting any portion of the project's requirements. Subcontractors may include but are not limited to a transportation broker, behavioral health organizations, pharmacy benefits managers, and physician-hospital organizations.
- All subcontractors must fulfill all state and federal requirements appropriate to the services or activities delegated under the subcontract.
- The MCEs must have policies and procedures addressing auditing and monitoring subcontractors' data, data submissions, and performance. The contracted MCEs must report contractor performance accurately and completely by integrating subcontractors' financial and performance data (as appropriate) into the contracted MCEs' information system to confirm contract compliance.

OMPP reserves the right to audit MCEs' subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. 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 MCE uses subcontractors to provide direct services to members, such as behavioral health services, the subcontractors must meet the same requirements as the MCE. The MCE must demonstrate its oversight and monitoring of the subcontractor's compliance with these requirements. The MCE 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.

MCE Health Information Systems

OMPP requires all MCEs to operate and maintain an information system sufficient to support the HHW, HCC, and HIP program requirements and capable of collecting and transmitting required data and reports to OMPP in the format specified by OMPP. Each contracted MCE maintains an information system that collects, analyzes, integrates, and reports data. Contracted MCEs report data to OMPP on:

- Utilization management: health needs screens, comprehensive health assessments screenings, prior authorization, care management, complex case management, disease management, services utilization, pregnancy identification
- Member services: member helpline, member portal, grievances, hearings and appeals, Consumer Assessment of Healthcare Providers and Systems
- 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: Third Party Liability, medical loss ratio, and benefit costs
- Clinical reports: newborns, well-child visits, preventive exams, health screenings, ambulatory care, emergency department, and inpatient utilization, follow up after hospitalization, and inpatient readmissions

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

OMPP requires that all contracted MCEs develop information system contingency plans in accordance with 45 CFR 164.308, which relates to administrative safeguards, and to comply with 42 CFR 438.242 relative to data. Contingency plans must include Data Backup plans, Disaster Recovery plans, and Emergency Mode of Operation plans. Application and Data Criticality Analysis and Testing and Revisions procedures are also required to be addressed within the MCE's contingency plan documents.

External Quality Review Arrangements

OMPP contracts with an External Quality Review Organization (EQRO), Qsource, to conduct external quality review services for all Indiana Medicaid programs and MCEs. The EQRO contract with Qsource began in 2021 and is a four-year contract with two one-year optional extensions. The HHW, HCC, HIP, and Indiana PathWays for Aging EQRs take place each summer, with the results reported each fall. The CHIP EQR is conducted each winter, with the results reported each spring.

Performance measures, PIPs, and standards related to elements in 42 CFR 438 subpart D and 438.330 are validated and reported by the EQRO per 42 CFR 438.364, and include the following activities:

- Validation of all MCE PIPs
- Validation of performance measures specific to Report 0510 Institution for Mental Disease (IMD) Member use
- Review of compliance with Medicaid and CHIP Managed Care Regulations
- Validation of encounter data
- Review of network adequacy specific to primacy care providers

The Annual Technical Report required by 42 CFR 438.364 is developed using information from the EQR. OMPP does not leverage the non-duplication or exemption options offered by CMS under 42 CFR 438.360. All mandatory external quality review-related activities per 42 CFR 438.358 are reviewed for all MCEs. A copy of the state's EQR is posted publicly at https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/.

SECTION VI. Improvements and Interventions

Improvements

OMPP's Quality Strategy Plan builds upon prior quality strategies, with a continued focus on preventive health care for all programs as well as specific priorities for certain populations served by the various managed care programs (e.g., HHW and HIP priorities on healthy moms and healthy children to ensure that quality health care is provided to all members). While each MCE has identified quality improvements, there are several initiatives in place that encompass all Medicaid programs. The interventions listed in Table 13 are at the forefront of planning and implementation of this Quality Strategy. Ongoing monitoring will provide OMPP with quality-related data for future monitoring and planning.

Some of the interventions that encompass all Medicaid programs are tracked through the pay for outcomes measures described by OMPP within this document.

Table 13. Cross-cutting Interventions for Managed Care Programs.

Intervention	Process	Stakeholders
Outcome-Based Contracting	• Pay for outcomes • Maintain and improve current metrics • Reporting that matches the state's goals • Monitor enrollment in the Right Choices program • Assure member access to care	OMPP Contracted MCEs
Prenatal/Postpartum Care Initiatives	• Notification of pregnancy monitoring • Smoking cessation initiatives for pregnant members • Monitoring member's access to care • Partnership with the IDOH • My Healthy Baby project • Indiana Pregnancy Promise Program that connects individuals to prenatal and postpartum care, other physical and mental health care, and treatment for opioid use disorder	OMPP Contracted MCEs IDOH Providers
Improve health care for Indiana's Children/EPSDT	• Increase the percentage of children and adolescents receiving well-care • Develop a protocol for provider adherence to in-depth physical and mental health screenings	OMPP Contracted MCEs Gainwell DMHA

Intervention	Process	Stakeholders
	• Ongoing provider education, monitoring, and outreach • Collaborating with IDOH to increase blood lead testing rate in Indiana • Monitor collaboration efforts between mental health services, PRTF, and Money Follows the Person services	EPSDT IDOH
Behavioral Health	• Collaborative project focused on follow-up after mental health hospitalization • Increase member access to SUD services and providers • Increase the number of IHCP enrolled SUD providers • Approval for and implementation of the SMI Waiver • Use of standard *IHCP residential/inpatient substance use disorder treatment prior authorization request form* to request prior authorization for inpatient and residential SUD treatment services	OMPP DMHA Contracted MCEs
Improving access to prenatal care and case management of high-risk pregnancies by improving the process for notification of pregnancy programs	• Monitor the improvements in the notification of pregnancy process	OMPP Contracted MCEs IDOH Providers

MCE information systems are used to collect and submit data to the state to validate performance. State staff directly manages all MCE report submissions. This direct management supports and deepens the OMPP's capacity to align and increase oversight processes across the MCEs and the Medicaid programs. Through the course of this alignment, a full comparative review of the report submissions by the contracted MCEs takes place to ensure that key performance indicators, both operational and clinical, are effectively being identified, collected, validated, and analyzed. Reporting dashboards are presented to the Quality Strategy Committee and sub-committees for review. The role of the Committee is to assist in the development and monitoring of the identified goals and strategic objectives of the written Quality Strategy and to advise and make recommendations to OMPP.

While the MCEs are required to submit annual HEDIS data, OMPP also collects quarterly reports on a variety of quality indicators for preventive health, children and adolescents, and mothers and newborns.

The increased access to data allows OMPP to continually track and monitor performance on key quality indicators and steer the focus toward improvement activities. Annually, OMPP revises the MCE reporting manual to keep the manual relevant to the quality and oversight needs of OMPP.

OMPP will continue to monitor and work with the MCEs, the state fiscal agent, and the EDW to identify and decrease the limitations within their specific health information systems that prevent encounter claims from being provided and loaded in a timely and accurate manner.

Adult and Child Quality Measures

Adult Core Quality Measure data is calculated following CMS instructions in the *Consolidated Implementation Guide* and the *Technical Specifications and Resource Manual*. Data is collected for members in managed care and fee-for-service members. For 2023, OMPP submitted rates for 24 of 34 Adult Core Quality Measures to CMS, sourced from both HEDIS and AHRQ measures.

Adult Core Measure Reported

Measure description	Measure Abbreviation	Rate
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 And Older	AAB	40.80
Antidepressant Medication Management	AMM	61.40
Asthma Medication Ratio: Ages 19 to 64	AMR	55.60
Breast Cancer Screening	BCS	50.00
Controlling High Blood Pressure	CBP	58.60
Contraceptive Care - Postpartum Women Ages 21 to 44	CCP	10.50
Cervical Cancer Screening	CCS	24.80
Contraceptive Care - All Women Ages 21 to 44	CCW	22.40
Screening for Depression and Follow-Up Plan: Age 18 and Older	CDF	0.30
Chlamydia Screening in Women Ages 21 to 24	CHL	56.90
Concurrent Use of Opioids and Benzodiazepines	COB	3.10
Colorectal Cancer Screening	COL	35.22
Follow-up After Emergency Department Visit for Substance Use: Age 18 and Older - 30 Days	FUA - 30	38.60
Follow-up After Emergency Department Visit for Substance Use: Age 18 and Older - 7 Days	FUA - 7	27.20
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older - 30 Days	FUH - 30	40.30
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older - 7 Days	FUH - 7	24.60
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older - 30 Days	FUM - 30	47.90
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older - 7 Days	FUM - 7	32.30

Hemoglobin A1c Control for Patients with Diabetes	HBD - Control	46.20
Hemoglobin A1c Control for Patients with Diabetes	HBD - Poor Control	45.90
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c) Poor Control (>9.0%)	HPCMI	0.10
Initiation and Engagement of Substance Use Disorder Treatment		
Initiation of SUD Treatment: Alcohol Use Disorder	IET	
18-64		43.60
65+		59.30
Engagement of SUD Treatment: Alcohol Use Disorder	IET	
18-64		17.90
65+		10.20
Initiation of SUD Treatment: Opioid Use Disorder		
18-64		70.10
65+		75.00
Engagement of SUD Treatment: Opioid Use Disorder		
18-64		48.80
65+		53.60
Initiation of SUD Treatment: Other Substance Use Disorder		
18-64		36.10
65+		74.10
Engagement of SUD Treatment: Other Substance Use Disorder		
18-64		15.50
65+		11.10
Initiation of SUD Treatment: Total		
18-64		44.50
65+		65.50
Engagement of SUD Treatment: Total		
18-64		22.10
65+		16.50
Medical Assistance with Smoking and Tobacco Use Cessation	MSC	
Advising Smokers and Tobacco Users to Quit		63.40
Discussing Cessation Medications		43.60
Discussing Cessation Strategies		42.80
Use of Opioids at High Dosage in Persons Without Cancer	OHD	1.10
Use of Pharmacotherapy for Opioid Use Disorder	OUD	

Total Rate		0.70
Buprenorphine		0.30
Oral naltrexone		0.40
Long-acting, injectable naltrexone		0.00
Methadone		0.00
Prenatal and Postpartum Care: Postpartum Care	PPC	76.40
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	SAA	52.90
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	78.80

OMPP has tracked and monitored the Child Core Quality Measures since the initiation by CMS. The Child Quality Measures are created and tracked by an outside vendor, Qsource. For 2023, OMPP reported on 21 of the 27 Child Core Quality Measures.

Child Core Measure Reported

Measure description	Measure Abbreviation	Rate
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years	AAB	77.40
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	ADD	
Initiation Phase		45.70
Continuation and Maintenance (C&M) Phase		53.90
Ambulatory Care: Emergency Department (ED) Visits	AMB	
< Age 1		96.90
Ages 1 to 9		44.10
Ages 10 to 19		32.60
Total (Ages <1 to 19)		41.80
Asthma Medication Ratio: Ages 5 to 18	AMR	
Ages 5 to 11		75.90
Ages 12 to 18		67.40
Total (Ages 5 to 18)		71.60
Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	
Blood Glucose		
Ages 1 to 11		34.60
Ages 12 to 17		52.30
Total (Ages 1 to 17)		45.80
Cholesterol		
Ages 1 to 11		22.00

Ages 12 to 17		28.50
Total (Ages 1 to 17)		26.10
Blood Glucose and Cholesterol		
Ages 1 to 11		20.10
Ages 12 to 17		26.60
Total (Ages 1 to 17)		24.20
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	APP	
Ages 1 to 11		58.60
Ages 12 to 17		61.00
Total (Ages 1 to 17)		60.10
Contraceptive Care - Postpartum Women Ages 15 to 20	CCP	
Most effective or moderately effective method of contraception		
Three Days Postpartum Rate		6.10
Ninety Days Postpartum Rate		46.90
Long-acting reversible method of contraception (LARC)		
Three Days Postpartum Rate		2.90
Ninety Days Postpartum Rate		15.20
Contraceptive Care - All Women Ages 15 to 20	CCW	
Most effective or moderately effective method of contraception		11.70
Long-acting reversible method of contraception (LARC)		1.60
Screening for Depression and Follow-Up Plan: Ages 12 to 17		0.20
Chlamydia Screening in Women Ages 16 to 20		45.20
Childhood Immunization Status	CIS	
DTaP		67.20
IPV		84.10
MMR		83.50
HiB		80.80
Hep B		83.50
VZV		83.00
PCV		67.90
Hep A		82.20
RV		66.80
Flu		39.50
Combo 3		59.10

Combo 7		51.80
Combo 10		28.30
Developmental Screening in the First Three Years of Life	DEV	
Children screened by 12 months of age		32.20
Children screened by 24 months of age		35.20
Children screened by 36 months of age		14.20
Children Total		26.80
Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17	FUA	
Follow-up within 30 days of ED visit Ages 13 to 17		30.80
Follow-up within 7 days of ED visit Ages 13 to 17		19.50
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17	FUH	
Follow-Up within 30 days after discharge Ages 6 to 17		66.80
Follow-Up within 7 days after discharge Ages 6 to 17		43.00
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17	FUM	
30-day follow-up after ED visit for mental illness Ages 6 to 17		63.10
7-day follow-up after ED visit for mental illness Ages 6 to 17		46.60
Immunizations for Adolescents	IMA	
Meningococcal		80.90
Tdap		83.70
Human Papillomavirus (HPV)		29.50
Combination 1 (Meningococcal, Tdap)		80.20
Combination 2 (Meningococcal, Tdap, HPV)		27.90
Lead Screening in Children - At least one lead capillary or venous blood test on or before the child's second birthday		57.00
Oral Evaluation, Dental Services	OEV	
Age <1		0.40
Ages 1 to 2		18.00
Ages 3 to 5		43.10
Ages 6 to 7		53.10
Ages 8 to 9		53.80
Ages 10 to 11		51.60
Ages 12 to 14		46.20
Ages 15 to 18		38.80

Ages 19 to 20		22.60
Total ages <1 to 20		40.40
Prenatal and Postpartum Care: Timeliness of Prenatal Care	PPC	83.10
Sealant Receipt on Permanent First Molars	SFM	
Rate 1 - At Least One Sealant		48.00
Rate 2 - All Four Molars Sealed		40.90
Prevention: Topical Fluoride for Children	TFL	
Ages 1 to 2		4.40
Ages 3 to 5		15.90
Ages 6 to 7		21.90
Ages 8 to 9		22.90
Ages 10 to 11		21.70
Ages 12 to 14		18.10
Ages 15 to 18		12.70
Ages 19 to 20		3.30
Total Ages 1 through 20		15.40
Well-Child Visits in the First 30 Months of Life	W30	
Rate 1 - Six or more well-child visits in the first 15 months		62.70
Rate 2 - Two or more well-child visits for ages 15 months to 30 months		65.50
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	WCC	
Body mass index (BMI) percentile documentation		
Ages 3 to 11		61.70
Ages 12 to 17		61.40
Total (Ages 3 to 17)		61.60
Counseling for Nutrition		
Ages 3 to 11		65.80
Ages 12 to 17		59.30
Total (Ages 3 to 17)		63.50
Counseling for Physical Activity		
Ages 3 to 11		57.10
Ages 12 to 17		56.60
Total (Ages 3 to 17)		56.90
Child and Adolescent Well-Care Visits	WCV	
Ages 3 to 11		55.00
Ages 12 to 17		49.20
Ages 18 to 21		25.00
Total (Ages 3 to 21)		48.60

SECTION VII. OMPP 2024 Initiatives

Standard Monitoring Compliance for 2024

Normal duties for monitoring compliance and ensuring quality health care is delivered to members will continue in 2024.

Hoosier Healthwise

The primary aim of the HHW program is to provide comprehensive health care coverage for uninsured Hoosiers to improve overall health, promote prevention and encourage healthy lifestyles. A strong focus is on healthy moms and healthy babies to improve birth outcomes. Families have access to health care through the same PMP for each member whenever possible. Continuity of care for family members provides enhanced opportunities for health care to all members of the household.

Healthy Indiana Plan

The primary aim of the HIP program is to provide adults access to a health care plan that empowers them to take charge of their health and prepares them to move to private insurance as they improve their lives. HIP provides incentives for members to be more health-conscious by accessing preventive health care and encourages appropriate use of the emergency room.

Hoosier Care Connect

The primary aim of HCC is to provide members who are age 65 and over or who had blindness or a disability a coordinated care program where their multiple health needs could be coordinated. This program also includes current and former wards and foster children. Health needs screens and comprehensive health assessments will continue to be monitored as pay for outcome measures as they remain instrumental in identifying individual member needs, coordinating care, improving quality outcomes, and maintaining consistency of care for these vulnerable members.

Indiana PathWays for Aging

The primary aim of the Indiana PathWays for Aging program is to provide coordinated care to members who are 60 years of age or older eligible for Medicaid on the basis of age, blindness, or disability and have limited income and resources. This program includes members with complex and chronic health conditions including those who are dually eligible for Medicare and Medicaid and/or receiving long-term services and support. OMPP and the MCEs will focus on three overarching quality goals for the Indiana PathWays for Aging program: person-centered services and supports, ensuring smooth transitions, and access to services (member choice).

Right Choices Program

The primary aim of the Right Choices Program is to assist risk-based managed care and fee-for-service members in obtaining the right care at the right time in the right place for each member. Within this model, RCP members may be restricted to one PMP, and one pharmacy. This allows all care to be managed by the member's PMP to ensure the member is receiving appropriate care. The MCEs 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 members by creating a medical home to support the member in obtaining the appropriate care at the right time in the right place.

For 2024, the focus of the Right Choices Program will include a monthly analysis of pharmacy claims identifying those members who have utilized opioids and controlled substances at a rate higher than the standard mean. This information will be uploaded into a single portal that can be accessed by MCE and OMPP staff as needed for review and analysis of Medicaid member usage.

Initiatives for 2024

In addition to normal duties for monitoring compliance and ensuring quality health care is delivered to members, OMPP will undertake the following initiatives to enhance and mature oversight infrastructure and compliance processes.

Policy Governance

The OMPP Coverage and Benefits team within the Clinical Outcomes Section continues to facilitate the structured Policy Consideration process to advance a value-driven program, focusing on cost-effective improvements to the health of the Indiana Health Coverage Programs population. The Policy Consideration process was designed to give internal and external stakeholders the ability to request changes and updates to the Medicaid coverage policies. This process defines how requests are submitted and reviewed by the office. Submitted requests go through a rigorous research and review process before policy changes are/can be made.

Monitoring and Reporting Quality

The OMPP Clinical Operation Quality staff works collaboratively with internal stakeholders (e.g., functional sections outside of Quality & Outcomes) and the MCEs to improve the oversight and reporting processes by ensuring that all contracted MCEs are measuring, calculating, and reporting in the same manner

The OMPP Clinical Operation Quality Section continues to collaborate to identify areas needing improvements, such as pharmacy and program integrity, and determine a collaborative approach to monitoring and reporting.

Health Equity

As part of our agency's health equity initiative, OMPP began focusing on infant mortality in 2021 with the goal of improving transparency and accountability recognizing that health disparities account for preventable mortality in minority populations. This initiative allows OMPP to expand our health equity commitment beyond the annual infant mortality data and analysis that is currently being completed.

In 2019, OMPP began work with the Indiana Department of Health (IDOH), the Indiana FSSA, and the Indiana Department of Child Services (DCS) on the My Healthy Baby Program. This initiative built a network of services and support for moms and babies with a goal of creating healthier outcomes for both. The goal of this program is to identify Medicaid members early in their pregnancies and connect them with a home visitor who provides personalized guidance and support to the woman during her pregnancy continuing through at least the first six to 12 months after her baby's birth. OMPP collaboration efforts have included making changes to the presumptive eligibility application to inform members about the program and establishing a data feed between IDOH and FSSA containing the demographic information on pregnant members identified through presumptive eligibility. In 2023, My Healthy Baby services were expanded into all 92 Indiana counties. OMPP will continue collaboration efforts specific to this initiative in 2024.

In December of 2019, CMS selected Indiana's Family and Social Services Agency as one of ten states to be awarded a five-year $50,000,000 Maternal Opioid Misuse (MOM) Model grant. For this cooperative grant OMPP will serve as a liaison between FSSA and the MCEs and will provide quality expertise. The MOM model was developed to improve the quality of care and reduce expenditures for pregnant and postpartum Medicaid beneficiaries with Opioid Use Disorder (OUD) as well as their infants. The MOM grant aims to increase access to evidence-based treatments, provide continuous screening and referrals for health- related social needs and create sustainable coverage and payment strategies that support ongoing coordination and integration of care. The MOM model, named the Pregnancy Promise Program, provides the opportunity for healthcare providers to improve care for mothers and infants affected by the opioid crisis by engaging providers in specialized training initiatives. The model is aimed at enhancing MCE care coordination and integration of care. By supporting the coordination of clinical care and integration of other services critical for health, wellbeing, and recovery, the Pregnancy Promise Program has the potential to improve quality of care and reduce the cost of providing medical care to mothers and infants. The Pregnancy Promise Program is one of several statewide initiatives to reduce maternal and infant mortality rates. Indiana will use these grant funds over the next five years to transition into the new model of care, and then full implementation of the plan will be realized in years three through five.

Smoking Cessation

The Indiana Health Coverage Programs (IHCP) has enhanced its coverage of tobacco cessation drug treatment through the pharmacy benefit. Effective Feb. 1, 2020, IHCP no longer requires copayments for tobacco cessation drugs. These drugs include but are not limited to, varenicline, bupropion for tobacco cessation, and nicotine replacement therapies. In 2019, IHCP also removed the requirement for prior authorizations for exceeding 180 days of tobacco cessation therapy. The goal of the program is to significantly improve the health of Medicaid members and to reduce the disease and economic burden that tobacco use places on them.

The MCEs provided detailed information on their smoking cessation initiatives and incentive programs during the April 2020 Quality Onsite meeting. In turn, IDOH has implemented their new vaping initiative that began statewide in 2020.

OMPP works closely with the IDOH Indiana Tobacco Quitline. The Indiana Tobacco Quitline is a free phone-based counseling service that helps Indiana smokers quit. OMPP in collaboration with IDOH, has facilitated increased quality of the monthly Quitline reports provided to the MCEs. OMPP and IDOH meet monthly to discuss any issues and trends with the reporting data. This partnership has resulted in a greatly increased accuracy of the reports being submitted to the MCEs, allowing for enhancement of their smoking cessation programs. This collaboration has strengthened the relationship between the MCEs and IDOH. In July 2021, IDOH began to have regular quarterly meetings with the MCEs to discuss their smoking cessation outreach practices and programs. OMPP and IDOH will continue this close and beneficial collaboration with the continuation of monthly meetings between representatives from the two agencies.

MCE Alignment

A core of OMPP's updated mission is to increase efficiency and reduce the administrative burden for both members and providers participating in Indiana Medicaid. OMPP will continue to work on our strategic initiative of aligning MCE activities so provider and member experiences among the MCEs is more uniform. One such activity is a collaboration we have with the MCEs and IDOH that focuses on tobacco cessation and improving maternal health outcomes.

Substance Use Disorder

Effective February 2018, FSSA received federal approval from CMS to implement a Section 1115 Substance Use Disorder (SUD) demonstration waiver. FSSA utilized this waiver to expand coverage for inpatient stays for opioid use disorder (OUD) and other SUD treatment to members 21 through 64 years of age in facilities that qualify as Institutions for Mental Disease (IMD), providing a compendium of services for members dealing with substance use addiction. Similarly in December 2019, FSSA received federal approval from CMS for a Section 1115 Serious Mental Illness (SMI) demonstration waiver that gives Indiana Medicaid the authority to pay for acute inpatient stays in an IMD for individuals diagnosed with an SMI. Both the SUD and SMI waivers were extended on Oct. 26, 2020, and remain in effect through Dec. 31, 2025. Prior to these waivers, Medicaid law prevented or restricted funding from being used for inpatient and residential SMI/SUD treatment at hospitals, nursing facilities, or other institutions with more than 16 beds. Under these waivers, patients receive longer, more appropriate inpatient stays aiding in achieving stabilization and more successful transitions back into their homes and communities. The change is expected to ultimately drive down the costs associated with overuse of emergency departments for mental health and substance use disorder crises as well as other costs caused by lack of access to appropriate care settings.

To oversee implementation of these waivers, OMPP hosts a monthly combined SUD/SMI waiver workgroup in partnership with the Division of Mental Health and Addiction. Priorities of the workgroup for 2024 and beyond include:

Appendix I: History and Overview of Managed Care Programs

Collectively, Hoosier Healthwise, Hoosier Care Connect, the Healthy Indiana Plan, and Indiana PathWays for Aging share in ensuring members' access to primary and preventive care services by seeking to improve quality, continuity, and appropriateness of medical care. The historical timeline for Indiana's risk-based managed care program is contained in Appendix II.

Hoosier Healthwise

Indiana established the HHW program in 1994 under the administration of OMPP. The state first introduced a primary care case management delivery system called PrimeStep. Two years later, Indiana added a risk-based managed care delivery system made up of MCE-contracted health plans, which are health maintenance organizations, authorized by the Indiana Department of Insurance, and contracted with OMPP.

HHW provides health care coverage for low-income families, some pregnant members, and children. The program covers medical care including, but not limited to, 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. Based on a Feb. 1, 2018, waiver approval, all newly pregnant members with incomes at or below 138% of the federal poverty level are served in the HIP program. Pregnant members with incomes above 138% of the FPL continue to be served in HHW. HHW members are eligible for benefits either through Medicaid or through CHIP.

CHIP health care coverage is for children up to age 19 and is available to members who may earn too much money to qualify for the standard HHW coverage. A child may be covered in CHIP under the managed care HHW Package C by paying a low-cost monthly premium. The managed care entities that provide CHIP benefits as part of HHW are Anthem Insurance Companies, Inc., Coordinated Care Corporation, Inc. d/b/a Managed Health Services, MDwise, Inc., and CareSource.

Healthy Indiana Plan

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

The HHW and HIP programs were aligned in 2011 to function under a family-focused approach. The family-focused approach was intended to align these two programs and allow a seamless experience for Hoosier families to establish a medical home model for increased continuity of care. The programs remained two distinct programs with two waivers/demonstrations from the federal government.

The HIP program also includes medically frail members. OMPP gathered data in 2015 regarding the members identified as medically frail and established a baseline to determine if they are receiving necessary health care and to determine if there are access to care issues. OMPP received CMS approval for what was then known as "HIP 2.0" on Jan. 27, 2015, and began accepting applications for the program. Services began just days later, as the enhanced HIP program launched on Feb. 1, 2015. In addition to processing new program applications, the launch of HIP 2.0 included the conversion of members previously enrolled in the original HIP program as well as all non-pregnant adults enrolled in HHW, Indiana's traditional Medicaid managed care program. More than 222,000 individuals were enrolled in HIP 2.0 by the end of

the first quarter of operations and, to date, HIP has continued to meet its enrollment goals with 739,973 individuals fully enrolled in HIP as of December 2021. All pregnant members with incomes 138% of the federal poverty level and below were moved into the HIP program beginning in February of 2018 and are included in the enrollment numbers.

In 2022, HIP continues to emphasize personal responsibility and preventive health services.

Hoosier Care Connect

In 2013, Indiana House Enrolled Act 1328 was passed by the Indiana General Assembly. This act tasked FSSA with managing care of the aged, blind, and disabled Medicaid members. In response, FSSA convened the ABD Taskforce comprised of staff from across key FSSA divisions and community stakeholders who worked in 2013 and 2014 to design the HCC risk-based managed care program for individuals with significant needs. HCC covers a variety of individuals who are not eligible for Medicare, including aged, blind, and disabled; individuals receiving Supplemental Security Income; individuals enrolled through Medicaid for Employees with Disabilities (M.E.D. Works).

In 2020, the state of Indiana held a procurement to choose new managed care entities to serve the HCC program. Through the Indiana Department of Administration procurement Anthem Insurance Companies, Inc., Coordinated Care Corporation, Inc. d/b/a Managed Health Services, and UnitedHealthcare Community Plan were selected to administer the new contract which went live on April 1, 2021.

Indiana PathWays for Aging

In 2024, FSSA is planning to launch a new managed long-term service and support (MLTSS) program for individuals aged 60 and older who receive Medicaid (or Medicaid and Medicare) benefits. FSSA's priority is alignment for Indiana PathWays for Aging members, with many of them expected to be dually eligible for Medicare and Medicaid. Due to the high number of dual eligible members participating in the program, all contracted MCEs will be required to operate a companion dual-eligible special needs plan (D-SNP) effective in 2026. In 2023, the state of Indiana held a procurement to choose new managed care entities to serve the Indiana PathWays for Aging population. Through the Indiana Department of Administration procurement, Anthem Insurance Companies, Inc., d/b/a Anthem Blue Cross and Blue Shield, Arcadian Health Plan, d/b/a Humana Healthy Horizons in Indiana, Molina Healthcare of Indiana, and UnitedHealthcare Insurance Company, d/b/a United Healthcare Community Plan were recommended to administer the new program. In October 2023, FSSA announced that one of the selected vendors, Molina Healthcare of Indiana, was unable to secure a D-SNP contract with the Centers for Medicaid and Medicare Services. As a result, FSSA did not offer a contract to Molina for the Indiana PathWays for Aging program. The Indiana PathWays for Aging program is expected to go-live on July 1, 2024.

Traditional Medicaid Populations

The Indiana Traditional Medicaid population is comprised of those groups of members not currently enrolled in HHW, HIP, HCC, or Indiana PathWays for Aging. Native American populations also have access to traditional fee-for-service Medicaid should they choose not to be enrolled in a MCE.

Traditional Medicaid members do not receive managed care services as the traditional Medicaid model utilizes a fee-for-service arrangement in which physicians, hospitals, and other providers contract directly with the state for services they provide.

The following are individuals covered under traditional Medicaid receiving fee-for-service benefits:

- Dually enrolled receiving Medicare and Medicaid benefits (unless enrolled in Indiana PathWays for Aging)
- Persons receiving home-and community-based services waiver benefits (unless enrolled in Indiana PathWays for Aging)
- Persons receiving care in a nursing facility or other state-operated facility (unless enrolled in Indiana PathWays for Aging)
- Individuals in a specific Medicaid aid category, such as Refugee or the Breast and Cervical Cancer aid category
- Others not in risk-based managed care

Appendix II: Historical Timelines

Risk-Based Managed Care

1994 Began with PCCM delivery system

1996 Enrollment into MCE contracted health plans were 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 capitation rates

2007 Expansion of pregnancy-related coverage (Package B) from 150 to 200 % FPL

2007 Indiana Check-up Plan legislation signed into law authorizing the Healthy Indiana Plan and a Request for Services is released to procure MCEs; Initial 1115 Demonstration Waiver Application submitted to CMS and is approved in December; DFR began processing applications

2008 Expansion of CHIP Package C from 200 to 250 % FPL

2008 Implementation of HIP

2008 Enrollment into HIP began

2009 HIP waitlist began. Waitlist opened in November of 2009 and 5,000 individuals on the waitlist were invited to apply for HIP

2009 Implementation of Open Enrollment (Plan Lock-in); Notification of Pregnancy; Pharmacy carve-out implemented.

2011 Implementation of the POWER account debit card; HIP opens 8,000 slots and waitlist members are invited to apply

2011 HIP and Hoosier Healthwise aligned under a family-focused approach.

2013 House Enrolled Act 1328 (HEA 1328) was passed by the Indiana General Assembly. This act tasked FSSA with managing care of the aged, blind, and disabled Medicaid members. In response, FSSA convened the ABD Taskforce comprised of staff from across key FSSA divisions.

2014 HIP-ESP is folded into the HIP program

2015 HIP modified with Pharmacy, Dental and Vision services carve-in

2015 Hoosier Care Connect was implemented on April 1. Pharmacy, Dental, and Vision services are carved-in

2015 Care Select program expired in August after complete integration of the HCC program

2016 RFP completed for the HHW and HIP programs with contracts awarded to Anthem, MDwise, MHS, and CareSource, effective Jan. 1, 2017

2017 Pharmacy and Dental services carved in for HHW

2021 RFP completed for the HCC program with contracts awarded to Anthem, MHS, and UnitedHealthcare, effective April 1, 2021

2023 RFP completed for the Indiana PathWays for Aging program with contracts awarded to Anthem, Humana, and United Healthcare, effective March 1, 2023

Hoosier Healthwise

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 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; Pharmacy carve-out implemented.

2011 HIP and Hoosier Healthwise aligned under a family-focused approach.

2016 RFP completed for the HHW and HIP programs with contracts awarded to Anthem, MDwise, MHS and CareSource effective Jan. 1, 2017

2017 Pharmacy and Dental services carved in for HHW

Healthy Indiana Plan & Enhanced Services Plan

2007 Indiana Check-up Plan legislation signed into law authorizing the Healthy Indiana Plan and a Request for Services is released to procure MCEs; 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 5,000 individuals on the waitlist were invited to apply for HIP

2011 Implementation of the POWER account debit card; HIP and HHW 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

2015 HIP 2.0 takes on a new focus for individuals to be more accountable with their health care choices

2016 RFP completed for the HHW and HIP programs with contracts awarded to Anthem,

MDwise, MHS, and CareSource, effective Jan. 1, 2017

2018 HIP waiver approval received from CMS. Additional areas of focus in HIP include an expanded incentives program that offers outcome-based incentives to members. The incentives include tobacco cessation, substance use disorder treatment chronic disease management, and employment-related incentives

2019 Gateway to Work is fully implemented requiring some HIP members to participate in job opportunities, attend school, volunteer, or participate in other qualifying activities

2020 Gateway to Work is suspended

2021 CMS approves HIP waiver for 10 years

Care Select

2007 Start of Care Select program in the Central Region

2008 Auto-assignment began in the Central Region

2008 Rollout of Care Select program in other regions

2008 Auto-assignment of remaining members

2008 Inclusion of wards and fosters in Care Select

2009 Auto-assignment of wards and fosters in Care Select

2010 Auto-assignment of remaining HCBS waiver members into Care Select

2010 Redesign of Care Select

2014 Redesign of Care Select, adding COPD as a disease state

2015 Care Select Program expires after implementation of Hoosier Care Connect

Hoosier Care Connect

2013 House Enrolled Act 1328 (HEA 1328) was passed by the Indiana General Assembly. This act tasked FSSA with managing care of the aged, blind, and disabled Medicaid members. In response, FSSA convened the ABD Task Force (Task Force) which was comprised of staff from across key FSSA divisions.

2015 HCC was implemented on April 1. Pharmacy, Dental, and Vision services were carved into managed care.

2015 Complete integration of Hoosier Care Connect occurs August 1.

2017 Anthem and MHS remain in HCC. MDwise departs the program.

2021 RFP completed for the Hoosier Care Connect programs with contracts awarded to Anthem, MHS, and UnitedHealthcare, effective April 1, 2021.

2024 Eligible members transitioned from HCC to Indiana PathWays for Aging program upon implementation of Indiana PathWays for Aging program on July 1, 2024

Indiana PathWays for Aging

2021 House Enrolled Act 1001 (HEA 1001) was passed by the Indiana General Assembly. This act tasked FSSA with submitting a report on the Agency's planned implementation of managed long-term services and supports (MLTSS).

2022 After convening with stakeholders for twelve (12) months, FSSA provided an update via report on progress regarding MLTSS implementation.

2023 RFP completed for the Indiana PathWays for Aging program with contracts awarded to Anthem, Humana, and United Healthcare, effective March 1, 2023

2024 Indiana PathWays for Aging programs slated to go-live on July 1, 2024

Appendix III: Indiana Health Coverage Program Specific Goals and Objectives

Hoosier Healthwise

Hoosier Healthwise					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (2022)**	**Statewide Performance Target for Objective (2024)**
Goal 1: Improve health outcomes through preventive care and behavioral health condition management					
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	HEDIS	30 Day - 27.77 07 Day – 17.78	30 Day – 30.94/33.33rd 07 Day – 20.00/33.33rd
		Follow-Up after Hospitalization for Mental Illness (FUH)	HEDIS	30 Day - 67.47 07 Day – 43.44	30 Day – 65.38/75th 07 Day – 44.29/75th
		Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS	30 Day - 61.58 07 Day – 47.14	30 Day – 64.29/75th 07 Day – 51.29/75th
		Initiation and Engagement of Alcohol and other Drug (IET)	HEDIS	Initiation of AOD - Alcohol Abuse or Dependence (Total) 31.18/NA Engagement of AOD - Alcohol Abuse or Dependence (Total) 9.63/33.33rd Initiation of AOD - Opioid Abuse or Dependence	Initiation of AOD - Alcohol Abuse or Dependence (Total) 33.80/10th Engagement of AOD - Alcohol Abuse or Dependence (Total) 10.89/50th Initiation of AOD - Opioid Abuse or Dependence (Total) 60.91/50th

Hoosier Healthwise					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (2022)**	**Statewide Performance Target for Objective (2024)**
				(Total) 55.66/33.33rd Engagement of AOD - Opioid Abuse or Dependence (Total) 34.60/50th Initiation of AOD - Other Drug Abuse or Dependence (Total) 43.70/50th Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.21/66.67th Initiation of AOD - Total (Total) 41.44/25th Engagement of AOD - Total (Total) 14.78/50th	Engagement of AOD - Opioid Abuse or Dependence (Total) 36.31/66.67th Initiation of AOD - Other Drug Abuse or Dependence (Total) 45.48/66.67th Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.89/75th Initiation of AOD - Total (Total) 44.32/50th Engagement of AOD - Total (Total) 16.94/66.67th
		Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	HEDIS	52.90/10th	57.79/33.33rd
1.2	Improve the use of preventive behavioral health screenings and	Metabolic Monitoring for Children and Adolescents on Antipsychotic (APM)	HEDIS	Metabolic Monitoring for Children and	Metabolic Monitoring for Children and

Hoosier Healthwise					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (2022)**	**Statewide Performance Target for Objective (2024)**
	follow up to screenings			Adolescents on Antipsychotics - Blood Glucose Testing (Total) 20.17/NA Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 26.81/10th Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 24.39/10th	Adolescents on Antipsychotics - Blood Glucose Testing (Total) 45.50/10th Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 30.36/25th Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 28.47/25th
		Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD-AD)	HEDIS	78.80/33.33rd	79.05/50th
		Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC)	HEDIS	NR	73.42/33.33rd
		Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD)	HEDIS	62.50/10th	64.87/33.33rd
Goal 2: Improve the health and wellness of pregnant persons, new mothers, infants, and children					

Hoosier Healthwise					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (2022)**	**Statewide Performance Target for Objective (2024)**
2.1	Ensure early detection and follow up regarding prenatal and postpartum depression	PPC: Timeliness of Prenatal Care	HEDIS	83.26/33rd	84.23/50th
		PPC: Postpartum Care	HEDIS	82.15/75th	82/75th
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Well-Child Visits in the First 30 Months of Life (W30)	HEDIS	61.95/10th	63.73/33.33rd
		Child and Adolescent Well-Care Visits (WCV)	HEDIS	48.40/50th	51.78/66.67th
		Childhood Immunization Status (CIS)	HEDIS	Retired	100% - ECDS
		Immunizations for Adolescents (IMA)	HEDIS	Retired	100% - ECDS
Goal 3: Improve oral health					
3.1	Prevent oral disease	Annual Dental Visits (ADV)	HEDIS	Retired	OED Not yet reported
3.2	Improve access to dental services	Dentists and Oral Surgeons Network Adequacy	OMPP	Unknown	Unknown
Goal 4: Improve the health and maintenance of members with chronic conditions					
4.1	Improve the health and reduce complications for members diagnosed with diabetes	CDC: HbA1c Testing	HEDIS	NR	NR
		HBD: Hemoglobin A1c Control for Patients with Diabetes - Poor HbA1c Control	HEDIS	59.06/NA	54.01/10th
		HBD: Hemoglobin A1c Control for Patients with Diabetes	HEDIS	33.46/NA	38.93/10th
Goal 5: Improve care coordination across the entire service continuum					
5.1	Reduce the number of inpatient readmissions for physical and behavioral health	Plan All-Cause Readmissions (PCR)	HEDIS	.9393/50th	.9272/66.67th
5.2	Ensure smooth transitions between level of care settings	Completion of Initial Health Needs Screening within 90 Days of MCE Enrollment	OMPP	52.30	?%

Healthy Indiana Plan

Healthy Indiana Plan					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (year)**	**Statewide Performance Target for Objective (year)**
Goal 1: Improve health outcomes through preventive care and behavioral health condition management					
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	HEDIS	30 Day – 39.26/50th 07 Day – 27.65/50th	30 Day – 40.53/66.67 07 Day – 29.98/75th
		Follow-Up after Hospitalization for Mental Illness (FUH)	HEDIS	30 Day – 46.82/10th 07 Day – 28.51/10th	30 Day – 50.56/25th 07 Day – 31.23/33.33rd
		Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS	30 Day – 45.23/10th 07 Day – 34.04/33.33rd	30 Day – 49.12/33.33rd 07 Day – 40.59/50th
		Initiation and Engagement of Alcohol and other Drug (IET)	HEDIS	Initiation of AOD - Alcohol Abuse or Dependence (Total) 40.37/33.33rd Engagement of AOD - Alcohol Abuse or Dependence (Total) 16.93/75th Initiation of AOD - Opioid Abuse or Dependence (Total) 67.15/75th	Initiation of AOD - Alcohol Abuse or Dependence (Total) 41.43/50th Engagement of AOD - Alcohol Abuse or Dependence (Total) 14.52/75th Initiation of AOD - Opioid Abuse or Dependence (Total) 66.15/75th Engagement of AOD - Opioid

Healthy Indiana Plan					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (year)**	**Statewide Performance Target for Objective (year)**
				Engagement of AOD - Opioid Abuse or Dependence (Total) 47.41/75th Initiation of AOD - Other Drug Abuse or Dependence (Total) 32.93/5th Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.98/75th Initiation of AOD - Total (Total) 41.42/25th Engagement of AOD - Total (Total) 21.48/75th	Abuse or Dependence (Total) 40.04/75th Initiation of AOD - Other Drug Abuse or Dependence (Total) 34.43/10th Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.89/75th Initiation of AOD - Total (Total) 44.32/50th Engagement of AOD - Total (Total) 18.87/75th
		Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	HEDIS	43.94/10th	55.02/25th
1.2	Improve the use of preventive behavioral health screenings and follow up	Metabolic Monitoring for Children and Adolescents on Antipsychotic (APM)	HEDIS	NA	NA
		Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD)	HEDIS	78.56/33rd	79.05/50th
		Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC)	HEDIS	72.25/25th	73.42/33.33rd

Healthy Indiana Plan					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (year)**	**Statewide Performance Target for Objective (year)**
		Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD)	HEDIS	59.69/10th	62.99/25th
Goal 2: Improve the health and wellness of pregnant persons, new mothers, infants, and children					
2.1	Ensure early detection and follow up regarding prenatal and postpartum depression	PPC: Timeliness of Prenatal Care	HEDIS	85.96/50th	86.86/66.67th
		PPC: Postpartum Care	HEDIS	80.88/66.67th	82.00/75th
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Well-Child Visits in the First 30 Months of Life (W30)	HEDIS	NR	66.76/50th
		Child and Adolescent Well-Care Visits (WCV)	HEDIS	19.76	
		Childhood Immunization Status (CIS)	HEDIS	Retired	100% - ECDS
		Immunizations for Adolescents (IMA)	HEDIS	Retired	100% - ECDS
Goal 3: Improve oral health					
3.1	Prevent oral disease	Oral Evaluation, Dental Services	HEDIS	Retired	OED Not yet reported
3.2	Improve access to dental services	Dentists and Oral Surgeons Network Adequacy	OMPP	Unknown	Unknown
Goal 4: Improve the health and maintenance of members with chronic conditions					
4.1	Improve the health and reduce complications for members diagnosed with diabetes	CDC: HbA1c Testing	HEDIS	NR	NA
		HBD: Hemoglobin A1c Control for Patients with Diabetes - Poor HbA1c Control	HEDIS	37.38/33.33rd	34.79/66.67th
		HBD: Hemoglobin A1c Control for Patients with Diabetes	HEDIS	36.60/5th	38.93/10th
Goal 5: Improve care coordination across the entire service continuum					
5.1	Reduce the number of inpatient readmissions for physical and behavioral health	Plan All-Cause Readmissions (PCR)	HEDIS	.9505/50th	.9272/66.67

Healthy Indiana Plan					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (year)**	**Statewide Performance Target for Objective (year)**
5.2	Ensure smooth transitions between level of care settings	Completion of Initial Health Needs Screening within 30 days or 90 Days of MCE Enrollment based on care program	OMPP	56.96	%?

Hoosier Care Connect

Hoosier Care Connect					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (year)**	**Statewide Performance Target for Objective (year)**
Goal 1: Improve health outcomes through preventive care and behavioral health condition management					
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	HEDIS	30 Days – 37.78/50th 07 Days – 25.81/50th	30 Days – 40.53/66.67th 07 Days – 27.73/66.67th
		Follow-Up after Hospitalization for Mental Illness (FUH)	HEDIS	30 Days – 56.74/33.33rd 07Days – 34.11/33.33rd	30 Days – 57.69/50th 07Days – 35.16/50th
		Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS	30 Days – 57.69/50th 07 Days – 40.93/50th	30 Days – 60.08/66.67th 07 Days – 46.35/66.67th
		Initiation and Engagement of Alcohol and other Drug (IET)	HEDIS	Initiation of AOD - Alcohol Abuse or Dependence (Total) 40.85/33.33rd Engagement of AOD - Alcohol Abuse or Dependence (Total) 11.46/50th Initiation of AOD - Opioid Abuse or Dependence (Total) 54.24/25th	Initiation of AOD - Alcohol Abuse or Dependence (Total) 41.43/50th Engagement of AOD - Alcohol Abuse or Dependence (Total) 13.15/66.67th Initiation of AOD - Opioid Abuse or Dependence (Total) 60.91/50th

Hoosier Care Connect					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (year)**	**Statewide Performance Target for Objective (year)**
				Engagement of AOD - Opioid Abuse or Dependence (Total) 31.32/50th Initiation of AOD - Other Drug Abuse or Dependence (Total) 38.75/25th Engagement of AOD - Other Drug Abuse or Dependence (Total) 11.77/50th Initiation of AOD - Total (Total) 41.48/25th Engagement of AOD - Total (Total) 14.20/50th	Engagement of AOD - Opioid Abuse or Dependence (Total) 36.31/66.67th Initiation of AOD - Other Drug Abuse or Dependence (Total) 41.80/50th Engagement of AOD - Other Drug Abuse or Dependence (Total) 13.36/50th Initiation of AOD - Total (Total) 44.32/50th Engagement of AOD - Total (Total) 16.94/66.67th
		Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	HEDIS	**63.42/50th**	**64.90/66.67th**
1.2	Improve the use of preventive behavioral health screenings and follow up	Metabolic Monitoring for Children and Adolescents on Antipsychotic (APM)	HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics -	Metabolic Monitoring for Children and Adolescents on Antipsychotics -

Hoosier Care Connect					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (year)**	**Statewide Performance Target for Objective (year)**
				Blood Glucose Testing (Total) 23.90/NA Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 35.91/33.33rd Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 31.08/33.33rd	Blood Glucose Testing (Total) 42.75/5th Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 36.18/50th Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 34.38/50th
		Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD)	HEDIS	80.05/50th	82.27/75th
		Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC)	HEDIS	80.33/66.67th	86.50/90th
		Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD)	HEDIS	71.83/50th	74.07/75th
Goal 2: Improve the health and wellness of pregnant persons, new mothers, infants, and children					
2.1	Ensure early detection and follow up regarding prenatal and	PPC: Timeliness of Prenatal Care	HEDIS	**82.83/33.33rd**	**84.23/50th**
		PPC: Postpartum Care	HEDIS	**70.6310th**	**73.97/25th**

Hoosier Care Connect					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (year)**	**Statewide Performance Target for Objective (year)**
	postpartum depression				
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Well-Child Visits in the First 30 Months of Life (W30)	HEDIS		
		Child and Adolescent Well-Care Visits (WCV)	HEDIS		
		Childhood Immunization Status (CIS)	HEDIS	Retired	100% - ECDS
		Immunizations for Adolescents (IMA)	HEDIS	Retired	100% - ECDS
Goal 3: Improve oral health					
3.1	Prevent oral disease	Oral Evaluation, Dental Services	HEDIS		
3.2	Improve access to dental services	Dentists and Oral Surgeons Network Adequacy	OMPP		
Goal 4: Improve the health and maintenance of members with chronic conditions					
4.1	Improve the health and reduce complications for members diagnosed with diabetes	CDC: HbA1c Testing	HEDIS		
		HBD: Hemoglobin A1c Control for Patients with Diabetes - Poor HbA1c Control	HEDIS		
		HBD: Hemoglobin A1c Control for Patients with Diabetes	HEDIS		
Goal 5: Improve care coordination across the entire service continuum					
5.1	Reduce the number of inpatient readmissions for physical and behavioral health	Plan All-Cause Readmissions (PCR)	HEDIS		
5.2	Ensure smooth transitions between level of care settings	Completion of Initial Health Needs Screening within 30 days or 90 Days of MCE Enrollment based on care program	OMPP		

Indiana PathWays for Aging

Indiana PathWays for Aging					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (2025)**	**Statewide Performance Target for Objective (2026)**
Goal 1: Improve health outcomes through preventive care and behavioral health condition management					
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	HEDIS		TBD
		Follow-Up after Hospitalization for Mental Illness (FUH)	HEDIS		TBD
		Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS		TBD
		Initiation and Engagement of Alcohol and other Drug (IET)	HEDIS		TBD
		Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	HEDIS		TBD
1.2	Improve the use of preventive behavioral health screenings and follow up	Metabolic Monitoring for Children and Adolescents on Antipsychotic (APM)	HEDIS		TBD
		Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD)	HEDIS		TBD
		Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC)	HEDIS		TBD
		Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD)	HEDIS		TBD
Goal 2: Improve the health and wellness of pregnant persons, new mothers, infants, and children					
Not applicable to program					
Goal 3: Improve oral health					
3.1	Prevent oral disease	Oral Evaluation, Dental Services (OED)	HEDIS		TBD
3.2	Improve access to dental services	Dentists and Oral Surgeons Network Adequacy	OMPP		TBD
Goal 4: Improve the health and maintenance of members with chronic conditions					
4.1	Improve the health and reduce complications for members diagnosed with diabetes	CDC: HbA1c Testing	HEDIS		TBD
		HBD: Hemoglobin A1c Control for Patients with Diabetes - Poor HbA1c Control	HEDIS		TBD
		HBD: Hemoglobin A1c Control for Patients with Diabetes	HEDIS		TBD

Indiana PathWays for Aging					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (2025)**	**Statewide Performance Target for Objective (2026)**
Goal 5: Improve care coordination across the entire service continuum					
5.1	Reduce the number of inpatient readmissions for physical and behavioral health	Plan All-Cause Readmissions (PCR)	HEDIS		TBD
		MLTSS-4: Medicaid Managed Long-Term Services and Supports Reassessment/Care Plan Update after Inpatient Discharge	CMS		TBD
		MLTSS-5: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls	CMS		TBD
5.2	Ensure smooth transitions between level of care settings	Completion of Initial Health Needs Screening within 90 Days of MCE Enrollment	OMPP		TBD
		Participants who Report Knowing who Their MCE Care Manager is	CAHPS		TBD
		MLTSS-3: Medicaid Managed Long-Term Services and Supports Shared Care Plan with Primary Care Provider	CMS		TBD
		MLTSS-8: Medicaid Managed Long-Term Services and Supports Successful Transition after Long-Term Facility Stay	CMS		TBD
5.3	Deliver person-centered services and supports	Service Coordinators who Have Successfully Completed Person-centered Planning Competency Training within 90 days of Hire	OMPP		TBD
		Participants who, in the Last 3 Months, reported that Their Service Plan Included Most or all of the Things that are Important to Them	CAHPS		TBD
5.4	Assure timely access to appropriate services and supports to enable participants to live in their setting of choice	Care Management Individualized Care Plan Developed and Implemented within 90 Days of MCE Effective Date for Members with Care Management Level of Service	OMPP		TBD
		Care Management Individualized Care Plan Developed and Implemented within 60 Days of MCE Effective Date for Members with Complex Care Management Level of Service	OMPP		TBD
		MLTSS-1: Medicaid Managed Long-Term Services and Supports Comprehensive Assessment and Update	CMS		TBD
		MLTSS-2: Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update	CMS		TBD
		MLTSS-6: Medicaid Managed Long-Term Services and Supports Admission to a Facility from the Community	CMS		TBD

Indiana PathWays for Aging					
Objective	**Objective Description**	**Quality Measures**	**Measure Source**	**Statewide Performance Baseline (2025)**	**Statewide Performance Target for Objective (2026)**
		MLTSS-7: Medicaid Managed Long-Term Services and Supports Minimizing Facility Length of Stay	CMS		TBD

Appendix IV: OMPP Quality Committee Descriptions

Table 14. Quality Committee Descriptions

Committee	Meeting Frequency	Description
Quality Assessment and Performance Improvement Committee	Quarterly (minimum of four times per year; ad hoc meetings may be scheduled based on business needs)	By carefully monitoring the effectiveness of the Indiana Quality Assessment and Performance (QAPI) Program as outlined in the State Quality Strategy Plan (QSP), the State infuses a culture of quality into all aspects of the Indiana Medicaid program. The State's QAPI is executed through the Managed Care Entities (MCEs) with oversight by the State. The purpose of the Office of Medicaid Policy and Planning (OMPP) Quality Assessment and Performance Improvement Committee (QAPI) is to help ensure Indiana Medicaid recipients receive the highest quality of care and service possible.
Mortality Review Committee	Quarterly (minimum of four times per year; ad hoc meetings may be scheduled based on business needs)	As part of the Quality Assurance/Quality Improvement (QA/QI) process, member deaths for individuals receiving Home and Community Based Services (HCBS) as part of the Indiana PathWays for Aging (PathWays) program are reviewed by the Clinical Operations Quality team, along with any information from critical incident reports involving Indiana PathWays for Aging members. The purpose of the Mortality Review Committee is to monitor member deaths for Indiana PathWays for Aging members and identify interventions which may be implemented program-wide to improve quality of care for all members.
Aging and LTSS Advisory Committee	Quarterly	New Committee 2024
Quality Strategy Committee	Quarterly	All MCEs meet quarterly with the Clinical Operations quality team to review progress towards quality strategy plan goals and objectives
Medicaid Advisory Committee	Quarterly	Indiana's Medicaid Advisory Committee is a venue for the public to provide input to the state Medicaid agency on aspects of the program. The MAC provides feedback on the program policies and proposed policies that ensure the program is responsive to concerns. The MAC meets quarterly. Committee members include elected officials, provider representatives, consumer representatives, taxpayer representatives, and citizens. The MAC is established by IC 12-15-33.
MCE Member and Informal Caregiver Advocacy Committee	Quarterly	New Committee 2024

Appendix V: Summary of Public Comments

[Placeholder for summary of comments received during the public comment and tribal consultation period along with a summary of the changes made by OMPP to address the comments]

Glossary

Key Terms

Term	Definition
Annual Adult Core Measures	The Adult Core Set includes a range of quality measures encompassing both physical and behavioral health determined by CMS.
Consumer Assessment of Healthcare Providers and Systems CAHPS®	Consumer Assessment of Healthcare Providers & Systems- Patient experience surveys that ask patients (or in some cases their families) about their experiences with, and ratings of, their healthcare providers and plans, including hospitals, home health care agencies, doctors, and health and drug plans, among others.
Code of Federal Regulations (CFR)	The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.
Core MMIS	IHCP current information processing system
Children's Health Insurance Program (CHIP)	Children's Health Insurance Program - children up to age 19 whose families have slightly higher incomes
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (HHS), which administers the Medicare (Title XVIII) and Medicaid (Title XIX) programs, and the State Children's Health Insurance Program (Title XXI)
Enterprise Data Warehouse (EDW)	State of Indiana's Enterprise Data Warehouse
External Quality Review (EQR)	An analysis and evaluation, completed by an independent organization, of information on quality, timeliness, and access to services the managed care entities furnish to members
External; Quality Review Organization (EQRO)	The independent organization that completes the External Quality Review of the state contracted managed care plans
Family and Social Services Administration (FSSA)	Indiana Family and Social Services Administration is a health care and social service funding agency with eight care divisions established by Indiana to consolidate and better integrate the delivery of human services by state government. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs; includes the Office of Medicaid Policy and Planning, the Division of Aging, the Division of Family Resources, the Division of Mental Health and Addiction, and the Division of Disability & Rehabilitative Services.

Healthy Indiana Plan (HIP)	Indiana Medicaid health-insurance program for Hoosiers ages 19 to 64 who meet specific income levels.
Healthcare Effectiveness Data and Information Set (HEDIS ®)	NCQA defines Healthcare Effectiveness Data and Information Set (HEDIS®) as a set of standardized performance measures designed to allow reliable comparison of the performance of managed health care plans.
Health Needs Screen (HNS)	Initial health needs assessment the MCEs must complete with members within 90 days of enrollment
Hoosier Care Connect (HCC)	Indiana's health care program for individuals who are aged 65 years and older, blind, or disabled and who are also not eligible for Medicare.
Hoosier Healthwise (HHW)	Indiana's health care program for children, low-income families, and pregnant women. Different benefit packages are available to the various populations eligible for Hoosier Healthwise: Package A (Standard) and Package C (CHIP).
Indiana Department of Health (IDOH)	Indiana State Agency in which the state health commissioner (commissioner) is the appointing authority and director of the department
Indiana Health Coverage Program (IHCP)	Indiana offers several health coverage options to qualified low-income individuals and families, individuals with disabilities and the elderly with limited financial resources. Each program is designed to meet the medical needs of that specific group of individuals. Each program uses a different set of measures to determine if a person qualifies for that program.
Indiana PathWays for Aging	The Indiana Family and Social Services Administration will launch a new program effective in July 2024 for Hoosiers aged 60 and over who receive Medicaid (or Medicaid and Medicare) benefits.
Long Term Support Services (LTSS)	• Care provided in the home, in community-based settings, or in facilities, such as nursing homes • Care for older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves • A wide range of services to help people live more independently by assisting with personal and healthcare needs and activities of daily living
Managed Care Entity (MCE)	An organization that meets all applicable requirements of Medicaid managed care organizations (MCO)
National Committee for Quality Assurance (NCQA)	National Committee for Quality Assurance is an independent 501c nonprofit organization that works with policymakers, employers, doctors, patients and health plans to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.
Office of Medical Policy	Office of Medical Policy and Planning under the Indiana Family and Social Services Administration (FSSA)

and Planning (OMPP)	
Pay for s	Contractors are required to participate in a pay for outcomes program that focuses
Performance Improvement Plan (PIP)	A plan to remediate an identified program deficiency in response to a sanction or action by the State involving a process of data gathering, evaluation, and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.
Quality	A formal set of activities to review and safeguard the quality of medical services
Quality Improvement (QI)	Quality improvement. Implementing corrective actions, based on assessment results, aimed at addressing identified deficiencies and improving outcomes.

Quick Acronyms Reference

Acronym	Meaning
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Center for Medicare & Medicaid Services
EDW	Enterprise Data Warehouse
EQR	External Quality Review
EQRO	External Quality Review Organization
FSSA	Family and Social Services Administration
HCC	Hoosier Care Connect
HEDIS ®	Healthcare and Data Information Set
HHW	Hoosier Healthwise
HIP	Healthy Indiana Plan
HNS	Health Needs Screening
IDOH	Indiana Department of Health
MHB	My Healthy Baby

MCE	Managed Care Entity
OMPP	Office of Medicaid Policy and Planning
PIP	Performance Improvement Projects
QA	Quality Assurance
QI	Quality Improvement