

Indiana Medicaid Managed Care Quality Strategy Plan -2017



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

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SECTION I. INTRODUCTION

MANAGED CARE GOALS, OBJECTIVES, OVERVIEW

Overview of Indiana Health Coverage Programs

Indiana continues to engage in activities to improve the lives of its members through planning and initiatives concentrating on timely access to health care, quality and cost management in Medicaid managed care. This strategy includes an interdisciplinary, collaborative approach through partnerships with enrollees, other governmental departments and divisions, providers, contractors, Managed Care Entities (MCE), Care Management Organizations (CMOs), academics, as well as community and advocacy groups.

The Indiana Family and Social Services Administration (FSSA) is the single State agency responsible for administering Medicaid programs. Per the US Census Bureau, the population of Indiana in 2015 was 6.619 million. Per Indiana's Office of Data Management, Reports, and Analysis (DMA) the Medicaid enrollment in December of 2016 was 1,414,615. Thus, Medicaid provides vital health care to approximately one in six Hoosiers. In 2017, Indiana's health care coverage will include services through the Hoosier Healthwise program (HHW), Children's Health Insurance Program (CHIP), Healthy Indiana Plan (HIP), Hoosier Care Connect (HCC) or fee-for-service (FFS). Indiana's risk based managed care (RBMC) programs include HHW, HIP and HCC. The CHIP members may be served through RBMC or FFS.

The Office of Medicaid Policy and Planning's (OMPP) Quality and Outcomes Section is charged with oversight of the Managed Care Entities and the Care Management Organizations through reporting, contract compliance and quality initiatives specific to HHW, CHIP, HIP and HCC programs. The OMPP Quality and Outcomes staff provide oversight to the health plans by monitoring data and reporting, seeks opportunities to enhance the quality of care provided to members, and contract compliance monitoring and supervision. Data collection and reporting is facilitated through the health plans' quarterly and annual self-reporting as well as through the Enterprise Data Warehouse program-wide reports.

OMPP Quality and Outcomes staff utilize data reporting for ongoing quality initiatives to identify areas for improvement. The contracted health plans must meet contract requirements which include developing a Quality Management and Improvement Program (QMIP) for each line of State business to monitor, evaluate and take action on aspects that impact the quality of care provided to members. Four important components of the QMIP are: the plan's Consumer Assessment of Healthcare Providers and Systems (CAHPS), Healthcare Effectiveness Data and Information Set (HEDIS), meeting the requirements of the National Committee for Quality Assurance (NCQA) and addressing opportunities for improvements identified in the External Quality Review. In addition to the plans' QMIP, each plan must annually conduct and submit to OMPP their CAHPS and HEDIS results and the NCQA rankings.

Since a large portion of the delivery of health care in 2017 to Indiana Medicaid members is via a managed care model, it is Indiana's goal to ensure that the contracted health plans not only perform the administrative functions of a typical insurer, but also be adept at addressing the unique challenges and needs of low-income populations. The plans are also expected to manage and integrate care along the continuum of health care services. OMPP expects the contracted health plans to:

- Improve overall health outcomes
- Foster personal responsibility and healthy lifestyles
- Increase consumer knowledge of health care by increasing health care literacy as well as providing price and quality transparency.
- Improve access to health care services

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

To ensure that these expectations are met, Indiana oversees the allocation of care throughout multiple means - administratively, fiscally and through the delivery of member services, provider services, service utilization, care management and claims payments. Medicaid Quality and Outcomes may use corrective action(s) when a contracted health plan fails to provide the requested services or otherwise fails to meet their contractual responsibilities to the State. It is the mission of the State to ensure that members receive services in an efficient and effective manner.

The four MCEs contracted with the State of Indiana are Anthem Insurance Companies, Inc. (Anthem), Coordinated Care Corporation, Inc. d/b/a Managed Health Services (MHS), MDwise, Inc., and CareSource. Two MCEs, Anthem and MHS, have the HHW, HIP and HCC lines of business for risk based managed care. The other two MCEs, MDwise and CareSource, have the HHW and HIP lines of business for risk based managed care. The MCEs are expected to achieve the goals and objectives set forth by OMPP and manage the care of members enrolled in the HHW, HIP and HCC programs.

OMPP has identified four global aims that equally support HHW, HIP and HCC goals and objectives. These are:

1. **Quality** – Monitor quality improvement measures and strive to maintain high standards
 - a) Improve health outcomes
 - b) Encourage quality, continuity and appropriateness of medical care
2. **Prevention** – Foster access to primary and preventive care services with a family focus
 - a) Promote primary and preventive care
 - b) Foster personal responsibility and healthy lifestyles
3. **Cost** – Ensure medical coverage in a cost-effective manner
 - a) Deliver cost-effective coverage
 - b) Ensure the appropriate use of health care services
 - c) Ensure Utilization Management best practices
4. **Coordination/Integration** – Encourage the organization of patient care activities to ensure appropriate care
 - a) Integrate physical and behavioral health services
 - b) Emphasize communication and collaboration with network providers

HISTORY AND OVERVIEW OF INDIANA’S RISK BASED MEDICAID MANAGED CARE PROGRAMS

Collectively, HHW, HIP and HCC 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 1.

Hoosier Healthwise (HHW) - Indiana established the HHW program in 1994 under the administration of OMPP. The State first introduced a Primary Care Case Management (PCCM) delivery system called *PrimeStep*. Two years later, the State added a risk based managed care (RBMC) delivery system made up of MCE contracted health plans,

which are Health Maintenance Organizations (HMOs), authorized by the Indiana Department of Insurance, and contracted with OMPP. The historical timeline may be found in Appendix 2.

HHW provides health care coverage for low income families, pregnant women, 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.

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

Hoosier Healthwise Strategic Objectives for Quality Improvements 2017

The development of the HHW Quality Strategy Initiatives is based on identified trends in health care issues within the State of Indiana, attainment of the current quality strategy goals, close monitoring by OMPP of the Managed Care Entities’ performance and unmet objectives, opportunities for improvement identified in the External Quality Review (EQR) and issues raised by external stakeholders and partners. OMPP has outlined initiatives for 2017 specific to the HHW Program in Table 1. Some of these objectives have been monitored and maintained from previous years, while other measures are new for the 2017 Quality Strategy.

TABLE 1		
2017 Hoosier Healthwise Initiatives		
OBJECTIVE	METHODOLOGY	GOAL
<p>1. Improvements in Children and Adolescents Well-Care (HEDIS) Percentage of members with well-child visits during first 21 years of life. HEDIS measure using hybrid data.</p>	<p>OMPP utilizes HEDIS measures for tracking the percentages of well-child services in children and adolescents.</p>	<p>Achieve at or above the 90th percentile for improvements in children and adolescent well-child (HEDIS).</p>
<p>2. Early Periodic Screening, Diagnosis and Treatment (EPSDT)</p>	<p>OMPP is aligning its EPSDT program requirements with the American Academy of Pediatrics Bright Futures Guidelines. OMPP anticipates the contracted health plans will provide follow-up and outreach to providers about the Bright Futures Guidelines and provider toolkits.</p>	<p>Achieve at or above 80% participation rate in the EPSDT program.</p>
<p>3. Improvement in Behavioral Health (HEDIS) Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders</p>	<p>OMPP uses HEDIS measures for tracking the percentages of members receiving follow-up.</p>	<p>Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).</p>

<p>4. Ambulatory Care (HEDIS) Number of outpatient and emergency department visits per member months</p>	<p>OMPP is using HEDIS AMB to track the utilization of ambulatory outpatient and emergency department visits to promote best practices in Utilization Management.</p>	<p>Achieve at or above the 75th percentile of Ambulatory Outpatient Care Visits (HEDIS). Achieve at or below the 10th percentile of Ambulatory Emergency Department Care Visits (HEDIS).</p>
<p>5. Frequency of Prenatal and Post-Partum Care (HEDIS) Increase the frequency of care for pregnant women</p>	<p>OMPP is using HEDIS measures for tracking the percentage of women receiving prenatal and postpartum care. Prenatal care – HEDIS FPC Post-partum care – PPC</p>	<p>Achieve at or above the 90th percentile for the frequency of prenatal, and at or above the 90th percentile for post-partum care.</p>
<p>6. Pregnant Women Smoking Cessation Increase the referral of pregnant women who smoke to the Indiana Tobacco Quitline for smoking cessation services</p>	<p>Monthly Indiana Tobacco Quitline reports</p>	<p>Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.</p>
<p>7. Right Choices Program (RCP): Provide quality health care through health care management; RCP administrators conduct utilization reviews, create a care coordination team and collaborate with the member to ensure that the member receives appropriate, medically necessary care</p>	<p>OMPP monitors monthly data to assess the contracted health plans' utilization management efforts to reduce inappropriate hospital, pharmacy, and physician utilization while making efforts to improve the member's health status and increase provider participation in the RCP program.</p>	<p>Achieve at or above 96% of RCP Periodic reviews completed on time.</p>

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

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

In 2015, these high risk individuals are being served as HIP's medically frail members. Individuals with certain physical, mental, and behavioral health conditions are required to have access to the standard Medicaid benefits. In HIP, this is known as the State Plan. The State plan benefits are comprehensive and include vision, dental, and non-emergent transportation. These members are identified through several avenues: member self-attestation, medical

<p>3. POWER Account Roll-Over HIP members who obtain a preventive exam during the measurement year receive power account roll-over. Only codes and code combinations listed in the categories ‘Preventive Care Counseling Office Visit’ and ‘Alternative Preventive Care Counseling Visit’ apply to this measure</p>	<p>OMPP will track the number of HIP members who receive a qualifying preventive exam.</p>	<p>Achieve at or above 85 % of the number of members who receive a preventive exam during the year.</p>
<p>4. ER Admissions per 1000 member months (HEDIS)</p>	<p>OMPP is using HEDIS measures for tracking ER admissions per 1000 member months.</p>	<p>Achieve at or below 75 visits per 1000 member months</p>
<p>5. Improvement in Behavioral Health (HEDIS) Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders</p>	<p>OMPP is using HEDIS measures for tracking the percentages of members receiving follow-up.</p>	<p>Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders.</p>
<p>6. Ambulatory Care (HEDIS) Number of outpatient and emergency department visits per member months</p>	<p>OMPP is using HEDIS AMB as a data based evidence to promote best practices in Utilization Management.</p>	<p>Achieve at or above the 90% percentile of Outpatient Visits (HEDIS) Achieve at or below the 10th percentile of Emergency Department Visits (HEDIS)</p>
<p>7. Pregnant Women Smoking Cessation Increase the referral of pregnant women who smoke to the Indiana Tobacco Quitline for smoking cessation services</p>	<p>Monthly Indiana Tobacco Quitline reports</p>	<p>Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.</p>
<p>8. Right Choices Program (RCP) Provide quality health care through health care management. RCP administrators conduct utilization reviews, create a care coordination team and collaborate with the member to ensure that the member receives appropriate, medically necessary care.</p>	<p>OMPP monitors monthly data to assess the MCEs’ utilization management efforts to reduce inappropriate hospital, pharmacy, and physician utilization while making efforts to improve the member’s health status and increase provider participation in the RCP program.</p>	<p>A minimum of 90% of the findings of appeals filed by members to be removed from RCP will be upheld because the member was correctly assessed as requiring RCP services.</p>

9. Medically Frail Provide quality health care to members identified as medically frail	Administrative Reporting	Identify individuals who meet the medically frail criteria and offer access to enhanced services.
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Overview of Traditional Medicaid Populations

The Indiana Traditional Medicaid Population is comprised of those groups of members not currently enrolled in HHW, HIP or HCC. Other members are being served through other programs such as Medicare or special aid categories such as the breast and cervical cancer programs.

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

- Dually enrolled receiving Medicare and Medicaid benefits
- Persons receiving Home and Community Based Services Waiver benefits
- Persons receiving care in a nursing facility or other State operated facility
- 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

Traditional Medicaid Strategic Objectives for Quality Improvement 2017

In 2017, OMPP will continue efforts to involve the traditional Medicaid population into the overall quality improvement efforts. OMPP will look at data to assist in answering two questions regarding the Traditional Medicaid population:

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

Table 3 shows the initiatives for which baseline data will be analyzed.

TABLE 3 2017 Traditional Medicaid Initiatives			
OBJECTIVE	METHODOLOGY	Baseline	Goal
1. Preventive Care (HEDIS AAP-like)	Administrative reporting through EDW using HEDIS specifications.	84.2%	Maintain with de minimis reduction in performance
2. Ambulatory Care Number of outpatient and emergency department visits per member months	Administrative reporting through EDW using HEDIS specifications.	ED 70.31 OP 286.42	Maintain with de minimis reduction in performance
3. Improvement in Behavioral Health Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders	Administrative reporting through EDW using HEDIS specifications.	53.5%	Maintain with de minimis reduction in performance

Hoosier Care Connect – In 2013 Indiana 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 (ABD) Medicaid enrollees. In response, FSSA convened the ABD Task Force (Task Force) 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. The historical timeline may be found in Appendix 5.

Hoosier Care Connect Strategic Objectives for Quality Improvement 2017

Beginning April 1, 2015 the Care Select and Traditional Medicaid members were transitioned over a 3 month period to the HCC risk based managed care program for individuals who are 65+ years of age, blind or disabled. Due to the members’ multiple needs a longer period of transition was implemented to aid them in the decision making process of choosing a health plan. Overall goals for 2017 includes the completion of the health needs screens and comprehensive assessments, follow up within 30 days for members after a behavioral health hospitalization, and follow up within 7 days including Medicaid rehabilitation option services. Measures are intended to promote positive health outcomes. Table 4 demonstrates the 2017 objectives specific to the HCC program.

TABLE 4 2017 Hoosier Care Connect Initiatives		
GOAL/OBJECTIVE	METHODOLOGY	MEASURE
1. Preventive Care (HEDIS AAP-like)	Administrative reporting through EDW using HEDIS specifications.	HEDIS 2015 data
2. Outpatient Ambulatory Visits (HEDIS AMB-like for outpatient)	Administrative reporting through EDW using HEDIS specifications	HEDIS 2015 data
3. Completion of Health Needs Screener (≥70%)	Administrative reporting	Percentage of newly enrolled MCE members, net of terminated members that have had a health screen assessment completed within 90 days.
4. Completion of Comprehensive Health Assessment Tool	Administrative reporting	A baseline has been established by each of the MCEs by percentage of newly enrolled MCE members, net of terminated members who have had a comprehensive health assessment completed within 150 days.
5. Hoosier Care Connect Members – to provide more effective and ongoing health promotion and disease prevention activities	Administrative reporting	A baseline has been established by each of the MCEs for number of members identified by stratification level, program participation length and average contacts per member per month.
6. Complex Case Management - to effectively tailor benefits to member need.	Administrative reporting	A baseline has been established by each of the MCEs for the number of CCM members by disease state, total contacts and average contacts per reporting period.

Development and Review of Quality Strategy

The OMPP Quality Team monitors the trends in health care in the State of Indiana for all Medicaid members. Quality measures are re-evaluated and established annually in the MCE contracts as a component of State wide quality initiatives as well as pay for performance metrics. OMPP monitors the progress of the metrics with the goal of improving health care for Medicaid members served by the contracted health plans. Periodically, external stakeholders identify issues or initiatives for OMPP consideration and the impact on the State. For example, in 2014 an initiative targeted at smoking cessation and pregnant women was added to pay for outcomes metrics and MCE contracts. The Indiana Medicaid Managed Care programs are reviewed through a variety of forums. Input from those forums are used to review the Quality Strategy Plan and to make annual adjustments.

OMPP and the MCE executive staff have regular meetings to address topics applicable to all care programs. A review of each program's accomplishments, paired with a fiscal analysis concerning program expenditures, allows OMPP to continue to progress through the strategic initiatives, making adjustments as necessary. Items identified in the executive meetings may be included in the Quality Strategy Plan as efforts to improve the delivery of health care, increase the quality of health care for those enrolled in Medicaid or improve fiscal responsibility.

The MCE quality directors include OMPP in monthly collaboration meetings to review and discuss their on-going Quality Improvement Projects (QIPs), Quality Management and Improvement Program (QMIP) Work Plans and strategic initiatives. The contracted health plans use the group for focused problem-solving, clarification, and joint partnership in quality reporting. These collaboration meetings will continue in 2017.

OMPP holds Quality Strategy meetings quarterly with these representatives to discuss progress of quality improvement projects, quality subcommittee activities, and reports of outcomes measures. The health plans submit quality improvement projects for discussion at each quarterly meeting. The HHW, HIP and HCC health plans submit quarterly clinical quality measures reports in various areas, such as the following:

- Preventive Services and Chronic Care
- Prenatal and Postpartum Health Outcomes
- Children and Adolescents Preventive Care
- Behavioral Health
- Utilization Management
- Ambulatory Care

Individual initiative reports are presented to the Quality Strategy Committee by the MCEs. The role of the Committee is to assist in development and monitoring of identified goals and strategic objectives of the written Quality Strategy and to advise and make recommendations to OMPP. The Quality Unit reports to the OMPP Quality Director, who reports directly to the OMPP Deputy Medicaid Director. The Quality Director is the sponsor of the Quality Strategy Committee and chairs the meetings. Currently, the members of the Quality Strategy Committee include representatives from:

- Office of Medicaid Policy and Planning (OMPP)
- Family and Social Services Administration Operations
- Division of Mental Health and Addiction (DMHA)
- Indiana State Department of Health (ISDH)
- Providers (pediatrician, adult health, behavioral health)
- Health Plan Quality Managers

- Advocacy groups
- Consumers
- Providers
- Academia
- Each of the 2016 quality initiative subcommittees:
 - Neonatal Quality
 - Quality Strategy Committee
 - Health Services Utilization Management Quality
 - Dental Advisory

The Quality Subcommittees, comprised of the individuals from within the stakeholder groups, meet Quarterly and focus on specific topic areas. The subcommittees support, advise and inform OMPP on the performance and progress toward the initiatives identified in the Quality Strategy Plan. Table 5 provides the annual schedule of Quality Committee meetings for 2017.

TABLE 5: Annual Schedule of the Quality Strategy Committee and Subcommittees			
Meeting	Description	Frequency	2017 Dates
Quality Strategy	Oversight of other focus groups, providing input for overarching Quality Strategy.	Quarterly, 1-3 pm	3/15, 6/14, 9/13, and 12/13
Neonatal Quality	Focus: Improve birth outcomes. Members of the group will continue to discuss and analyze data relative to healthy moms and healthy babies.	Quarterly, 1-3 pm	3/7, 6/6, 9/5 and 12/5
Health Services Utilization Management	Focus: Utilization issues related to behavioral health, Right Choices Program and prior authorization issues.	Quarterly, 9-11 am	3/22, 6/21, 9/21 and 12/20
Reimbursement, Financial Reporting	Focus: Discuss the OMPP and Milliman financial reporting requirements	Three times a year	4/13, 7/13, and 10/12
Dental Advisory Panel	Focus: Improve oral health. Member of the group will provide input on dental policy and provide clinical recommendations to improve oral health and overall health of our members.	Quarterly, 9-11 am	3/16, 6/15, 9/14 and 12/14

For 2016, the Quality Strategy Committee meeting participants held in depth presentations and discussions regarding the MCEs’ 2016 Quality Management and Improvement Work Plans and Quality Improvement Projects (QIPs). Specifically the QIPs focusing on completion of the health needs screener assessment and behavioral health follow up were discussed in detail including strategies employed to increase rates for both measures. The Health Services Utilization Subcommittee focused on the MCEs’ programs for prior authorization, medication therapy management, applied behavioral analysis services, and Indiana’s Right Choices Program. The Neonatal

Subcommittee focused on the state's infant mortality rate and the MCEs' efforts to identify pregnant mothers early in the pregnancy through the use of the notice of pregnancy forms. The MCEs also discussed services and initiatives focused on pregnant members, newborns, and postpartum members. As a result of this shared information, the stakeholders' participation and cooperation is used to monitor, evaluate, share best practices and improve performance. Committee members actively participate on behalf of the State of Indiana and the many Hoosiers reliant on quality health care. OMPP strives to continue raise the bar for health care and improve the quality of life for thousands of infants, children, adolescents and adult Hoosiers across the State of Indiana. OMPP maintains an on-going review of movement within the strategic objectives through these quality committees.

The findings from the annual External Quality Review are used to monitor quality initiatives and identify areas for improvement. Initiatives may be identified for inclusion in the Quality Strategy Plan or for program modifications. The 2016 External Quality Review for the 2015 calendar year focused on themes across multiple facets. One theme was assessing member access to services either through availability of providers (access reports), making appointments (directory review) or baseline for the future (dental services). Another theme was performing drill down analytics of HEDIS measures (IET, well child, prenatal care). As in the past, the External Quality Review included a desk review, an onsite review and a post-onsite review.

Focus studies selected for the 2016 EQR include: initiation and engagement of alcohol and other drug treatment, audit of provider directories, timeliness of prenatal care, preventative care services delivered to children, and access to dental coverage. These EQR topics are reflective of OMPP's current priorities.

SECTION II. ASSESSMENT

QUALITY AND APPROPRIATENESS OF CARE

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

NATIONAL PERFORMANCE MEASURES

The MCEs monitor, evaluate and take effective action to identify and address needed improvements in the quality of care delivered to members in the HHW, HIP and HCC programs. This includes necessary improvements by all providers in all types of settings. In compliance with State and federal regulations, the contracted health plans submit quality improvement data, including data that meets HEDIS standards for reporting and measuring outcomes, to OMPP. This includes data on the status and results of quality improvement projects. Additionally, the MCEs submit information requested by OMPP to complete annual quality reports.

MONITORING AND COMPLIANCE

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

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

OMPP Quality and Outcomes staff oversees contract compliance by enforcing reporting requirements mandated within the MCEs' contracts. Each contracted health plan is required to document outcomes and performance results, as instructed within each program reporting manual, to demonstrate data reliability, accuracy and validity. The MCE Reporting Manuals provide guidance by OMPP on required performance reporting for the health plans contracted to deliver services for HHW, HIP and HCC. The MCE Reporting Manuals are tailored to the goals of each program and describe 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 2016, the periodic MCE reports timeframes for submission were increased in order to closely monitor the start-up of the HIP program expansion and the phase in of HCC. To more closely monitor implementation, daily and weekly reports were submitted by the MCEs to track member and provider concerns. In general, reports are submitted monthly and 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 health plan 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. Anomalies are identified and targeted for discussion at the Quality Strategy Committees 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. The alignment of program processes has continued, as the HIP program has been modified and grown in size substantially and the HCC program has been implemented. Processes have been developed and implemented to improve accountability, compliance, and reliance on the operations and health outcome achievements of the State's contracted health plans.

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

Typically, OMPP Quality and Outcomes staff review and update the reporting manuals annually based on current needs of the programs and in conjunction with the contracted health plans. For 2015, the HIP reporting manual underwent an extensive overhaul to better reflect the priorities of the expanded HIP program. Draft versions were sent to the health plans for input and clarification to better ensure integrity of data. The HCC reporting manual was developed by utilizing a combination of reports from HHW and Care Select in order to best reflect the program priorities. The HHW 2015 reporting manual underwent minor changes from 2014 to bring consistency between the same reports for different programs. During 2016 the MCE reporting for program integrity underwent a major overhaul resulting in more granular documentation being provided by the MCEs. Representatives from all the MCEs attended an in depth training on the program integrity reporting changes to assure a consistent understanding of the data elements and reporting requirements. OMPP also began the process of further refining the reporting requirements for the Quality Management and Improvement Work Plan and the Quality Improvement Projects.

The typical annual review of the managed care reporting manuals may trigger:

- Changes to reporting requirements
- Improvement of submission processes, templates and retention
- Manual revisions which clarify and document specification changes
- Increases in reporting consistency across contracted health plans

OMPP incorporated multiple steps within the HHW, HIP and HCC 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 health plans as well as data for progress toward pay for outcomes measures and quality initiatives. A dashboard comparison of quality initiatives is shared at the quarterly Quality Strategy Committee, Neonatal, and Health Services Utilization Subcommittee meetings.

EXTERNAL QUALITY REVIEW (EQR)

OMPP contracts with Burns & Associates, Inc. (B&A) to conduct the required External Quality Reviews (EQR) for HHW, HIP and the Indiana's Children's Health Insurance Program (CHIP). The HHW and HIP EQR takes place each summer, and the results are reported each fall. The CHIP EQR is conducted each winter, and the

results are reported each spring. In 2016 the EQR was expanded to include the new HCC program. In 2017, the EQR will address HHW, HIP, HCC and CHIP performance of 2016.

In Calendar Year (CY) 2016 B&A met with OMPP and agreed to conduct the following:

- Assess the reliability of the information provided by the MCE to its members enrolled in each program about providers
- Assess the consistency of provider information within a program but across MCEs
- Assess the consistency of provider information between the MCEs and HPE
- Learn about current challenges in the transmission of information from HPE to the MCEs (and back)
- Evaluate member access to providers within each program by validating geoaccess reports submitted by the MCEs for each program
- Assess the adequacy of coverage for the provision of dental services throughout the state for HCC and HIP members and to set a baseline of utilization for future monitoring
- Examine the ratio of prenatal visits per week that the mother was enrolled with the MCE and compare to ACOG recommendations
- Examine the utilization of both well care visits (as defined by HEDIS) as well as other primary care visits
- Determine if there is disparity in the rate of either well care or primary care visits among the subpopulations

SECTION III. STATE STANDARDS

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

ACCESS STANDARDS

AVAILABILITY OF SERVICES

OMPP Quality and Outcomes requires the MCEs to develop and maintain a comprehensive network to provide services to its HHW, HIP and HCC members. The network must include providers serving special needs populations such as people who are aged, blind, or disabled. For its HHW population, the network must include providers serving children with special health care needs.

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 the 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 health plans must ensure that all of their contracted providers are registered Indiana Health Coverage Program (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 in order to receive reimbursement from the MCEs. The contracted health plans encourage out-of-network providers, particularly emergency services providers, to enroll in the IHCP.

Each health plan must develop and have under contract its specialist and ancillary provider network prior to receiving enrollment. In 2016, for HCC and the dental carve-in, the MCEs made significant progress in regards to network adequacy and were allowed to close some of some networks after providing documentation to OMPP Quality and Outcomes that network adequacy requirements had been met for both of these scenarios.

Maintain and Monitor Network of Appropriate Providers:

The MCEs are obligated to consider the following elements when developing, maintaining and monitoring the provider networks:

- Anticipated enrollment
- Expected utilization of services, taking into consideration the characteristics and health care needs of HHW, HIP and HCC 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 distance, travel time, the means of transportation ordinarily used by members and whether the location provides physical access for members with disabilities
- The 2016 EQR completed focus studies relating to the audit of provider directories, beneficiary access to providers, and beneficiary access to dental services

OMPP Quality and Outcomes reserves the right to implement corrective actions and will assess liquidated damages if the contracted health plan fails to meet and maintain the specialist and ancillary provider network access standards. OMPP's corrective actions may include, but are not limited to, withholding or suspending new member enrollment from the contracted health plan until the contracted health plan's specialist and ancillary provider network meets established standards. OMPP monitors the health plans' 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 Enrollee 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 primary medical provider if that provider is not a women's health specialist. The MCEs must have an established mechanism to permit a female member direct access such as a standing referral from the member's PMP or an approved number of visits. The health plans may also establish claims processing procedures that allow payment for certain women's health codes without prior authorization or referral.

Second Opinions:

The managed care health plans 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 health plan 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 health plan has met the network access standards and has received State approval to close the network. The health plan must authorize and pay for out-of-network care if the MCE is unable to provide necessary covered medical services within sixty (60) miles of the member's residence by the health plan's provider network. The health plan 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 health plan is unable to provide the covered services in-network. The health plan 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 managed care health plan may require out-of-network providers to obtain prior authorization from the contracted health plan before rendering any non-self-referral or non-emergent services to Contractor members. If the out-of-network provider has not obtained such prior authorization, the health plan may deny payment to that out-of-network provider. The health plan must cover and reimburse for all authorized, routine care provided to its members by out-of-network providers.

To ensure adequate and timely services are available to members, the health plan must make nurse practitioner services available to members. If nurse practitioner services are available through the contracted health plan, the contracted health plan must inform the member that nurse practitioner services are available. Members are allowed to 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.

For HIP members, MCEs must make covered services provided by Federally Qualified Healthcare Centers (FQHCs) and Rural Health Clinics (RHCs) 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 health plan's network.

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

Out-of-Network Provider Coordination with MCEs for Payment:

Out-of-Network Provider Reimbursement – Hoosier Healthwise

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

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

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

Out-of-Network Provider Reimbursement – HIP

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

Provider Credentialing:

All managed care health plans must have written credentialing and re-credentialing policies and procedures to ensure 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 re-credentialing process for all contracted providers must meet the National Committee for Quality Assurance (NCQA) guidelines. The same provider credentialing standards must apply across all managed care programs, including HHW, HIP and HCC programs.

The MCEs use OMPP's standard provider credentialing form during the credentialing process. The contracted health plans must ensure that providers agree to meet all of 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 particular 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 health plan also serves commercial members. The health plan must also make covered services available twenty four (24)-hours-a-day, seven (7)-days-a-week, when medically necessary. In meeting these requirements, the 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 ninety (90) calendar days in advance of the contracted health plan's inability to maintain a sufficient network in any county.

Provider Incentive Program

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

Cultural Competency

Data on race, ethnicity and primary language is sent to the MCEs via the Enrollment Roster. This information is to be utilized by the health plans to communicate effectively and appropriately with their population. The health plans must make all written information available in English and Spanish, and other prevalent languages, including American Sign Language, identified by OMPP, upon the member's request. In addition each health plan must identify additional languages that are prevalent among its membership. The MCE must also inform members that information is available upon request in alternative formats and how to obtain them. OMPP defines alternative 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 health plans upon request. The MCEs must also ensure that all of its contracted providers can respond to the cultural, racial and linguistic needs of the populations that they serve.

OMPP will assess liquidated damages and impose other authorized remedies for an MCE's non-compliance with the network development and network composition requirements.

ASSURANCES OF ADEQUATE CAPACITY AND SERVICES

All MCEs are contractually obligated to:

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

OMPP Operations requires each of the contracted health plans to submit network access reports. For HHW, the plans submit these reports annually. For HIP and HCC, the network access reports submitted quarterly in 2015 allowed the State to monitor new program implementation and network adequacy. Since the health plans have demonstrated compliance with OMPP's access standards, the MCEs will submit network access reports on an annual basis and at any time there is a significant change to the provider network for 2016. 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 with respect to participation, reimbursement or indemnification of any provider, solely on the basis of 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 health plan's members. The MCEs may also manage provider enrollment in order to establish and maintain quality measures and control costs consistent with the health plan's responsibilities.

Acute Care Hospital Facilities

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

Primary Medical Provider (PMP) Requirements

In order to assure availability of primary medical providers for members around the State, OMPP's managed care contracts include provisions on PMPs:

- PMPs are allowed to contract with one or multiple health plans. A PMP may also participate as a specialist in another health plan. 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 health plans 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 thirty (30) miles of the member's residence. Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians (HHW only), 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 health plan's PMP contract must state the PMP panel size limits, and the MCE must assess the PMP's non-HHW, HIP and HCC practice when assessing the PMP's capacity to serve the health plan's members. The fiscal agent maintains a separate panel for PMPs contracted with more than one contracted health plan. The OMPP Quality and Outcomes team monitors the MCE's PMP network to evaluate its member-to-PMP ratio.
- Each health plan must have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services twenty four (24)-hours-a-day, seven (7)-days-a-week. In addition PMPs must have a mechanism in place to offer members direct contact with their PMP or the PMP's qualified clinical staff person, through a toll-free telephone number twenty four (24)-hours-a-day, seven (7)-days-a-week. Each PMP must be available to see members at least three (3) days per week for a minimum of twenty (20) hours per week at any combination of no more than two (2) locations. Each MCE must also assess the PMP's patient base who are not members of HHW, HIP and HCC to ensure that the PMP's HHW, HIP and HCC population is receiving services on an equal basis with the PMP's non-managed care population.
- The health plans must ensure that the PMP provide "live voice" coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The health plans must also ensure that members have telephone access to their PMP (or appropriate designee such as a covering physician) in English and Spanish twenty four (24)-hours-a-day, seven (7)-days-a-week.

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

Specialist and Ancillary Provider Network Requirements

In addition to maintaining a network of PMPs, the 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 health plan may contract as a specialist with other health plans.

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

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

Table 6 Network Provider Specialties	
Specialties	Ancillary Providers
➤ Anesthesiologists*	➤ Diagnostic testing*
➤ Cardiologists*	➤ Durable Medical Equipment providers
➤ Cardiothoracic surgeons**	➤ Home Health
➤ Oral Surgeons **	➤ Prosthetic suppliers**
➤ Dermatologists**	
➤ Endocrinologists*	
➤ Gastroenterologists*	
➤ General surgeons*	
➤ Hematologists	
➤ Infectious disease specialists**	
➤ Interventional radiologists**	
➤ Nephrologists*	
➤ Neurologists*	
➤ Neurosurgeons**	
➤ Non-hospital based anesthesiologist (e.g., pain medicine)**	
➤ OB/GYNs*	
➤ Occupational therapists*	
➤ Oncologists*	
➤ Ophthalmologists*	
➤ Optometrists*	
➤ Orthopedic surgeons*	
➤ Orthopedists	
➤ Otolaryngologists	

Table 6 Network Provider Specialties	
Specialties	Ancillary Providers
<ul style="list-style-type: none"> ➤ Pathologists** ➤ Physical therapists* ➤ Psychiatrists* ➤ Pulmonologists* ➤ Radiation oncologists** ➤ Rheumatologists** ➤ Speech therapists* ➤ Urologists* 	

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

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

In addition, the health plans must demonstrate the availability of a few specialty providers. The MCEs must have providers with training, expertise and experience in providing smoking cessation services, especially to pregnant women. Evidence that providers are trained to provide smoking cessation services must be available during OMPP’s monthly on-site visits. 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 (CDC) which illustrate that persons affected by a bleeding disorder receiving treatment from a federally recognized treatment center require fewer hospitalizations, experience less bleeding episodes and experience a forty percent (40%) reduction in morbidity and mortality. The health plans must also arrange for laboratory services only through those IHCP enrolled laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.

Non-Psychiatrist Behavioral Health Providers

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

The health plans 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 thirty (30) minutes or thirty (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 forty-five (45) minutes or forty-five (45) miles. The health plan must provide assertive outreach to members in rural areas where behavioral health services may be less available than in urban areas.
- The health plans also must monitor utilization in rural and urban areas to assure equality of service access and availability. The following list represents behavioral health providers that should be available in each health plan’s network:
 - Outpatient mental health clinics

- Community mental health centers
- Psychologists
- Certified psychologists
- Health services providers in psychology (HSPPs)
- Certified social workers
- Certified clinical social workers
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Persons holding a master's degree in social work, marital and family therapy or mental health counseling

COORDINATION 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 health plan 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 health plan must protect each member's privacy in accordance with the confidentiality requirements stated in 45 CFR 160 and 164, which address security and privacy of individually identifiable health information. The health plan 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 health plan would have paid in the absence of third party liability (TPL), after subtracting the amount paid by the primary payer.

OMPP requires that each MCE coordinate 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 health plan must not prevent or unduly delay a member from receiving medically necessary services. Each health plan remains responsible for the costs incurred by the member with respect to 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 IC 12-15-8 and 405 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 – Packages A and P

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

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

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 are not required to coordinate

benefits but 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 not required to coordinate benefits but must report the member's coverage to the State. The 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.

Special Needs:

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

In accordance with 42 CFR 438.208(c)(2), which specifies allowable staff, 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. When the further assessment confirms the special health care need, the member must be placed in the appropriate level of care coordination, either 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's health plan from another health plan. Contractor activities supporting special health care needs populations 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

COVERAGE AND AUTHORIZATION OF SERVICES

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

The 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 health plans' members. Pursuant to 42 CFR 438.210(b), relating to authorization of services, the contracted health plans must:

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

The State 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 pending, denied, suspended claims, etc.

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

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

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 (PLP) 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 health plan's utilization management program:

- Not be limited to traditional utilization management activities, such as prior authorization
- Integrate with other functional units as appropriate and 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; identify aberrant provider practice patterns (especially related to emergency room, inpatient services, transportation, drug utilization, preventive care and screening exams); ensure active participation of a utilization review committee; evaluate efficiency and appropriateness of service delivery; incorporate subcontractor's performance data and facilitate program management and long-term quality and identify critical quality of care issues
- Link members to disease management, care management and complex case management

- Encourage health literacy and informed, responsible medical decision making. For example, the health plan should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and obtain services in the appropriate treatment setting. Each health plan is also responsible for identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care.

OMPP requires that the health plan monitors utilization through retrospective reviews, identifies areas of high and low utilization and identifies key reasons for the utilization patterns. Each health plan must identify those members that are high utilizers of emergency room services and/or other services and perform the necessary outreach and screening to 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 health plan must also use this data to identify additional disease management programs that are needed. Any member with emergency room utilization at least three (3) standard deviations outside of the mean for the population group is to be referred to care management or complex case management. When identifying members who over-utilize services, the health plan may use Indiana's restricted card program, the Right Choices Program (RCP), or they may refer members to care management or complex case management.

The health plans must monitor pharmacy utilization as identified when stratifying a member for care. For 2017 pharmacy services for HHW members has been carved in and will be managed by each MCE. Pharmacy services for HIP and HCC members continue to be managed by the MCE through their own pharmacy benefits managers. As a part of the utilization review, the health plans will assess a member's utilization as compliant with, contraindicated or in conflict with their diagnoses and health care needs.

As part of its utilization review, the health plans should monitor access to preventive care, specifically to identify members who are not accessing preventive care services in accordance with accepted preventive care standards such as those published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. The 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 potential under- or over-utilization of physical and behavioral health services, the MCEs submit a variety of utilization reports to OMPP. The health plans 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 screener 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. In regards to members with assessed behavioral health needs, the health plans monitor use of services for their members with special needs as well as members with a diagnosis of serious emotional disturbance, severe mental illness and/or substance abuse.

STRUCTURE AND OPERATIONS STANDARD

PROVIDER SELECTION

Provider Enrollment and Disenrollment

The contracted health plans must follow established procedures to enroll and disenroll providers, including PMPs. In enrolling and disenrolling providers, the MCEs may distinguish whether the provider participates in HHW, HCC, and/or HIP 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.

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

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

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

The health plan 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 on a regular basis. Such notice must be provided within fifteen (15) calendar days of the MCE's receipt or issuance of the provider termination notice.

ENROLLEE INFORMATION

Member Enrollment

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

New Member Materials

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

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

PMP Selection

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 thirty (30) calendar days of the member's enrollment, the health plan assigns the member to a PMP. Unless the member elects otherwise, the

member must be assigned to a PMP within thirty (30) miles of the member's residence and the health plan considers any prior provider relationships when making the assignment. The MCE must document at least three (3) telephone contact attempts made to assist the member in choosing a PMP. OMPP approves the health plan'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.

Health Needs Screener

Since February 2011, each MCE has been required to conduct a health needs screener for new members. The health needs screener is used to identify the member's physical and/or behavioral health care needs, special health care needs, as well as the need for disease management, care management and/or complex case management services. The health needs screener may be conducted in person, by phone, online or by mail. For 2017 some MCEs will be utilizing kiosks located in retail businesses as well for members to be able to complete their health needs screener. Members who utilize these kiosks will receive a financial incentive upon completion of the screener which can then be utilized immediately. The health plans use an OMPP-approved standard health screening tool. The Health Needs Screener (HNS) may be supplemented with additional questions developed by the health plan or partnered with the health plan's comprehensive health assessment tool. Any additions to the health screening tool must be approved by OMPP. For pregnant HHW members, a completed Notification of Pregnancy (NOP) form fulfills the health needs screener requirement.

In 2014, the HNS was reviewed and modified to meet updated NCQA standards. The MCEs worked with OMPP to ensure that the screening tool met the needs of initial member screening and to identify HIP members who may be medically frail individuals. The new tool was operationalized in 2015.

The health screening must be conducted within ninety (90) calendar days of a new member's enrollment in the plan. The contracted health plan is encouraged to conduct the health screening at the same time it assists the member in making a PMP selection. Non-clinical staff may conduct the health needs screener. Data from the health screening or NOP assessment form, current medications and self-reported medical conditions will be used to meet the needs of individual members through disease management or care coordination. Each MCE may use its own proprietary stratification methodology to determine which members should be referred to specific disease management programs, ranging from member education and awareness efforts to care coordination.

HIP members may be identified as medically frail through the health needs screener, claims analysis or self-report during enrollment. The MCEs have 60 days to confirm the member's status in order to assure appropriate care coordination is provided to the member.

The initial health screener is followed by a detailed comprehensive health assessment by a health care professional when a member is identified through the screening as having a special health care need or when there is a need to follow up on problem areas found in the initial health screening. OMPP also requires each health plan 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 health needs screener, 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.

Children with Special Health Care Needs

OMPP requires each MCE to have care plans to address the special needs populations and for 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 Bureau (MCHB) and published by the American Academy of Pediatrics (AAP):

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

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

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

Member Disenrollment from contracted health plans

In accordance with 42 CFR 438.6(k) 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 health plan.

The MCE must notify the local county DFR office within thirty (30) calendar days of the date it becomes aware of the death of one of its members, giving the member's full name, address, Social Security Number, member identification number and date of death. The 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 (HIPAA) 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 health plan's Information System (IS) supports 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 the same as the State's. The MCEs' IS plans for privacy and security shall include, but not be limited to:

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

GRIEVANCE SYSTEMS

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 health plans' appeals process must:

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

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

Member Notice of Grievance, Appeal and Fair Hearing Procedures

The 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 into 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 health plan’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 health plan 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 health plans must have policies and procedures addressing auditing and monitoring subcontractors’ data, data submissions and performance. The Contracted health plans must integrate subcontractors’ financial and performance data (as appropriate) into the contracted health plans’ information system to accurately and completely report Contractor performance and confirm contract compliance.

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 health plan uses subcontractors to provide direct services to members, such as behavioral health services, the subcontractors must meet the same requirements as the health plan. The health plan must demonstrate its oversight and monitoring of the subcontractor’s compliance with these requirements. The health plan must require subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors.

MEASUREMENT AND IMPROVEMENT STANDARDS

Table 7 indicates the 2017 OMPP Care Programs Quality Measures which apply to HHW, the HIP and HCC. These Pay for Outcomes (P40) goals are listed by managed care program. OMPP continues a commitment to quality improvement and closely monitors the health care program goals and works closely with the contracted health plans to ensure quality improvement.

Program	HEDIS Code	State Reports	Description
Hoosier Healthwise P40 Goals			
	AMB	QR-GSU1	Ambulatory Care
	W15	QR-CA1	Well-Child Annual in the First 15 Months - Six or More Visits
	W34	QR-CA2	Well-Child Annual Visits in the Third, Fourth, Fifth and Sixth Years of Life
	AWC	QR-CA3	Adolescent Well Child Visits
	FUH	QR-BH2	Follow-up After Hospitalization for Mental Illness: 7-Day Follow-Up
	PPC	QR-MN3	Postpartum Care - Percentage of Deliveries with Post-Partum Visit
	FPC	QR-MN3	Frequency of Ongoing Prenatal Care

		Administrative and Quitline data	Referral to the Quitline for Pregnant Members who Smoke
HIP P40 Goals			
	AMB	QR-GSU8	ER Admissions per 1000 Member Months
	AAP	QR-PCC1	Adult Ambulatory and Preventive Care
	FUH	QR-BH2	Follow-up After Hospitalization for Mental Illness: 7-Day Follow-Up
		QR-HS1	Health Needs Screener
		Administrative and Quitline data	Referral to the Quitline for Pregnant Members who Smoke
Hoosier Care Connect P40			
	FUH	QR-BH2	Follow-up After Hospitalization for Mental Illness: 7-Day Follow-Up with MRO Services
	FUH	QR-BH2	Follow-up After Hospitalization for Mental Illness: 30-Day Follow-Up
		QR-HS1	Health Needs Screener
		QR-CHAT1	Comprehensive Health Assessment Tool
	AMB	QR-GSU7	ER admissions per 1000 member months
	AAP	QR-PCC1	Adult Ambulatory and preventive care

PRACTICE GUIDELINES

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

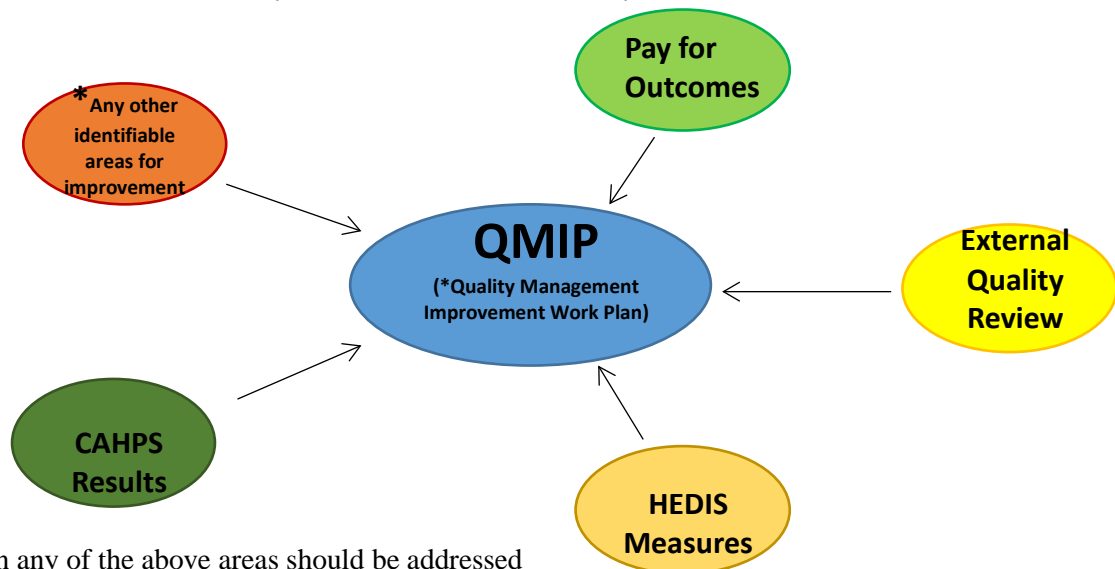
QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT

The State places great emphasis on the delivery of quality health care to HHW, HIP and HCC members. Performance monitoring and data analysis are critical components in assessing how the health plans maintain and improve quality of care delivered across the State. Each reportable measure monitored by OMPP is either a HEDIS specification or is a State initiative. OMPP works with the health plans to establish common definitions and understanding across plans for consistency in meeting HEDIS specifications and/or meeting State needs. MCE reporting is monitored monthly, quarterly and annually. In 2015 with the HIP expansion and implementation of HCC, some weekly and monthly reporting was utilized to track critical implementation indicators. Data is compared to contract specifications, HEDIS measures and between plans. During quarterly Quality Strategy Committee meetings, MCE performance data is shared. Specific priorities of each health care program have been identified and are presented in a dashboard format comparing the health plans’ performance. OMPP uses a confirmation report process to provide feedback periodically to the health plans on individual values.

Evaluation of reporting standards, definitions and templates is a continuous process. As HEDIS revisions occur, OMPP makes reporting adjustments to reflect current national benchmarking practices. As Indiana initiatives evolve, reporting changes are made further refine the data and ensure contract compliance. Concurrently, the

development and implementation of overarching quality strategy initiatives reflects HEDIS measures and State data reporting.

OMPP identified Pay-for-Outcomes measures by program. As illustrated in Table 7, a performance measure may apply to one or more health care programs. Annually, drafts of the next year’s Quality Management and Improvement Work Plans (QMIPs) and Quality Improvement Project plans (QIPs) are submitted to OMPP for review and approval. The QIPs are the equivalent of the CMS-required Performance Improvement Plan (PIP). OMPP has worked with the health plans in 2015 to identify sources of input to the QMIP. The diagram below illustrates a minimum of six sources: the External Quality Review, HEDIS outcomes, CAPHS outcomes, Pay for Outcomes results and other identified areas for improvement. Gaps in any of these sources should be addressed in the health plan’s QMIP as well as any additional areas identified by OMPP.



*All gaps in any of the above areas should be addressed in the QMIP.

*Any additional areas for improvement will be identified by OMPP.

In the 2014 EQR process the QMIP and QIP forms were updated, a new schedule of submission was established and the MCEs were provided with training and guidance in regards to the development and implementation of their QMIPS. The QIP templates were revised to allow for greater detail and efficacy in their development and subsequently that of the QMIP while focusing on improving the delivery of health care benefits and services to members. The MCEs are required to develop an individualized QMIP for each of their Medicaid lines of business; although, a specific PIP may be utilized across multiple programs. These forms were again updated in 2016 via the EQR process and continue to be refined by OMPP. The MCEs develop and submit draft QMIPS and PIPs by October 31 for the prospective year. OMPP provides feedback to the MCEs as needed prior to implementation of the QMIP on January 1. In 2016, OMPP increased focus on the measurement and effectiveness of the QIP interventions identified by the plans to achieve the desired improvement. OMPP provided technical assistance as needed and feedback to the plans specific to whether or not the identified interventions were measurable.

To assess quality strategy effectiveness and to determine strategies for the following year, the health plans review and monitor current member service utilization. Monitoring is conducted through data mining at the MCE level, reviewing data reports from the state fiscal agent HP and referrals from providers. Individuals with extensive utilization are further assessed for appropriateness in Indiana’s restricted card program, the Right Choices

Program, or for disease management, care management or complex case management programs. Individuals who underutilize appropriate healthcare services are encouraged to participate in preventive care services, and their PMPs are provided gaps in care reports to increase the utilization of preventive care.

Health need assessments are used to identify individuals with special health care needs. Until July 2015, the Indiana Care Select program provided disease management for individuals with diabetes, congestive heart failure, coronary artery disease, chronic kidney disease, severe mental illness, COPD, severe emotional disturbance, depression and/or the co-morbidities of diabetes and hypertension as well as the co-morbidities of any combination of these disease states. After that date, those members transitioned to the HCC program. HHW and HIP provide disease management, care management and complex case management programs targeting individuals with special health care needs.

OMPP has outlined nineteen (19) quality-related incentives measures in 2017. The outcome measures are composed of withhold measures and bonus measures. Across all three (3) Medicaid programs there are ten Healthcare Effectiveness Data and Information Set (HEDIS) withhold measures; one HEDIS-like measure; and five administrative measures. Targets for HEDIS measures are reviewed annually and updated when new NCQA benchmarks become available. The State recognizes that performance improvement is an ongoing process and intends to retain targets for at least two years. This allows for a longer timeframe for initiatives to take shape. At the end of 2016, performance measures were reviewed and certain targets were dropped or added to create targets more appropriate for meeting the needs of the Medicaid population and current State initiatives. Contract amendments occur on an annual basis, or more frequently as needed, if program changes occur. The Pay-for-Outcomes program is reviewed and updated as needed during the annual contract process.

Table 8 reflects the performance measures established by the OMPP for the Pay-for-Outcomes program –CY17.

Table 8 Pay-for-Outcomes Contracting – CY17		
Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect
P4O Measures Aligned Across Programs		
Follow-up After Hospitalization for Mental Illness: 7-Day Follow-up	Follow-up After Hospitalization for Mental Illness: 7-Day Follow-up	Follow-up After Hospitalization for Mental Illness: 7-Day Follow-up with MRO services
Percent of maternity discharges who make contact with the Quitline	Percent of maternity discharges who make contact with the Quitline	
	Heath Needs Screener	Heath Needs Screener
	ED admissions per 1000 member month	ED admissions per 1000 member month
	Adult Preventive Care	Adult Preventative Care
Program Specific P4O Measures		
Well-Child Visits in the First 15 months - Six or more visits		Comprehensive Health Assessment
Well Child Visits in the third, Fourth, Fifth and Sixth Years of Life		Follow-up After Hospitalization for Mental Illness: 30-Day Follow-up
Adolescent Well Child Visits		

Postpartum Care - Percentage of Deliveries with Post-Partum Visit		
Frequency of Ongoing Prenatal Care		
Ambulatory care; ED and outpatient		

The contracted health plans may receive additional compensation for achieving or exceeding established metrics for Pay-for-Outcomes measures. Such additional compensation is subject to the health plans’ complete and timely satisfaction of its obligations under the state fiscal year 2017 contract. This includes timely submission of the contracted health plans’ HEDIS Report for the measurement year, the Certified HEDIS Compliance Auditor’s attestation, the Consumer Assessment of Healthcare Providers and Systems report as well as timely submission of the Priority Reports.

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

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

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

OMPP may, at its option, reinstate a health plan’s eligibility for participation in the Pay-for-Outcomes program once the contracted health plan has properly remediated all prior instances of non-compliance and OMPP has satisfactory assurances of acceptable future performance. To provide an incentive to the MCEs for submitting encounter claims, Pay-for-Outcomes results are verified by the OMPP. Data must reconcile to a variance no greater than 2 percent for HHW, HCC and HIP.

OMPP works diligently to organize monitoring and reporting systems. One aspect of the OMPP quality improvement program is the monthly on-site monitoring visit with each contracted health plan. OMPP completes an in-depth review of various operational, reporting and quality topics at the on-site visit. A Monthly On-site Monitoring Tool is prepared by OMPP Quality and Outcomes staff based on a selected topic of focus and sent to each health plan at the first of the month. The purpose of the Monthly On-site Monitoring Tool is to gain practical

insight into the current daily operational practices, reporting results and internal quality assurance programs relative to the current month’s chosen topic. The health plan returns the Monthly On-site Monitoring Tool to OMPP with written responses to topic inquiries and other detailed quality and operational documentation for review by OMPP Quality and Outcomes. Requested data for review often consists of policies and procedures, trending and collection data, member/topic examples and other specific information. OMPP Quality and Outcomes completes a detailed review of the supporting documentation submitted by the contracted health plan. Based on this detailed review, OMPP Quality and Outcomes prepares the agenda and a set of drill-down questions that is sent to the health plan in advance of the on-site visit. At the on-site visit, OMPP Quality and Outcomes staff discusses the health plan’s performance as it relates to the operational, reporting and quality expectations. The health plans have an opportunity to provide additional topic information and ask questions to gain a better understanding of the state’s expectations and suggestions for improvement.

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

State Defined Performance/Quality Improvement Projects

OMPP requires standard processes for submission of QMIP Work Plans and Performance/Quality Improvement Projects (QIPs) from the contracted health plans.

- QMIP Work Plan template: contracted health plans are required to use a standard template for submission of QMIP Work Plans. This standardized template is a helpful tool for reviewing the draft work plans as well as the quarterly progress updates submitted by the contracted health plans.
- QIPs: contracted health plans are required to submit QIPs prospectively using the OMPP approved standard template for each quality improvement project. The use of a standard form was a recommendation from the External Quality Review (EQR), performed by Burns and Associates.

Table 9 exhibits identified Performance/Quality Improvement Project topics of focus for 2017 for HHW, HIP and HCC.

TABLE 9 Performance/Quality Improvement Projects for 2017 Hoosier Healthwise, HIP, and Hoosier Care Connect			
	Hoosier Healthwise	HIP	Hoosier Care Connect
Anthem	New member HNS Appropriate Use of ER Services Health Needs Screener Follow-up After Behavioral Health Inpatient Stay	Unnecessary ED Utilization Follow-up After Behavioral Health Inpatient Stay Adult Preventative Visit Improvement New member HNS	Unnecessary ED Utilization Follow-up After Behavioral Health Inpatient Stay Adult Preventative Visit Improvement New member HNS

MDwise	NOP Completion HNS Completion	NOP Completion HNS Completion Follow-up After Behavioral Health Inpatient Stay	NOP Completion HNS Completion Follow-up After Behavioral Health Inpatient Stay
MHS	ER Utilization Alcohol and Other Drug Dependence Treatment HNS Rate	ER Utilization Alcohol and Other Drug Dependence Treatment HNS Rate	ER Utilization Alcohol and Other Drug Dependence Treatment HNS Rate
CareSource	Percentage of members using Kiosk to complete HNS Percentage of members in Job Connect Program based on Ambulatory or Preventative visits	Percentage of members using the Kiosk to complete HNS Percentage of members in Job Connect Program based on Ambulatory or Preventative visits	

HEALTH INFORMATION SYSTEMS

OMPP requires all MCEs to operate and maintain an Information System (IS) 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 health plan maintains an Information System that collects, analyzes, integrates and reports data. Contracted health plans report data to OMPP on:

- Utilization management – health needs screeners, health screenings, prior authorization, care management, complex case management, disease management, services utilization, pregnancy identification
- Member services - member helpline, grievances, hearings and appeals, Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Provider reports – claims disputes, credentialing, enrollments and disenrollments, geographic access, compliance

- Quality management and improvement – quality management and improvement work plan, program integrity report, quality improvement projects, HEDIS
- Financial reports – TPL, benefit limits, spending by source and service, stop loss, physician incentive plan
- Clinical reports – newborns, well child visits, preventive exams, health screenings, ambulatory care, ER and inpatient utilization, follow up after hospitalization, inpatient readmissions

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

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

SECTION IV. IMPROVEMENT AND INTERVENTIONS

IMPROVEMENTS

OMPP’s strategic plan for 2017 builds upon the plans from 2015 and 2016. There is a continued focus on preventive health care for all programs as well as a HHW priority on healthy moms and healthy children to ensure that quality health care is provided to all Indiana Medicaid members. While each MCE has identified quality improvements for 2017, there are several initiatives in place that encompass all Medicaid programs. The interventions listed in Table 9 are at the forefront of planning and implementation of this Quality Strategy. On-going 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. The HHW, HIP, and HCC performance contracting is based on HEDIS results submitted by the contracted health plans to OMPP.

Table 10 displays all cross-cutting interventions for the managed care programs.

TABLE 10 Cross-Cutting Interventions for all Managed Care Programs		
Intervention	Process	Stakeholders
Outcome-Based Contracting	<ul style="list-style-type: none"> • Pay-for-Outcomes (P4O) • Maintain and improve current metrics with slight modifications • Require reporting that matches State’s goals • Monitor enrollment in the Right Choices program 	OMPP Contracted Health Plans
Prenatal/Postpartum Care Initiatives	<ul style="list-style-type: none"> • Monitor Presumptive Eligibility for Pregnant Women; further review of provider participation • Modify the Notification of Pregnancy at the provider level • Further refine smoking cessation initiatives for pregnant women • Monitoring women’s access to care 	OMPP Contracted Health Plans ISDH IPN Providers
Improve Healthcare for Indiana’s Children/EPSDT	<ul style="list-style-type: none"> • Increase % of children and adolescents receiving well-care • Develop protocol for provider adherence to in-depth physical and mental health screenings • On-going provider education, monitoring, and outreach • Monitor collaboration efforts between mental health services, PRTF and Money Follows the Person services • Develop a CDC/CMS data linkage 	OMPP Contracted Health Plans HP DMHA EPSDT
Behavioral Health	<ul style="list-style-type: none"> • Collaborative project focused on follow-up after mental health hospitalization 	OMPP DMHA Contracted Health Plans

<p>Improving Access to Prenatal Care & Case Management of High-Risk Pregnancies by improving the process for Presumptive Eligibility for Pregnant Women (PE) and Notification of Pregnancy (NOP) Programs.</p>	<ul style="list-style-type: none"> • Monitor the improvements in the PE and NOP process made in 2014. • Monitor with OMPP Data Management Analysis teams monthly and quarterly reports to assess the effectiveness of PE and NOP improvements. 	<p>OMPP IPN CKF Contracted Health Plans ISDH Providers</p>
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INTERMEDIATE SANCTIONS

For contract year 2015, Table 11 describes MCE performance results for HHW upon which payout percentages are based upon.

Table 11. “Pay –for-outcomes” Measures Overview

MCE HHW P40 Measures	Anthem			MHS			MDwise			Contract 2013 performance rates	Contract 2014 performance rates	Contract 2015 Performance rates
	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015
Utilization of Ambulatory Services in Outpatient Visits (HEDIS AMB)	297.14	276.78	269.32	285.51	274.97	264.80	266.21	264.75	200.69	318.74 362.60 412.43	318.74 362.60 412.43	≥25 TH percentile but < 50 TH percentile ≥50 TH percentile but <75 TH percentile ≥75 TH percentile
Utilization of Ambulatory Services in ED Visits (HEDIS AMB)	69.09	67.37	54.41	66.78	64.61	53.48	61.91	61.15	40.77	65.70 53.98 44.56	65.70 53.98 44.56	≤50 TH percentile but >25 TH percentile ≤25 TH percentile but >10 TH percentile < 10 TH percentile
Well Child Visits (0-15 months) HEDIS measure (HEDIS W15) using hybrid data.	66.38%	70.60%	73.15%	71.74%	71.63%	67.07%	71.05%	77.35%	77.13%	65.16% 70.90% 77.44%	65.16% 70.90% 77.44%	≥50 TH percentile but <75 TH percentile ≥75 TH percentile but <90 TH percentile > 90 TH percentile
Well Child Visits (3-6 years). HEDIS measure (HEDIS W34) using hybrid data.	70.43%	77.55%	72.69%	72.63%	74.04%	72.12%	76.89%	83.22%	84.58%	72.26% 78.51% 82.08%	72.26% 78.51% 82.08%	≥50 TH percentile but <75 TH percentile ≥75 TH percentile but <90 TH percentile > 90 TH percentile

Adolescent well child Visits (12-21 years). HEDIS measure (HEDIS AWC) using hybrid data.	60.93%	60.79%	58.88%	62.03%	61.30%	61.06%	58.88%	73.82%	72.87%	48.18% 57.40% 65.45%	48.18% 57.40% 65.45%	≥50 TH percentile but <75 TH percentile ≥75 TH percentile but <90 TH percentile > 90 TH percentile
Follow-up after Hospitalization for Mental Illness. HEDIS measure (HEDIS FUH) using administrative data.)	65.42%	68.36%	68.62%	63.09%	64.85%	69.47%	51.66%	60.45%	67.81%	44.65% 54.80% 68.79%	44.65% 54.80% 68.79%	≥50 TH percentile but <75 TH percentile ≥75 TH percentile but <90 TH percentile > 90 TH percentile
Post-Partum Visits. Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery (HEDIS measure using hybrid data.)	75.41%	74.13%	74.71%	70.95%	71.63%	72.56%	71.53%	74.21%	76.64%	N/A N/A 73.83%	N/A N/A 73.83%	≥90 TH percentile
Percentage of Smokers Advised to Quit (CAHPS survey)	74.91%	72.28%	70.52%	72.30%	72.00%	73.80%	72.80%	74.90%	71.60%	70.0% 73.0% 76.0%	70.0% 73.0% 76.0%	Program ended in 2015
Percentage of maternity discharge who made contact with the tobacco Quitline	N/A	N/A	1.0%	N/A	N/A	0.6%	N/A	N/A	0.5%	N/A	Started in 2015	0.5% 0.75% 1.0%

Frequency of ongoing Prenatal Care (HEDIS FPC 81+%Hybrid)	80.33%	79.95%	81.21%	81.37%	76.98%	78.60%	83.94%	78.88%	80.05%	$\geq 75^{\text{th}}$ percentile $\geq 90^{\text{th}}$ percentile	$\geq 75^{\text{th}}$ percentile $\geq 90^{\text{th}}$ percentile	$\geq 75^{\text{th}}$ percentile $\geq 90^{\text{th}}$ percentile
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For contract year 2016, Table 12 describes MCE performance results for HIP upon which payout percentages are based

MCE HIP P40 Measures	Anthem			MHS			MDwise			Contract 2013 performance rates	Contract 2014 performance rates	Contract 2015 performance rates
	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015
Rate of ER admission per 1,000 member months (HEDIS – AMBA measure for ED visits)	57.54	73.59	92.46	81.16	92.8	110.42	67.85	78.53	71.04	>=85 but <90 >=80 but <85 < 80	>=85 but <90 >=80 but <85 < 80	≥85 but <90 ≥80 but <85 < 80
Rate of Preventive Exam Visit in Measurement Year – Roll-over Measure	92.69%	91.17%	83.23%	91.14%	88.64%	80.84%	91.20%	88.30%	81.73%	>=70% but <75% >=75% but<80% >=80%	>=70% but <75% >=75% but<80% >=80%	≥25 th percentile but <50 th percentile ≥50 th percentile but < 75 th percentile ≥75 th percentile
Percentage of Smokers Advised to Quit (CAHPS Survey)	80.74%	77.72%	N/A	78.30%	80.70%	N/A	83.40%	83.60%	N/A	70% 73% 76%	70% 73% 76%	Program ended in 2015
Percent of maternity discharges who made connection with the quit line	N/A	N/A	1.0%	N/A	N/A	0.6%	N/A	N/A	0.5%	N/A	Program started in 2015	0.5% 0.75% 1.0%

HNS Completion	N/A	N/A	5%	N/A	N/A	32%	N/A	N/A	19%	N/A	Program started in 2015	≥70% but <73% ≥73% but <76% ≥76%
FUH 7- Day	N/A	44.24%	46.05	N/A	52.98%	43.33%	N/A	35.25%	38.91%	N/A	Program started in 2015	≥50 th percentile but <75 th percentile ≥75 th percentile but <90 th percentile ≥90 th percentile

For contract year 2016, Table 13 describes MCE performance results for HCC upon which payout percentages are based.

Table 13 “Pay for outcomes” Measures Overview				
MCE HCC P4O measures	Anthem	MHS	MDwise	Contract 2016 performance rates
	2015	2015	2015	
HNS completion	3%	46%	12%	≥70% but <73% ≥73% but < 76% ≥76%
CHAT completion	13.95%	41.56%	67%	≥73% but <76% ≥76% but <79% ≥79 %
FUH 30-day	67.84 %	55.03%	57.89%	≥74 % but <84.2% ≥84.2% but < 86.2% ≥86.2%
FUH 7-day with MRO	45.88%	40.74%	36.84%	≥67% but < 70.7% ≥70.7% but < 72.8% ≥72.8%
ER admissions per 1000 member months	115.68%	112.51	139.23	≥85 but < 90 ≥80 but < 85 < 80
Adult preventive care	96.43%	92.13%	N/A(Population too small to measure)	≥ 25 th percentile but <50 th percentile ≥50 th percentile but < 75 th percentile ≥75 th percentile

Indiana health plan contracts include provisions for failure to perform remedies. Non-compliance remedies include 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 health plans and holds them accountable for maintaining and improving Medicaid programs. The disposition of any corrective action depends upon the nature, severity and duration of a deficiency or non-compliance.

HEALTH INFORMATION TECHNOLOGY

OMPP requires all contracted health plans to operate and maintain an Information System (IS) sufficient to support the HHW, HIP and HCC program requirements. IS must be capable of collecting and transmitting required data and reports to the OMPP in the format specified by the OMPP. Data from the contracted health plans are used to complete monthly, quarterly, and annual reports to monitor and compare clinical outcomes against targets, standards and benchmarks as set forth by OMPP. The State staff directly manages all health plan report submissions. This direct management supports and deepens the OMPP's capacity to align and increase oversight processes across the health plans and the Medicaid programs. Through the course of this alignment, a full comparative review of the report submissions by the contracted health plans takes place to ensure that key performance indicators, both operational and clinical, are effectively being identified, collected, validated and analyzed. Reports are presented to the Quality Strategy Committee. The role of the Committee is to assist in the 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. For 2017 the MCE HHW, HIP and HCC reporting manuals have been tailored more precisely to reflect the priorities and focus of each program. This specificity enables a more thorough analysis of the population served and expectations set for the MCEs. While there are numerous commonalities for program comparisons, each program-specific reporting manual is geared toward that program's priorities. This will assist OMPP in receiving meaningful quality data.

SECTION VI. INITIATIVES AND CONCLUSIONS

THE OMPP INITIATIVES FOR 2017

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 in order 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 and encourages appropriate use of the emergency room.

Hoosier Care Connect

The primary aim of HCC in 2015 was to transition eligible members who are age 65 and over or with blindness or a disability to a coordinated care program where their multiple health needs may be coordinated. This program also includes current and former wards and foster children. In 2017 health needs screens and comprehensive health assessments will continue to be monitored and instrumental to identifying member needs, coordinating care and improving quality outcomes and consistency of care for these vulnerable members.

Right Choices Program

The primary aim of the Right Choices Program is to assist RBMC and FFS 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, one hospital for non-emergency visits and one pharmacy. This allows all care to be managed by the member's PMP to ensure the member is receiving appropriate care. The health plans evaluate members for potential enrollment in the program when members are identified as not utilizing health care services appropriately, i.e. multiple Emergency Room visits, pharmacy visits and physician visits that are not medically necessary. The program's design is to assist RCP enrollees by creating a medical home to support the member in obtaining the appropriate care at the right time in the right place.

Policy Governance

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

Monitoring and Reporting Quality

The OMPP Quality staff works collaboratively with the health plans to improve the oversight and reporting processes by ensuring that all contracted health plans are measuring, calculating and reporting in the same manner. Quality team staff reviewed the health plans' proposed 2016 QMIP Work Plans and QIPs. QMIP Work Plan progress is monitored during On-site Monitoring Visits.

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

Improving Birth Outcomes

In 2013 the Medicaid Medical Advisory Cabinet, the entity which provides medical expertise, data and analytic resources to OMPP, provided scholarly literature research on presumptive eligibility (PE) and notice of pregnancy (NOP) initiatives. In this endeavor, potential barriers were identified and modifications were made to PE and NOP in 2014. OMPP will continue to monitor the PE and NOP changes to validate improvement within the PE process and the program and data reporting.

In 2014, as part of OMPP's commitment to healthy babies and healthy moms, the HHW MCEs developed detailed marketing/strategy plans for approval by OMPP that targeted smoking cessation in pregnant women. These marketing/strategy plans were required to contain eight (8) components such as counseling, Indiana Tobacco Quitline, incentives, pharmacology, rural outreach and involvement, early identification and increased identification of pregnant members and data collection. In 2017 these efforts will be continued with the overall aim of healthy moms and healthy babies.

In 2017 OMPP will be monitoring services to pregnant HIP women and the subsequent birth outcomes using the same metrics as currently used in HHW. OMPP will use this baseline data to not only identify HIP quality initiatives in 2017 but also to deepen partnerships with other state agencies such as the Indiana State Department of Health's Maternal and Child Division to decrease infant mortality in the state of Indiana. This initiative continues to be an OMPP priority to improve health outcomes.



CONCLUSION

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

Collaboration among the health plans, state agencies, providers, advocacy groups and OMPP is representative of the State’s dedication to performance and quality. Throughout the process of developing and narrowing the focus for improvements in 2017 OMPP gathered input for this Quality Strategy from a variety of staff and stakeholders. Additionally, the Quality Strategy Committee and its sub-committees will drill down further to sculpt the focus of the strategic objectives described in this quality strategy to monitor outcomes and plan for future endeavors.

The State of Indiana 2017 Quality Strategy will be presented to the Quality Strategy Committee and will be made available through a public posting on the State website.

Appendix 1

Risk Based Managed Care Historical Timeline

- **1994** Began with PCCM delivery system
- **1996** Enrollment into MCE contracted health plans was optional
- **1998** Expanded to include CHIP Package A (Medicaid Expansion up to 150% FPL)
- **2000** Expanded to include CHIP Package C (Separate State-designed benefit package; to 200% FPL)
- **2005** Enrollment into MCE contracted health plans became mandatory statewide, PCCM discontinued
- **2007** New MCE contracted health plans contract cycle; Behavioral health “carved-into” MCE 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 health plans; 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 five thousand (5,000) individuals on waitlist invited to apply for the Healthy Indiana Plan
- **2009** Implementation of Open Enrollment (Plan Lock-in); Notification of Pregnancy (NOP); 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 (ABD) Medicaid enrollees. In response, FSSA convened the ABD Task Force (Task Force) comprised of staff from across key FSSA divisions.
- **2014** HIP-ESP is folded into the HIP program
- **2015** HIP 2.0 modified with Pharmacy, Dental and Vision services carve-in

- **2015** Hoosier Care Connect implemented on April 1st. Pharmacy, Dental and Vision services are carved-in
- **2015** Care Select program expired in August after complete integration of the Hoosier Care Connect program
- **2016** RFP completed for the HHW and HIP programs with contracts awarded to Anthem, MDwise, MHS, and CareSource
- **2016** Pharmacy and Dental services carved-in for HHW

Appendix 2

Hoosier Healthwise Historical Timeline

- **1994** Began with PCCM delivery system
- **1996** Enrollment into MCE contracted health plans was optional
- **1998** Expanded to include CHIP Package A (Medicaid Expansion up to 150% FPL)
- **2000** Expanded to include CHIP Package C (Separate State-designed benefit package; to 200% FPL)
- **2005** Enrollment into MCE contracted health plans became mandatory statewide, PCCM discontinued
- **2007** New MCE contracted health plans contract cycle; Behavioral health “carved-into” MCE plans capitation
- **2007** Expansion of pregnancy-related coverage (Package B) from 150 to 200 %FPL
- **2008** Expansion of CHIP Package C from 200 to 250 %FPL
- **2009** Implementation of Open Enrollment (Plan Lock-in); Notification of Pregnancy (NOP); 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
- **2016** Pharmacy and Dental services carved-in for HHW

Appendix 3

Healthy Indiana Plan & Enhanced Services Plan Historical Timeline

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

Appendix 4

Care Select Historical Timeline

- **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

Appendix 5

Hoosier Care Connect Historical Timeline

- **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 (ABD) Medicaid enrollees. In response, FSSA convened the ABD Task Force (Task Force) which was comprised of staff from across key FSSA divisions.
- **2015** Hoosier Care Connect implemented on April 1st. Pharmacy, Dental and Vision services carve-in.
- **2015** Complete integration of Hoosier Care Connect occurs

APPENDIX VI**Progress Update for the 2016 Hoosier Healthwise Initiatives**

1) Improvements in Children and Adolescents Well-Care – Percentage of members with well-child visits during the first 21 years of life. HEDIS measure using hybrid data
For the well-child visits birth to 15 months (W15), one of the plans exceeded the HEDIS 90th percentile; a second plan increased their score from 2014 and achieved above the 75th percentile, and the third scored above the 50th percentile.

For the well-child visits 3 to 6 years (W34), two of the plans achieved above the HEDIS 50th percentile while the third plan achieved above the 90th percentile.

For the well-child visits 12-21 years, one plan achieved above the HEDIS 50th percentile, a second achieved above the 75th percentile, and the third achieved above the 90th percentile.

2) Early Periodic Screening, Diagnosis and Treatment (EPSDT)

In Indiana, 82.4% of Medicaid recipients aged 20 years and under are enrolled in the HHW program. The overall rate of EPSDT screening for the HHW program is 77%. When this rate is compared to the statewide average of 69%, it is apparent that the state's fee for service population screening ratio is quite low, with markedly better results being achieved in the HHW managed care population. A breakdown of EPSDT results by age group in HHW reveals that the highest screening rates were achieved for those children 5 and below with 85 to 92% of this population receiving services.

3) Improvement in Behavioral Health – percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders using HEDIS hybrid data

All three MCEs scored above the HEDIS 90th percentile for this initiative illustrating their commitment to providing Medicaid members' with needed services.

4) Ambulatory Care – number of outpatient and emergency department visits per member months utilizing HEDIS

For the HEDIS AMB measure, none of the three plans achieved the set goals for outpatient visits per member months. However two of the plans achieved above the 50th percentile and one above the 75th percentile for decreasing the number of emergency department visits per member months.

5) Smoking Cessation – percentage of maternity discharges who are referred to the Indiana Tobacco Quitline and make at least one (1) contact with the Quitline

Two of the plans earned 50% of the total bonus monies possible while the third plan earned 75% of their bonus dollars.

6) Full term pregnancy – decrease the number of early elective deliveries

Since OMPP adopted a stringent policy in July of 2014 regarding prohibition of reimbursement for early elective deliveries, early elective deliveries have ceased for Indiana's Medicaid members.

7) Frequency of Prenatal and Post-Partum Care – HEDIS hybrid data is utilized to measure the frequency of prenatal and post-partum care for women

All three plans achieved above the 90th percentile for frequency of ongoing prenatal care. Two of the three plans achieved above the 90th percentile for the number of postpartum care visits.

8) Right Choice Program (RCP) – provide quality health care through health care management for those members who require assistance with obtaining healthcare services in an appropriate manner

Nearly 96% of all the reviews completed on behalf of those RCP members were completed in a timely manner.

Progress Update for the 2016 Healthy Indiana Plan Initiatives

1) Access to Care - HIP members shall have access to primary care within a maximum of 30 miles of the member's residence and at least two providers of each specialty type within 60 miles of member's residence

For 2016, 100% of Indiana's HIP members had access to primary care within a maximum of 30 miles per quarterly geographical access reporting provided by all three MCEs to OMPP. One of the focus studies completed in the 2016 External Quality Review, for the calendar year 2015, involved an in depth review of geographical access to primary care for all Indiana Medicaid members by MCE and region.

2) Access to Care - HIP members shall have access to vision care within a maximum of 60 miles of the member's residence and at least two providers of each specialty type within 60 miles of the member's residence

For 2016, 100% of Indiana's HIP members had access to primary care within a maximum of 60 miles per quarterly geographical access reporting provided by all three MCEs to OMPP. One of the focus studies completed in the 2016 External Quality Review, for the calendar year 2015, involved an in depth review of geographical access to dental and vision care for all Indiana Medicaid members by MCE and region.

3) POWER Account Roll-Over - HIP members who obtain a preventive exam during the measurement year receive power account roll-over.

For 2016, all of the plans reported a rate of preventive examinations for HIP members between 39-45%. HIP Plus members had a higher rate of receipt of preventive care as opposed to HIP Basic members. Indiana's HIP program experienced a dramatic increase in member enrollment beginning in February of 2015. The massive influx of membership into the HIP program caused preventive care outcomes to decrease. These rates did increase over the course of 2016 and OMPP continues to work closely with the MCEs to develop strategies to increase the percentage of members receiving preventive care to allow for power account roll-over.

4) ER Admission per 1000 member months – HIP members should achieve at or below 75 ER visits per 1000 member months.

Utilizing HEDIS 2016 scores, for measurement year 2015, one MCE achieved this goal with a rate of 71.04. The other two MCEs achieved higher rates. OMPP spent considerable efforts in 2016 evaluating the MCEs' ER practices and development of strategies to decrease the rates. OMPP analyzed quarterly HIP reporting submitted by the MCEs including the ER admission rates and feedback was provided verbally and via dashboard reviews. OMPP will continue these monitoring efforts in 2017.

5) Improvement in Behavioral Health - Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders.

Two of the three MCEs achieved the 2015 OMPP pay-for-outcome metrics set for the HEDIS 7-day FUH by increasing the percentage of their members who received these visits. Each plan's rate increased over the year during 2016. OMPP analyzed quarterly HIP reporting submitted by the MCEs that documented each plan's rate of follow-up within 7 days of discharge from hospitalization for members with mental health disorders, and feedback was provided verbally and via dashboard reviews. OMPP will continue these monitoring efforts in 2017.

6) Ambulatory Care – Number of outpatient visits per member months.

The three MCEs continue to attempt to increase the percentage of HIP members who receive an outpatient visit. The range of HEDIS percentiles achieved by the plans range from 10th percentile to the 50th percentile. Reporting submitted by the MCEs to OMPP during 2016 showed that all the MCEs reported much higher rates of outpatient visits per member months for those members enrolled in HIP Plus versus those enrolled in either the HIP State Plan or HIP Basic. The rates between those enrolled in HIP Plus and HIP State Plan were not only higher but were similar as expected with HIP Basic members receiving one half to one third fewer outpatient visits per member months. The HIP Plus and HIP State Plan rates increased over the course of 2016. OMPP provides feedback to the plans regarding their ambulatory care rates via verbal feedback as well as dashboard reviews. OMPP will continue to monitor the MCE results for this metric in 2017.

7) Pregnant Women Smoking Cessation – Increase the referral of pregnant women who smoke to the Indiana Tobacco Quitline for smoking cessation services.

All three MCEs increased their referrals of pregnant members to the Quitline for 2016 and received from 50-100% of their pay-for-outcome incentives from OMPP.

8) Right Choices Program (RCP) – To provide quality health care through health care management OMPP requires each plan's RCP administrators to conduct utilization reviews, create a care coordination team and collaborate with each RCP member to ensure that the member receives appropriate, medically necessary care.

For 2016, over 97% of all RCP periodic reviews on members were conducted within the required time frames.

9) Medically Frail - Provide quality health care to members identified as medically frail.

Of the 24,394 medically frail members served in HIP during 2016, **95.56%** of them received at least one preventive service.

Progress Update for the 2016 Traditional Medicaid Initiatives

- 1) Preventive Care (HEDIS AAP-like)** – The traditional Medicaid members experienced a de minimis reduction in the receipt of preventive care for 2016 with a rate of 83.5% achieved.

- 2) Ambulatory Care** – Traditional Medicaid members experienced an increase in the utilization of emergency department visits to 89.35 visits per thousand member months. However this population experienced a dramatic increase in outpatient services per thousand member months increasing from 286.42 in 2015 to 507.92 in 2016.

- 3) Improvement in Behavioral Health** – The percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders increased from 53.5% in 2015 to 56.8% in 2016.

Progress Update for the 2016 Hoosier Care Connect Plan Initiatives

1) Preventative Care (HEDIS APP-like) - Indicate the percentage of Hoosier Care Connect members who had a preventative or ambulatory visit ages 20 years and older.

Due to the HCC program's start date of April 1, 2015, there are only 9 months of data is available. The HCC population for one of the plans was not measureable for HEDIS purposes. The other two plans scores range from 92% to 96%.

2) Outpatient Ambulatory Visits (HEDIS AMB-like for outpatient) - Identify the occurrence of **Hoosier Care Connect** outpatient visits per 1,000 member months for those members ages 20 years and older.

The 2016 HEDIS results based on the 2015 measurement year show the plans achieved a rate of 403 to 525 per thousand member months. OMPP administrative reporting for 2016 showed all of the plans increasing in their rate for AMB, ranging from 468 to 538.8 per thousand member months. OMPP will continue to monitor the plans efforts in 2017.

3) Completion of Health Screenings for New Members - The percentage of newly enrolled MCE members, net of terminated members, that have had a health screening assessment completed within 90 days.

For 2015 the plans did not meet the required goal of 73% completion. For 2016 each plan showed increases in the rates from the prior year. The plans' performances did however increase over the course of 2016. OMPP will continue to monitor their efforts on HNS completion.

4) Completion of Comprehensive Health Assessment Tool - The percentage of enrolled MCE members who were stratified into complex case management or the Right Choices Program, net of terminated members, who have had a comprehensive health risk assessment completed within 150 days.

In 2015 the plans baselined their completion rates for the CHAT. All plans showed an increase over the course of 2016 with all three plans achieving a rate of above 70%. OMPP will continue to monitor the plans' efforts to increase their completion rates for the CHAT in 2017.