OMPP Quality & Outcomes Reporting

Freeing the Data
Managed Care Oversight

• Number of federal requirements at 42 CFR 438, operationalized through contracts and Q&O team
• Monthly onsite visits at MCE offices focused on particular topic established in advance
• Regular meetings with agency/division leadership; functional area coordination and oversight
• Non-compliance addressed through Corrective Action Plans, liquidated damages, suspending member assignment, etc.
Quality Strategy Plan

42 CFR 438.340

• State’s annual plan to assess MCE delivery of services
• Built around continuous quality improvement (CQI)
• Establishes quality subcommittees
External Quality Reviews

42 CFR 438.350 et seq.

• Must be a competent and independent entity
• Validates performance improvement activities
• Identifies other areas for improvement based on feedback from other sources
• All health plans required by state law to be NCQA-accredited within one year of operation
• Accreditation is proxy measure for CQI activities in key areas
• Plan ratings published by NCQA specific to lines of business
Monthly/Quarterly Reports

- Aggregated and synthesized to make comparison easier
- Uses data submitted by MCEs
- Stoplight system makes performance easy to gauge
Quality and Outcomes Reporting

The FSSA Office of Medicaid Policy and Planning (OMPP) conducts continuous quality improvement projects and contract oversight throughout the year. This webpage contains high level descriptions of key quality improvement processes and links to various resources to help interested parties see how Indiana's Medicaid program is performing.

Managed Care

OMPP contracts with four health insurance companies to deliver healthcare to more than a million Medicaid members. These companies are Anthem, CareSource, Managed Health Services (MHS), and MDwise. Indiana has three managed care programs: the Healthy Indiana Plan, Hoosier Healthwise, and Hoosier Care Connect.

Contracts

OMPP uses a base contract for each managed care program with a consistent scope of work by program unless otherwise noted. Contracts are typically awarded from a competitive procurement and are for a base period of four years with two optional years (consistent with IC 12-15-30-4). Amendments (denoted as "AM") are needed from time to time to adjust rates for actuarial soundness, modify scope of work language, or update requirements. Managed Care Entity contracts must be approved by the Centers for Medicare and Medicaid Services (CMS) to ensure federal requirements are met and rates are actuariably sound. Below is a table of all the current CMS-approved contracts in effect for managed care entities. All non-confidential, fully approved contracts are publicly available at the Indiana Transparency Portal, as required by Executive Order 05-07.

<table>
<thead>
<tr>
<th>Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW) Contracts</th>
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<tr>
<td><strong>Anthem</strong></td>
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https://www.in.gov/fssa/ompp/5533.htm
Questions?

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