Office of Medicaid Policy & Planning

Indiana Medicaid Managed Care Quality Strategy Plan 2020

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION

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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), 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 FSSA's Data and Analytics unit, the Medicaid enrollment in December of 2019 was 1,429,443 of which 1,109,932 were in managed care. Thus, Medicaid provides vital health care to approximately one in six Hoosiers. In 2020, 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 FSSA Office of Medicaid Policy and Planning's (OMPP) Quality and Outcomes Section is charged with oversight of the Managed Care Entities through reporting, contract compliance and quality initiatives specific to the 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 and 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 78% of the delivery of health care in 2020 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 IHCP's Risk-Based Managed Care Programs

Collectively, Hoosier Healthwise, Hoosier Care Connect, and the Healthy Indiana Plan 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 *Prime*Step. Two years later, the State added a risk-based managed care (RBMC) delivery system made up of MCE contracted health plans, which are Health Maintenance Organizations (HMOs), authorized by the Indiana Department of Insurance, and contracted with OMPP. The historical timeline may be found in Appendix 2.

HHW provides health care coverage for low income families, some 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. Based

on a February 1, 2018 waiver approval all newly pregnant women at or above 138% of the federal poverty level (FPL) are served in the Healthy Indiana Plan (HIP). Pregnant members with incomes above 138% of the FPL continue to be served in Hoosier Healthwise.

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 2020

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 2020 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 2020 Quality Strategy.

TABLE 1	2020 Hoosier Healthwise Initiatives	
OBJECTIVE	METHODOLOGY	GOAL
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.	OMPP utilizes HEDIS measures for tracking the percentages of well-child services in children and adolescents.	Achieve at or above the 90th percentile for improvements in children and adolescent well-child (HEDIS).
2. Early Periodic Screening, Diagnosis and Treatment (EPSDT)	OMPP utilizes HEDIS measures for tracking the percentages. 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.	OMPP monitors EPSDT compliance through MCE reporting of HEDIS prevention and screening, access/availability of care and utilization measures specific to children and adolescents. OMPP verifies compliance through the inclusion of several of these HEDIS measures as part of our HHW pay for outcomes program including well child visits (W15, W34, and AWC), annual dental visits (ADV) and lead screening for children (LSC).
3. Improvement in Behavioral Health (HEDIS) Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders	OMPP uses HEDIS measures for tracking the percentages of members receiving follow-up.	Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).

TABLE 1	2020 Hoosier Healthwise Initiatives	
OBJECTIVE	METHODOLOGY	GOAL
4. Ambulatory Care (HEDIS) Number emergency department visits per member months	OMPP is using HEDIS AMB to track the utilization of ambulatory outpatient and emergency department visits to promote best practices in Utilization Management.	Achieve at or below the 10th percentile of Ambulatory Emergency Department Care Visits (HEDIS).
5. Annual Dental Visit	OMPP is using HEDIS for tracking the percentage of members, aged 2-20 years, who had at least one dental visit during the measurement year.	Achieve at or above the 75th percentile for member dental visits during the measurement year.
6. Lead Screening in Children	OMPP is using HEDIS for tracking the percentage of children 2 years of age who had one or more capillary or venous blood lead tests for lead poisoning by their second birthday.	Achieve at or above the 75th percentile for lead screening in children.
7. Medication Management for People with Asthma	OMPP is using HEDIS for tracking the percentage of members, aged 5-11 years, who remained on an asthma controller medication for at least 75% of their treatment period.	Achieve at or above the 90th percentile for medication management for people with asthma.

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 hospital services, mental health care, physician services, prescriptions and diagnostic exams.

The Healthy Indiana Plan - Enhanced Services Plan (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.

As of 2015, these high risk individuals, previously enrolled in HIP-ESP, 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 records and claims, pharmacy claims, and the Social Security Administration disability determination. The medically frail status is confirmed by utilizing the Milliman Underwriting Guidelines (MUG). Once the member has been found to be medically frail, this determination is reviewed annually. A detailed comprehensive health assessment is then completed and utilized to identify a member's individualized needs and ultimately allow for stratification into the appropriate level of care coordination whether it be disease management, care management, or complex case management.

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

OMPP gathered data in 2015 regarding the members identified as medically frail and established a baseline to determine if they are receiving necessary health care and to determine if there are access to care issues. OMPP

received CMS approval for HIP 2.0 on January 27, 2015 and began accepting applications for the program. Services began just days later, as the enhanced HIP 2.0 program launched on February 1, 2015. In addition to processing new program applications, the launch of HIP 2.0 included the conversion of members previously enrolled in the original HIP program as well as all non-pregnant adults enrolled in Hoosier Healthwise, Indiana's traditional Medicaid managed care program. Over 222,000 individuals were enrolled in HIP 2.0 by the end of the first quarter of operations, and to date HIP has continued to meet its enrollment goals with 420,075 individuals fully enrolled in HIP as of December 31, 2019. All pregnant women with incomes at 130% of the Federal Poverty Line (FPL) and below were moved into the HIP program beginning in February of 2018 and are included in the enrollment numbers.

In 2020, HIP continues to emphasize personal responsibility and preventive health services. CMS approved Indiana's request for a HIP waiver and effective 2/1/2018, outcomes-based incentives to members became aligned with specific health challenges faced by HIP members in relationship to tobacco cessation, substance use disorder treatment, chronic disease management and employment. The historical timeline may be found in Appendix 3.

HIP Strategic Objectives for Quality Improvement 2020

Table 2 demonstrates the objectives specific to OMPP's Healthy Indiana Plan. Some of these objectives have been monitored and maintained from previous years while other measures are new for the 2020 quality strategy.

TABLE 2	2020 Healthy Indiana Plan Initiatives	
OBJECTIVE	METHODOLOGY	GOAL
1. Access to Care HIP members shall have access to primary care within a maximum of 30 miles of the member's residence and at least two providers of each specialty type within 60 miles of member's residence.	The MCE must ensure that each member has an ongoing source of primary care appropriate to the member's needs. Data is collected through administrative data.	90% of all HIP members shall have access to primary care within a minimum of 30 miles of member's residence and at least two providers of each specialty type within 60 miles of member's residence.
2. Access to Care HIP members shall have access to dental care within a maximum of 30 miles of the member's residence and vision care within a maximum of 60 miles of the member's residence.	The MCE must ensure that each member has an ongoing source of dental and vision care appropriate to the member's needs. Data is collected through administrative data.	90% of all HIP members shall have access to dental care within a maximum of 30 miles of the member's residence and vision care within a maximum of 60 miles of member's residence.
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.	OMPP will track the number of HIP members who receive a qualifying preventive exam.	Achieve rate at or above the 75th percentile of NCQA 2020 Quality Compass of members who received a preventative exam.

TABLE 2	2020 Healthy Indiana Plan Initiatives	
OBJECTIVE	METHODOLOGY	GOAL
4. ER Admissions per 1000 member months (HEDIS)	OMPP is using HEDIS AMB measures for tracking ER admissions per 1000 member months.	Achieve at or below 80 visits per 1000 member months.
5. Improvement in Behavioral Health (HEDIS) Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders	OMPP is using HEDIS measures for tracking the percentages of members receiving follow-up.	Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders.
6. Timeliness of Ongoing Prenatal Care (HEDIS)	OMPP is using HEDIS for tracking the percentage of women receiving timeliness of ongoing prenatal care.	Achieve at or above the 50th percentile for the timeliness of prenatal.
7. Frequency of Post-partum Care (HEDIS)	OMPP is using HEDIS for tracking the percentage of women who receive required post-partum visits.	Achieve at or above the 75th percentile for required post-partum visits.
8. Pregnant Women Smoking Cessation Increase the referral of pregnant women who smoke to the Indiana Tobacco Quitline for smoking cessation services.	Monthly Indiana Tobacco Quitline reports.	Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.
9. Completion of Health Needs Screen	Administrative reporting.	Achieve at or above the 60% for all new members completing the health needs screening within ninety (90) days of enrollment.
10. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 7 day (FUA)	HEDIS measure (HEDIS FUA) using administrative data	Achieve at or above the 75th percentile for NCQA 2021 Quality Compass.
11. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 30 day (FUA)	HEDIS measure (HEDIS FUA) using administrative data	Achieve at or above the 75th percentile for NCQA 2021 Quality Compass.

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. Some members are being served through other programs such as Medicare or special aid categories such as the breast and cervical cancer programs. Traditional Medicaid members do not receive managed care services as the traditional Medicaid model utilizes a fee-for-service arrangement in which physicians, hospitals, and other providers contract directly with the State for services they provide.

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

- Dually enrolled receiving Medicare and Medicaid benefits
- 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 2020

In 2020, OMPP will continue efforts to involve the traditional Medicaid population into the overall quality improvement efforts. OMPP develop outreach materials on the importance of breast cancer screenings and follow-up after emergency department visits for alcohol and other drug abuse or dependence. These will be provided to FSSA's Bureau of Developmental Disabilities Services for distribution to waiver providers and independent case managers serving Home and Community Based Services Waiver populations. OMPP anticipates that these educational materials will result in an increase of these services to Medicaid members.

Table 3 demonstrates the objectives specific to OMPP's Traditional Medicaid initiatives.

TABLE 3	2020 Traditional Medicaid Initiatives		
OBJECTIVE	METHODOLOGY	2019 Baseline	Goal
1.Breast Cancer Screening (HEDIS BCS) Percentage of women who had a mammogram to screen for breast cancer.	Administrative reporting through Enterprise Data Warehouse (EDW) using HEDIS specifications.	30.53%	Increase the 2019 baseline rate by 5%.
2.Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (HEDIS FUA 7-Day)	Administrative reporting through Enterprise Data Warehouse (EDW) using HEDIS specifications.	7.58%	Increase the 2019 baseline rate by 5%.

Hoosier Care Connect (HCC)

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 Taskforce (Taskforce) comprised of staff from across key FSSA divisions and community stakeholders who worked in 2013 and 2014 to design the Hoosier Care Connect 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 2020

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 2020 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 2020 objectives specific to the HCC program.

TABLE 4	2020 Hoosier Care Connect Initiatives	
MEASURE	METHODOLOGY	GOAL
1. Preventive Care (HEDIS)	OMPP is using HEDIS measures for tracking preventive care.	Achieve at or above the 75th percentile for members nineteen (19) years and older who had a preventive care visit.
2. ER Admission per 1000 Member Months (HEDIS)	OMPP is using HEDIS measures for tracking ER admissions per 1000 member months.	Achieve at or below 80 visits per 1000 member months.
3. Completion of Health Needs Screen (≥60%)	Administrative reporting	Achieve completion of a Health Needs Screen for ≥ 60% of all members during the first ninety (90) days of enrollment.
4. Completion of Comprehensive Health Assessment Tool	Administrative reporting	Achieve completion of a comprehensive health assessment for ≥79% of all members during the first one hundred and fifty (150) days of enrollment.
5. Improvement in Behavioral Health (HEDIS) Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders – with MRO	HEDIS-like measure based on specifications developed by OMPP, including Medication Rehabilitation Option HCPCS codes.	Achieve at or above 75th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders - with Medicaid rehabilitation option (MRO) services.
6. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 7 days(FUA)	HEDIS measure (HEDIS FUA) using administrative data	Achieve at or above 75th percentile for members 13 years of age and older who receive follow-up within 7 days of the ED visit of alcohol and other drug abuse.
7. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 30 days (FUA)	HEDIS measure (HEDIS FUA) using administrative data	Achieve at or above 75th percentile for members 13 years of age and older who receive follow-up within 30 days of the ED visit of alcohol and other drug abuse.

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. For 2020, OMPP has added the HEDIS Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA), 7-day and 30-day measures, to our pay for outcomes measures as part of the effort to focus on providing services to those members with alcohol dependency or substance use disorder. The Indiana Medicaid Managed Care programs are reviewed through a variety of forums. Input from those forums is 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 2020.

OMPP holds Quality Strategy meetings quarterly with these representatives to discuss the 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 the development and monitoring of identified goals and strategic objectives of the written Quality Strategy and to advise and make recommendations to OMPP. The Program Evaluations Unit reports to the OMPP Program Evaluation Manager who reports directly to the OMPP Quality and Outcomes Director. The OMPP Quality and Outcomes Director reports directly to the OMPP Deputy Medicaid Director. The OMPP Quality Director is the sponsor of the Quality Strategy Committee. Currently, the members of the Quality Strategy Committee include representatives from:

- Office of Medicaid Policy and Planning (OMPP)
- Division of Mental Health and Addiction (DMHA)
- Indiana State Department of Health (ISDH)
- Providers (pediatrician, adult health, behavioral health)
- Health Plan Quality Managers
- Advocacy groups
- Consumers
- Providers
- Academia

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 2020.

TABLE 5	Annual Schedule of the Quality Strategy Committee and Subcommittees		
Meeting	Description	Frequency	2020 Dates
Quality Strategy	Oversight of other focus groups, including neonatal and health services utilization issues and providing input for overarching Quality Strategy.	Quarterly, 1-3 pm	6/15, 9/22, and 12/9
Dental Advisory Panel	Focus: Improve oral health. Provide input on dental policy and provide clinical recommendations to improve oral health and overall health of members.	Biannually, 10:30-12:30 and 1:00-3:30 pm	6/18 and 12/8

In 2019, the Quality Strategy Committee, and Health Services Utilization Subcommittee and Neonatal Subcommittees were combined into a single quarterly meeting. Presentations were provided on OMPP's SUD Waiver, ISDH's vaping initiative, ASPIN's services including health insurance navigation, MCE specific tobacco cessation programs, ISDH's OB Navigator initiative, and the Indiana Perinatal Quality Improvement Collaborative (IPQIC). In-depth discussions were held specific to the MCEs' 2019 Quality Management and Improvement Work Plans and OMPP required Quality Improvement Projects (QIPs) for HNS completion and care coordination for members who have experienced an emergency department visit for alcohol and other drug abuse dependence. The Indiana Perinatal Quality Improvement Collaborative (IPQIC). Quality dashboards specific to MCE reporting were provided and also discussed during these meetings. 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 raising 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 (EQR) 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 2019 External Quality Review for the 2018 calendar year focused on themes across multiple facets. Focus studies for the 2019 EQR were:
- Validation of performance Measures
- Validation of Performance Improvement Projects
- Validation of Provider Directories;
- Focus Study on Potentially Preventable Emergency Department Visits
- Focus Stud on Preventive Care for Adults and Well Visits for Children
- Focus Study on Delivery of Prenatal Care Services
- Focus Study on Health Needs Screening Tool

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 Measure

The MCEs monitor, evaluate and take 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 Manual provide guidance from OMPP on required performance reporting for the health plans contracted to deliver services for HHW, HIP and HCC. The MCE Reporting Manual is 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 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. Quality and Outcomes conducts quarterly Reporting Meetings to discuss the MCEs' data submissions. Representatives from OMPP pharmacy, program integrity, HCC, HHW, contract compliance, and the HIP unit meet to discuss the various reports submitted, analyze the data, identify discrepancies, and develop feedback for the MCEs. Anomalies that are identified may also be targeted for discussion at the Quality Strategy 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. In 2019 the HHW, HIP, and HCC reporting manuals experienced a major overhaul with the implementation of streamlined the reporting processes and increased consistency in reporting for both the MCEs and OMPP. All reports were reviewed to determine whether they were needed for all programs, required alignment in terms of reporting periods and submission and, if reports should be deleted, revised or created to capture more meaningful data.

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.

OMPP developed a Quality and Outcomes portal to provide a high level description of key quality improvement processes and links to various resources to help interested parties see how Indiana's Medicaid program is performing. Monthly and quarterly reports from the MCEs are aggregated and synthesized on this site via a stoplight system to make performance easier to gage. This portal can be accessed at:
https://www.in.gov/fssa/ompp/5533.htm.

External Quality Review (EQR)

OMPP contracts with Burns & Associates, Inc. (B&A) to conduct the required External Quality Reviews (EQR) for HHW, HCC, HIP and the Indiana's Children's Health Insurance Program (CHIP). The HHW, HCC 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 2017 the EQR was expanded to include the new HCC program. In 2019, the EQR addressed HHW, HIP, HCC and CHIP performance of 2018.

In Calendar Year (CY) 2019 B&A met with OMPP and agreed to conduct the following for CY 2018 experience:

- Validation of performance Measures
- Validation of Performance Improvement Projects
- Validation of Provider Directories;
- Focus Study on Potentially Preventable Emergency Department Visits
- Focus Study on Preventive Care for Adults and Well Visits for Children
- Focus Study on Delivery of Prenatal Care Services
- Focus Study on Health Needs Screening Tool

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. For example in 2016, for HCC and the dental carve-in, the MCEs made significant progress in regards to network adequacy and some were allowed to close their networks after providing documentation to OMPP Quality and Outcomes that network adequacy requirements had been met.

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

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 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 contractually required mileage standards. 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

Payment of out-of-network providers for coordination varies by program. In 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 Health Coverage Programs (IHCP) amount equal to 98% of the Medicaid fee-for-service (FFS) reimbursement rates that exist for participating IHCP providers at the time the service was rendered.

Health plans contracted to administer HIP 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.

Hoosier Care Connect health plans must reimburse any out-of-network provider's claim for authorized services provided to HCC members at a rate it negotiates with the out-of-network provider, or in the absence of a negotiated rate, an amount equal to 98% of the Medicaid fee-for-service rate.

Provider Credentialing

Providers must first be enrolled as an IHCP provider prior to initiating credentialing with an MCE ([42 CFR 455](#)). 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.

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

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, including: [42 CFR 438. (3)(i)](#); [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(b).

Cultural Competency

Data on race and ethnicity 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 requires each of the contracted health plans to submit network access reports. In 2019 OMPP revised and substantially enhanced the network access reporting by aligning the requirements to ensure consistency by all MCEs in reporting the number of providers and member access. The newly designed reporting requires each MCE to provide the unique count of providers under contract by provider specialty and county location. The reports now require the MCEs to utilize the IHCP Provider Type and Specialty that is assigned to the provider. For those specialties without a pre-defined IHCP Provider Type or Specialty, the MCEs are required to use the nationally-recognized taxonomy code for the provider in assigning them to a specialty category. Each provider is to be counted once based on the county in which the rendering provider is located. The unique providers by county are then compared to the MCE's capitation payment file containing the total members enrolled with then in each line of business in the month of September. Enrollees are then segmented into one of the state's 92 counties. Each member is then tested to determine the distance that the member would need to travel to seek the services of each provider category listed on the report. OMPP believes that this enhanced reporting will provide a more accurate accounting of member access to the services they need. The MCEs will submit network access reports on an annual basis in October of each year and at any time there is a significant change to the provider network for 2020. 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.

In 2017 OMPP contracted with the Bowen Center for Health Workforce Research and Policy to perform a robust evaluation of Indiana's capacity to provide health services for all Medicaid members. The report evaluated the capacity of the workforce of primary care physicians, dentists, and psychiatrists who are actively providing care to Medicaid enrollees. It identified gaps between enrolled providers and those actively providing services in an effort to inform targeted provider activation and provider enrollment strategies with the goal of ultimately increasing access to health care services for Medicaid members,

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

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, 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 size when assessing the PMP's capacity to serve the health plan's Medicaid members. DXC, OMPP's fiscal agent, maintains a separate panel for those PMPs contracted with more than one health plan. The OMPP Quality and Outcomes utilizes data from the MCEs and DXC and 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 provides "live voice" coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The 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* ➤ Cardiologists* ➤ Cardiothoracic surgeons** ➤ Oral Surgeons ** ➤ Dermatologists** ➤ Endocrinologists* ➤ Gastroenterologists* ➤ General surgeons* ➤ Hematologists ➤ Infectious disease specialists** ➤ Interventional radiologists** ➤ Nephrologists* ➤ Neurologists* ➤ Neurosurgeons** ➤ Non-hospital based anesthesiologist (e.g., pain medicine)** ➤ OB/GYNs*	➤ Diagnostic testing* ➤ Durable Medical Equipment providers ➤ Home Health ➤ Prosthetic suppliers**

Table 6	Network Provider Specialties	
Specialties	Ancillary Providers	
➢ Occupational therapists* ➢ Oncologists* ➢ Ophthalmologists* ➢ Optometrists* ➢ Orthopedic surgeons* ➢ Orthopedists ➢ Otolaryngologists ➢ 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.

Physician Faculty Access to Care (PFAC)

For 2020 OMPP's PFAC reimbursement is intended to generally mirror the fee-for-service required payment arrangement for Medical School Faculty under the state plan. Eligible medical school physicians and practitioners are paid an enhanced rate for utilization and delivery of services to Medicaid members for the purpose of increasing the overall access to services by ensuring Medicaid members have access to care via physicians in academic medical centers. It is anticipated that this payment arrangement will enhance the quality strategy goals previously stated for Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect including increasing adult and child preventive care HEDIS measures to the 50th percentile, reducing emergency department use to below 80 visits per 1,000 members, and increase the timeliness of prenatal care PPC-AD Core Measure to 60% for pregnant women. The enhanced payment differential may be reduced, based on performance metrics listed in

the state plan. OMPP will tie its provider performance under this payment arrangement to the following measures: percent of patients seen in clinics in less than 7 days; median lag times for clinic visits for all specialties; median time for patients to see a provider within the ER; and percentage of patients who report they would recommend hospital or clinic. The performance targets were developed following a review of baseline historical data and national benchmarks. The state intends to re-evaluate performance targets annually during the duration of this arrangement.

TABLE 4	Additional 2020 Physician Faculty Access to Care Measures	
MEASURE	METHODOLOGY	GOAL
1. Percent of Patients seen in clinics within 7 days of requesting appointment.	Administrative reporting	More than 35% of patients are seen in clinics in fewer than 7 days from the time the patient requests the appointment.
2. Median lag time for clinic visits for all specialties.	Administrative reporting	More than 55% of all new patients are seen within 3 weeks for specialty care visits.
3. Median time for patients to see a provider within the emergency department.	Administrative reporting	Emergency department wait times are under 40 minutes
4. Percentage of patients who report they would recommend hospital or clinic.	Administrative reporting	More than 70% of patients would recommend the hospital or clinic

Institutions for Mental Disease

In 2016, OMPP, in accordance with 42 CFR 438.3(e)(2), began to reimburse the MCEs for services provided to Members ages 19 to 64 years who experienced short-term stays of no more than 15 days in a calendar month in facilities designated as Institutions for Mental Disease (IMD) facilities. Member access to mental health and substance use disorder services was therefore expanded by OMPP's formal designation of twelve facilities as IMDs.

In December, 2019, the Indiana Family and Social Services Administration received federal approval from the Centers for Medicare and Medicaid Services of a Medicaid waiver, to take effect on January 1, 2020, that gives Indiana Medicaid the authority to pay for acute inpatient stays in institutions for mental disease for individuals diagnosed with a serious mental illness (SMI). Until now, Medicaid law prevented funding from being used for inpatient SMI treatment at any hospital, nursing facility or other institution with more than 16 beds. Through this new waiver, Indiana will be able to cover acute inpatient stays in IMDs for individuals whose primary diagnosis is a serious mental illness. Because approximately 25% of individuals with a serious mental illness also have a substance use disorder, this waiver will allow for consistency in their treatment. According to Indiana Medicaid records, in state fiscal year 2019, only about half of Indiana's traditional Medicaid members receiving inpatient psychiatric services accessed those services through an institution for mental disease. Approval of the waiver amendment will mitigate these barriers to access and will shift services from less appropriate settings to facilities like hospitals and larger mental health treatment facilities. Under this new waiver, many patients will be able to receive longer, more appropriate inpatient stays, aiding in achieving stabilization and more successful transitions back into their homes and communities. The change is expected to ultimately drive down the costs associated with overuse of the emergency department for mental health problems and psychiatric crises as well as other costs caused by lack of access to appropriate care settings.

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 of Benefits and Continuity of Care

If a member is also enrolled in or covered by another insurer, the MCE is responsible for coordinating benefits to maximize the utilization of third party coverage. The 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 coordinates benefits and payments with the other insurer for services authorized by the MCE that were provided outside the MCE's plan. Such authorization may occur prior to provision of service, but any authorization requirements imposed on the member or provider of service by the contracted 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 – Package A

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 required to coordinate benefits and must report the member's coverage to the State. OMPP requires each MCE to assist the State in its efforts to terminate the member from HIP due to the existence of other health insurance.

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

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

Each 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:

- Include activities above and beyond traditional utilization management activities, such as prior authorization
- Integrate with other functional units as appropriate and support the Quality Management and Improvement Program
- Have policies, procedures and systems in place to assist utilization management staff to identify instances of over- and under-utilization of emergency room services and other health care services;
- Have policies, procedures and systems in place to identify aberrant provider practice patterns related to emergency room, inpatient services, transportation, drug utilization, preventive care and screening exams
- Utilize policies, procedures and systems in place to ensure positive outcomes including active participation of a utilization review committee; evaluation of efficiency and appropriateness of service delivery; and incorporation subcontractor's performance data and facilitate program management and long-term quality and identify critical quality of care issues
- Connect members to disease management, care management and complex case management
- Encourage health literacy and informed, responsible medical decision making. For example, the 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. Beginning in 2017 pharmacy services for HHW members were carved in to 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 screen as well as their own comprehensive health assessments. OMPP also receives quarterly reporting on how members are stratified, upon completion of assessment(s), into the appropriate level of care coordination including disease management, care management and complex case management. 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.

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 identification number and the applicable phone numbers for member assistance.

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

Primary Medical Provider (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 Screen

Since February 2011, each MCE has been required to conduct a health needs screen for new members. The health needs screen 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 screen may be conducted in person, by phone, online or by mail. For 2020 some MCEs will be utilizing kiosks located in retail businesses as well for members to be able to complete their health needs screen. Members who utilize these kiosks will receive a financial incentive upon completion of the screen which can then be utilized immediately in that specific retail business. The health plans use an OMPP-approved standard health screening tool. The Health Needs Screen (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 and HIP members, a completed Notification of Pregnancy (NOP) form fulfills the health needs screen requirement.

OMPP completed a revision of the required Health Needs Screen (HNS) for 2020. During early 2019 the OMPP Quality team completed an in depth review on screening tools being utilized by twenty-five other state Medicaid agencies. Based on this review a decision was made to reduce the content of the Indiana HNS from 63 questions to 13 questions with the goals of increased member engagement, earlier completion of the necessary comprehensive health assessments, and increased numbers of members receiving care coordination services. These thirteen questions focus on initial identification of member physical and behavioral health conditions, use of any medications, pregnancy status, smoking and vaping, and lead testing. One question focuses on the member's possible need in regards to various social determinants of healthy including housing, food insecurity, safety and transportation. The MCEs provided OMPP with their specific mapping to each of the thirteen questions

including timeframes for the completion of referrals and assessments, assignment of risk scores and placement into care coordination. OMPP will conduct routine reviews during 2020 to verify that each MCE is completing this revised HNS and following their processes for all newly assigned members.

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 screen. 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 care coordination programs, ranging disease management involving member education and awareness efforts to care management or complex case management.

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

The initial health screen is followed by a detailed comprehensive health assessment tool (CHAT) 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 screen, 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 develop 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 Division of the Indiana State Department of Health 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) screen health domains based on the National Committee on Quality Assurance study design. The scoring for the LWIM screen identifies a child as potentially having a special health care need if the screening identifies needs in one or more of seven (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 438.56(2) 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 FSSA Division of Family Resources (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) is compliance with the HIPAA Transaction and Code Set requirements for electronic health information data exchange, National Provider Identifier requirements and Privacy and Security Rule standards. The MCEs' electronic mail encryption software for HIPAA security purposes must be as stringent as the State's security level. The MCEs' 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.

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 2020 OMPP Quality and Outcomes Quality Measures which apply to the HHW, HIP and HCC programs. These Pay for Outcomes (P4O) goals are listed by managed care program. OMPP continues a commitment to quality improvement and closely monitors the health care program goals working closely with the contracted health plans to ensure quality improvement.

Table 7		2020 P4O Goals by Program	
Program	HEDIS Code	State Reports	Description
Hoosier Healthwise P4O Goals			
	AMB	No report	Ambulatory Care- ED visits
	W15	Report 0401	Well-Child Annual in the First 15 Months - Six or More Visits
	W34	Report 0401	Well-Child Annual Visits in the Third, Fourth, Fifth and Sixth Years of Life
	AWC	Report 0401	Adolescent Well Child Visits
	FUH	Report 0402	Follow-up After Hospitalization for Mental Illness: 7-Day Follow-Up
	LSC	Report 0508	Lead Screening for Children
	MMA	Report 0402	Medication Management for People with Asthma
	ADV	Administrative data	Annual Dental Visit
Healthy Indiana Plan P4O Goals			
	AMB	Report 0402	ED Admissions per 1000 Member Months
	AAP	Report 0402	Adult Ambulatory and Preventive Care
	FUH	Report 0402	Follow-up After Hospitalization for Mental Illness: 7-Day Follow-Up
		Report 0512	Health Needs Screen
		Administrative and Quitline data	Referral to the Quitline for Pregnant Members who Smoke
	PPC	Report 0402	Timeliness of Ongoing Prenatal Care
	FPC	Report 0402	Postpartum Care – Percentage of Deliveries with Post-Partum Visit
	FUA	No report	Follow-up after Emergency Department Visit for Alcohol and other Drug Dependence 7- Day Follow-Up
	FUA	No report	Follow-up after Emergency Department Visit for Alcohol and other Drug Dependence 30-Day Follow-Up
Hoosier Care Connect P4O			
	FUH	Report 0402	Follow-up After Hospitalization for Mental Illness: 7-Day Follow-Up with MRO Services
	FUH	Report 0402	Follow-up After Hospitalization for Mental Illness: 30-Day Follow-Up
		Report 0512	Health Needs Screen
		Report 0513	Comprehensive Health Assessment Tool
	AMB	No report	ED admissions per 1000 member months
	AAP	Report 0402	Adult Ambulatory and preventive care
	FUA	No report	Follow-Up after Emergency Department Visit for Alcohol and other Drug Dependence 7-Day Follow-Up
	FUA	No report	Follow-Up after Emergency Department Visit for Alcohol and other Drug Dependence 30-Day Follow-Up

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. 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 continues to work with the health plans to identify sources of input to the QMIP. The diagram below illustrates a minimum of six sources: the External Quality Review, HEDIS outcomes, CAHPS 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.

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 updated in 2017 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 measureable. OMPP continued to refine the QIP reporting instructions and requirements during 2017. Technical assistance and guidance were provided to the MCEs in the form of review and recommendations for their 2019 and 2020 QIPs.

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 screens 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 Hoosier Care Connect (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 eighteen (18) quality-related incentives measures in 2020. The outcome measures are composed of withhold measures and bonus measures. Across all Medicaid managed care programs there are thirteen Healthcare Effectiveness Data and Information Set (HEDIS) withhold measures; one HEDIS-like measure; and four 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 2019, performance measures were reviewed and revised, 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.

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 2020 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 31 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. As an incentive to the MCEs for submitting all encounter claims, Pay-for-Outcomes results are verified by the OMPP. Data must reconcile to a variance no greater than 2 percent for HHW and HIP. For HCC data must reconcile to a variance of no greater than 2 percent for pharmacy and 10 percent for other categories of service.

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 are 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 may use either the OMPP developed standard template or their own formatted document for submission of their QIPs. This allows for greater transparency into the development, implementation, review, and quarterly update of each MCE's QIPs.

For 2020, OMPP required all MCEs to develop a QIP specific to increasing the rates of completion for the Health Needs Screen. All MCEs were also required to create a QIP with interventions related to: increasing the speed of engagement with care or case management for members with a recent ER visit related to substance abuse; increasing the number of individuals with a substance use disorder diagnosis who are engaged in care or case management; and increase the percent of individuals who has an ER visit with a principal diagnosis of alcohol or other drug abuse or dependence who have a follow-up visit within 7 or 30 days (HEDIS FUA measure).

Table 9 exhibits identified Performance/Quality Improvement Project topics of focus for 2020 for HHW, HIP and HCC.

TABLE 9	Performance/Quality Improvement Projects for 2020		
Plan	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect
Anthem	Follow-up after ER visit for alcohol and other drug abuse (7 FUA days) Follow-up after hospitalization (FUH 7 days) Improve New Member Health Needs Screen (HNS) Completion	Follow-up after ER visit for alcohol and other drug abuse (7 FUA days) Follow-up after hospitalization (7 days) Improve New Member Health Needs Screen (HNS) Completion	Follow-up after ER visit for alcohol and other drug abuse (7 FUA days) Follow-up after hospitalization (7 days) Improve New Member Health Needs Screen (HNS) Completion
MDwise	Well-child visits during the first 15 months (W15) Improve New Member Health Needs Screen (HNS) Completion Case Management for Members with Substance Use Following Discharge from ER (FUA 7 & 30 days)	Improve New Member Health Needs Screen (HNS) Completion Post-partum timeliness (PPC) Case Management for Members with Substance Use Following Discharge from ER (FUA 7 & 30 days)	
MHS	Improving the Performance Rate of Well-Child Visits in the First 15 Months of Life (W15) Decrease Hospital Readmission for members with Behavioral Health diagnosis	Improve New Member Health Needs Screen (HNS) Completion Improving the Performance Rate of Follow Up after	Improving the Performance Rate of Well-Child Visits in the First 15 Months of Life (W15) Improve New Member Health Needs Screen (HNS) Completion

TABLE 9	Performance/Quality Improvement Projects for 2020		
Plan	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect
	Improve New Member Health Needs Screen (HNS) Completion Improving the Performance Rate of Follow Up after Hospitalization for Mental Illness (FUH 7 days & 30 days) Case Management for Members with Substance Use Following Discharge from ER (FUA 7 & 30 days)	Hospitalization for Mental Illness (FUH 7 days & 30 days) Case Management for Members with Substance Use Following Discharge from ER (FUA 7 & 30 days)	Improving the Performance of Follow Up after Hospitalization for Mental Illness (FUH 7 days & 30 days) Case Management for Members with Substance Use Following Discharge from ER (FUA 7 & 30 days)
CareSource	Improve New Member Health Needs Screen (HNS) Completion Improve lead testing rates for children ages 12-24 months through provider-focused strategies (LSC) Improve W34 well visit rates through practitioner-level in-home assessments Case Management for Members with Substance Use Following Discharge from ER (FUA 7 & 30 days)	Improve New Member Health Needs Screen (HNS) Case Management for Members with Substance Use Following Discharge from ER (FUA 7 & 30 days)	

MCE 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 screens, comprehensive health assessments screenings (CHAT), prior authorization, care management, complex case management, disease management, services utilization, pregnancy identification
- Member services – member helpline, member portal, grievances, hearings and appeals, Consumer Assessment of Healthcare Providers and Systems (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 – Third Party Liability (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 information system (IS) with capabilities to perform the data receipt, transmission, integration, management, assessment, and system analysis tasks. Data from the MCEs is used to complete monthly and quarterly reports as required by OMPP. Also, data is utilized internally to assess 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 plans in accordance with 45 CFR 164.308, which relates to administrative safeguards and to comply with 42 CFR 438.242 relative to data. . Contingency plans must include: Data Backup plans, Disaster Recovery plans and Emergency Mode of Operation plans. Application and Data Criticality analysis and Testing and Revisions procedures are also required to be addressed within the Contractor's contingency plan documents.

SECTION IV. Improvement and Interventions

Improvements

OMPP's Quality Strategy Plan for 2020 builds upon the plans from 2018 and 2019. There is a continued focus on preventive health care for all programs as well as HHW and HIP priorities on healthy moms and healthy children to ensure that quality health care is provided to all IHCP members. While each MCE has identified quality improvements for 2020, 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.

OMPP also intends to contract with a non-emergency medical transportation (NEMT) broker for the fee-for-service population this year. The broker will be paid a fully capitated per-member-per-month payment consistent with other managed care arrangements in Indiana. The broker will help ensure members have adequate access to transportation providers and ability to get to primary appointments for preventive care.

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	- 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 - Assure member access to care	OMPP Contracted Health Plans

TABLE 10	Cross-Cutting Interventions for all Managed Care Programs	
Intervention	Process	Stakeholders
Prenatal/Postpartum Care Initiatives	• 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 • Partnership with the ISDH OB Navigator Project	OMPP Contracted Health Plans ISDH Providers
Improve Healthcare for Indiana's Children/EPSDT	• Increase percentage 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 DXC DMHA EPSDT
Behavioral Health	• Collaborative project focused on follow-up after mental health hospitalization • Increase member access to SUD services and providers • Increase the number of IHCP enrolled SUD providers • Approval for and implementation of the SMI Waiver • Use of standard *IHCP Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form* to request prior authorization for inpatient and residential SUD treatment services	OMPP DMHA Contracted Health Plans
Improving Access to Prenatal Care & Case Management of High-Risk Pregnancies by improving the process for Presumptive Eligibility for Pregnant Women (PE) and Notification of Pregnancy (NOP) Programs.	• Monitor the improvements in the PE and NOP processes • Monitor with OMPP Data Management Analysis teams monthly and quarterly reports to assess the effectiveness of PE and NOP improvements	OMPP Contracted Health Plans ISDH Providers

Intermediate Sanctions

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.

For contract year 2019, Table 11 describes MCE performance results for HHW upon which payout percentages are based.

Table 11.			Hoosier Healthwise "Pay –for-outcomes" Measures Overview								
Anthem			MHS			MDwise			CareSource		
2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018
Utilization of Ambulatory Services in ED Visits (HEDIS AMB)											
52.09 < HEDIS 25th percentile	47.46 < HEDIS 25th percentile	43.25 < HEDIS 25th percentile	50.06 < HEDIS 25th percentile	46.19 < HEDIS 25th percentile	43.10 <HEDIS 25th percentile	51.98 < HEDIS 25th percentile	49.66 < HEDIS 25th percentile	46.49 <HEDIS 25th percentile	N/A	48.09 <HEDIS 25th percentile	48.69 <HEDIS 25th percentile
Well Child Visits (0-15 months) with ≥6 visits HEDIS measure (HEDIS W15) using hybrid data.											
75.0% > HEDIS 90th percentile	75.08% > HEDIS 75th percentile	72.99% >HEDIS 75th percentile	58.89% Not eligible for incentive payment	69.59% > HEDIS 75th percentile.	63.99% Not eligible for incentive payment	77.38% > HEDIS 90th percentile	73.31% > HEDIS 90th percentile	72.26% >HEDIS 75th percentile	N/A	Data not available	57.42% Not eligible for incentive payment
Well Child Visits (3-6 years). HEDIS measure (HEDIS W34) using hybrid data.											

Table 11.			Hoosier Healthwise "Pay –for-outcomes" Measures Overview								
Anthem			MHS			MDwise			CareSource		
2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018
79.55% > HEDIS 75th percentile	76.34% < HEDIS 50th percentile	71.15% Not eligible for incentive payment	69.95% Not eligible for incentive payment	64.48% <HEDIS 50th percentile.	69.59% Not eligible for incentive payment	88.58% > HEDIS 90th percentile	80.78% > HEDIS 75th percentile	81.51% >HEDIS 75th percentile	N/A	50.36% Not eligible for incentive payment	64.96% Not eligible for incentive payment
Adolescent well child Visits (12-21 years). HEDIS measure (HEDIS AWC) using hybrid data.											
69.49% > HEDIS 75th percentile	63.07% < HEDIS 75th percentile	67.71% >HEDIS 90th percentile	61.30% > HEDIS 75th percentile	60.10% > HEDIS 75th percentile	62.53% >HEDIS 75th percentile	68.14% > HEDIS 90th percentile	69.65% > HEDIS 90th percentile	68.93% >HEDIS 90th percentile	N/A	41.12% Not eligible for incentive payment	46.96% Not eligible for incentive payment
Follow-up after Hospitalization for Mental Illness. HEDIS measure (HEDIS 7-Day FUH)											
63.17% > HEDIS 75th percentile	52.46% < HEDIS 75th percentile	44.48% >HEDIS 50th percentile	84.03% > HEDIS 90th percentile	50.00% > HEDIS 75th percentile	49.18% >HEDIS 75th percentile	81.57% > HEDIS 90th percentile	51.53% > HEDIS 75th percentile	46.47% >HEDIS 75th percentile	N/A	35.83% Not eligible for incentive payment	39.94% >HEDIS 50th 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.)											

Table 11.			Hoosier Healthwise "Pay –for-outcomes" Measures Overview								
Anthem			MHS			MDwise			CareSource		
2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018
75.89% > HEDIS 90th percentile	76.40% < HEDIS 90th percentile	72.34% >HEDIS 75th percentile	72.05% Not eligible for incentive payment.	67.64% Not eligible for incentive payment.	63.02% >HEDIS 25th percentile	73.72% > HEDIS 90th percentile	72.26% > HEDIS 25th percentile	66.91% >HEDIS 50th percentile	N/A	56.45% Not eligible for incentive payment	67.15% >HEDIS 50th percentile
Percentage of maternity discharge who made contact with the tobacco Quitline											
0.55% Eligible for 50% of incentive payment.	Data not available	*Data not available*	0.42% Not eligible for incentive payment	Data not available	*Data not available.*	0.37% Not eligible for incentive payment.	Data not available	Data not available	N/A	Data not available	Data not available
Timeliness of ongoing Prenatal Care (HEDIS FPC 81+% Hybrid)											
84.82% > HEDIS 90th percentile	82.97% > HEDIS 90th percentile	88.52% >HEDIS 75th percentile	72.53% Not eligible for incentive payment	74.94% >HEDIS 75th percentile.	77.62% Not eligible for incentive payment	86.62% > HEDIS 90th percentile	84.54% > HEDIS 90th percentile	84.18% Not eligible for incentive payment	N/A	31.63% Not Eligible for incentive payment	75.21% Not eligible for incentive payment

For contract year 2018, Table 12 describes MCE performance results for HIP upon which payout percentages are based.

Table 12.			Healthy Indiana Plan "Pay-for-Outcomes" Measures Overview								
Anthem			MHS			MDwise			CareSource		
2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018
Rate of ER admission per 1,000 member months (HEDIS – AMB measure for ED visits)											
92.46 Not eligible for incentive payment.	87.95 Eligible for 50% of incentive payment	79.23 Eligible for 100% of the incentive withhold	97.05 Not eligible for incentive payment.	91.32 Not eligible for incentive payment.	88.82 Eligible for 50% of the incentive withhold	97.05 Not eligible for incentive payment	94.69 Not eligible for incentive payment.	92.27 Not eligible for incentive payment	N/A	102.18 >HEDIS 75th percentile	80.94 Eligible for 75% of the incentive withhold
Rate of members 19+ who had Preventive care Visit (HEDIS AAP using administrative data)											
83.34% < HEDIS 25th percentile	83.20% > HEDIS 50th percentile	84.20% >HEDIS 50th percentile	75.82% Not eligible for incentive payment.	76.64% >HEDIS 25th percentile	81.78% >HEDIS 50th percentile	79.32% >HEDIS 25th percentile	79.25% > HEDIS 25th percentile	81.80% >HEDIS 50the percentile	N/A	78.54% Not eligible for incentive payment	73.22% Not eligible for incentive payment
Percent of maternity discharges who made connection with the quit line											
N/A	Data not available	0.97% Not eligible for an incentive payment	N/A	Data not available	1.84% Eligible for 50% of the incentive withhold	N/A	Data not available	0.89% Not eligible for incentive payment	N/A	Data not available	0.89% Not eligible for incentive payment

Health Needs Screener Completion											
Data not available.	17.94% Not eligible for incentive payment	21.95% Not eligible for incentive payment	Data not available	39.07% Eligible for 50% of incentive payment	54.37% Not eligible for incentive payment	Data not available	Data not available	50.38% Not eligible for incentive payment	Not participating	30.42 % Not eligible for incentive payment	20.81% Not eligible for incentive payment
FUH 7- Day (HEDIS FUH using hybrid data)											
43.26% Not eligible for incentive payment	36.35% Not eligible for incentive payment.	32.37% Not eligible for incentive payment	45.99% > HEDIS 50th percentile	33.66% Not eligible for incentive payment	32.95% Not eligible for incentive plan	41.81% Not eligible for incentive payment.	36.20% Not eligible for incentive payment.	31.02% Not eligible for incentive payment	Not participating	60.11% Not eligible for incentive payment	26.05% Not eligible for incentive payment

For contract year 2018, Table 13 describes MCE performance results for HCC upon which payout percentages are based.

Table 13. Hoosier Care Connect "Pay for outcomes" Measures Overview								
Anthem			MHS			MDwise		
2016	2017	2018	2016	2017	2018	2016	2017	2018
HNS completion								
Data not available	22.26 % Eligible for 50% incentive payment	19.90% Not eligible for withhold	Data not available	30.42% Eligible for 50% of incentive payment	34.09% Not eligible for incentive payment	Data not available	Not participating	Not participating
CHAT completion								
59% Not eligible for incentive payment.	76.40% Eligible for 50% of incentive payment	84.67% Eligible for 100% of the incentive withhold	89.64% Eligible for 100% of incentive payment	85.96% Eligible for 100% of incentive payment.	78.12% Eligible for 50% incentive withhold	89.64% Eligible for 100% of incentive payment.	Not participating	Not participating
Follow-up after Hospitalization 30-day								
69.22 % Not eligible for incentive payment.	61.19% Not eligible for incentive payment.	57.92% Not eligible for withhold	66.99% Not eligible for incentive payment.	58.78% Not eligible for incentive payment.	60.54% Not eligible for withhold	66.51% Not eligible for incentive payment.	Not participating	Not participating
Follow-up after Hospitalization 7-day with MRO								

Table 13.			Hoosier Care Connect "Pay for outcomes" Measures Overview					
Anthem			MHS			MDwise		
2016	2017	2018	2016	2017	2018	2016	2017	2018
72% Not eligible for incentive payment	65.06% Not eligible for incentive payment.	59.35% Not eligible for withhold	71% Eligible for 75% of incentive payment.	60.11% Not eligible for incentive payment	62.90% Not eligible for withhold	79% Eligible for 100% of withhold payment.	Not participating	Not participating
ER admissions per 1000 member months								
N/A	105.88 Not eligible for incentive payment	95.39 Not eligible for withhold	N/A	102.18 Not eligible for incentive payment	97.37 Not eligible for withhold	N/A	Not participating	Not participating
Adult preventive care								
N/A	85.35% >HEDIS 50th percentile	85.67% >HEDIS 75th percentile	N/A	78.54% >HEDIS 25th percentile	81.89% >HEDIS 50th percentile	N/A	Not participating	Not participating

State Health Information Technology

OMPP's legacy information system, Indiana*AIM*, was replaced on February 13, 2017 with the new *Core*MMIS, which stands for Core Medicaid Management Information System. Along with *Core*MMIS, a new provider interface called the Provider Healthcare Portal (Portal) replaced Web interChange. These new tools offered enhanced features allowing the MCEs and providers to access Medicaid information and functions more easily and efficiently. Together with the state's modular enterprise data warehouse (EDW) and pharmacy benefit manager (PBM), these systems comprise the state Enterprise Medicaid System (EMS). Functionality of the EMS, especially *Core*MMIS, will continue to be enhanced throughout 2020.

FSSA continues to work toward achievement of the Health Information Technology for Economic and Clinical Health (HITECH) goals and objectives under the Medicaid Promoting Interoperability (PI) Program (formally the Electronic Health Records Incentive Program). By advancing Health Information Technology (HIT) and multi-statewide Health Information Exchanges (HIEs) in Indiana through supporting the design, development, testing, and implementation of core infrastructure and technical solutions, FSSA will promote health information exchange among Medicaid Eligible Professionals (EPs) and Eligible Hospitals (EHs). OMPP does and will continue to benefit greatly from this type of data sharing and coordination.

The Implementation Advance Planning Document (IAPD) and State Medicaid HIT Plan (SMHP) for 2020 will focus on many initiatives, such as the following:

- Continued administration and expansion of HIT- Enabled Community-Wide Approach to Opioid Treatment and the Quality Care for Indiana Medicaid Long-Term Care Patients projects spearheaded by Purdue Healthcare Advisors - https://pha.purdue.edu/news-folder/purdue-fssa-partner-to-bring-new-care-models-process-improvements-and-technology-systems-to-four-indiana-communities-to-improve-opioids-addiction-treatment-and-hospital-transitions-from-long-term-care/

- HIE Strategic Planning and Governance –Indiana completed an HIE Assessment/Maturity Model analysis by Briljent in order to establish our current and target HIE states. Post Assessment activities include developing a governance model, engaging HIE stakeholders, performing gap analysis, and leveraging public and private sector resources to strengthen the sustainability and effectiveness of HIE activities in Indiana.

Continued implementation by the Indiana State Department of Health of a Public Health Promoting Interoperability hub that consists of: modernization and upgrades to systems used to perform real time bidirectional communication and query capabilities, a centralized knowledge base for all information (including training and outreach for Medicaid providers and facilities), as well as security risk assessments of internal and external systems that transmit, store and utilize PI data.
- Continued administration of the Medicaid Promoting Interoperability Program (formerly the EHR Incentive Program) - https://www.in.gov/medicaid/providers/632.htm. HITECH funding for the program will be phased out starting in 2021 with some funds remaining for one to two additional years specific to audit and administration allowing the state to plan for continued operability and sustainability of the HIT environment.

INSPECT is Indiana's prescription drug monitoring program and serves as a tool to address the problem of prescription drug abuse and diversion in Indiana. By compiling controlled substance information into an online database INSPECT performs two critical functions by maintaining a clearinghouse of patient information for health care professionals, and providing an important investigative tool for law enforcement. INSPECT seeks to enhance the ability of prescribers such as physicians, advanced practice nurses, physicians assistants and dispensers as they perform critical public health functions. The Substance Use-Disorder Prevention that Promotes Opioid Recovery Treatment for Patients and Community Act, SUPPORT, was implemented in October of 2018 with the focus on ending the opioid crisis. Most importantly this legislation removed restrictions for Medicare and Medicaid members in need of opioid addiction treatment and focuses on the overprescribing of opioid medications. In October of 2019, CMS approved FSSA's implementation and planning design for enhancing INSPECT and Health Information Technology in Indiana; as a result, Indiana was awarded over $18 million for use in 2020. This funding will allow for further design, development and implementation of the INSPECT data platform in anticipation of the October 1, 2021 implementation date for the Medicaid PARTNERSHIP Act which will require all providers to make a "good faith effort" to review the INSPECT data base prior to prescribing a controlled substance (Schedule I through Schedule IV). The funding will also facilitate the ability of INSPECT to respond to queries between contiguous states, and will enable enhancements in electronic prescribing, reporting, data analytics and infrastructure.

OMPP continues to share data with and utilize data from internal and external partners. A project is currently in place to allow data exchange between OMPP and the Department of Child Services to enhance service coordination. The MCEs can retrieve data collected and stored in the Children and Hoosiers Immunization Registry Program (CHIRP), a secure web-based application that is administered by the Indiana State Department of Health.

MCE Information Systems are used to collect and submit data to the state to validate performance. 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. Reporting dashboards are presented to the Quality Strategy Committee and to sub-committees for review. The role of the Committee is to assist in the development and monitoring of the identified goals and strategic objectives of the written Quality Strategy and to advise and make recommendations to OMPP.

While the MCEs are required to submit annual HEDIS data, OMPP also collects quarterly reports on a variety of quality indicators for preventive health, children and adolescents and mothers and newborns. The increased access to data allows OMPP to continually track and monitor performance on key quality indicators and steer the focus toward improvement activities. The OMPP in conjunction with our external quality review (EQR) vendor, Burns and Associates worked to complete a total revision of the MCE reporting manual. The three reporting manuals that previously existed for the HHW, HIP and HCC programs were integrated into a single reporting manual. The 75 reports in the HHW manual, 101 reports in the HIP manual, and 86 reports in the HCC manual were cross-walked to determine which reports were common to more than one program and which were unique to a specific program. Every report was given a provisional assignment of eliminate, retain with changes, or retain with no changes. Reporting instructions and templates were then reviewed by OMPP and MCE subject matter experts to recommend changes. The agreed upon changes were then incorporated into the reporting instructions and newly created templates that added automatic calculation fields and new validation fields.

Upon completion of the revised reporting manual, twelve dashboard reports were created that dynamically link key measures submitted by the MCEs from the quarterly reports in the reporting manual. Each dashboard is formatted on one page in landscape format and contains up to four measures allowing for up to four quarters of trend reporting. Results for a specific measure are displayed for each of OMPP's three programs side-by-side for ease of comparison across programs.

During 2020, OMPP will continue to monitor and work with the MCEs, the state fiscal agent, and the EDW to identify and decrease the limitations within their specific health information systems that prevent encounter claims from being provided and loaded in a timely and accurate manner. Many challenges were identified in 2017 in regards to the MCEs' submission of encounter claims. The process of claims submission begins with providers sending the MCEs complete, accurate and timely encounter claims for services rendered. Each MCE then receives these claims after multiple vendors process them and sends them to OMPP's fiscal agent, DXC. DXC puts these claims through multiple front end edits and audits before submitting them to Optum, the Enterprise Data Warehouse (EDW). Optum then submits the encounter claims to the FSSA Enterprise Data Warehouse (EDW). The reversal of this process for the purposes of reconciliation and data analyses involves the claims being pulled from the EDW and provided to Milliman, Myers and Stauffer, OMPP, and FSSA Data and Analytics. These multiple interfaces pose substantial challenges to the MCEs. OMPP continues to work with all MCEs to identify the specific barriers and develop processes to either remediate or work around them. As part of this process moving forward in 2020, OMPP will continue to work with the plans, Milliman and FSSA Data and Analytics to reconcile the eligibility files (HIPAA 834 files) as part of the encounter data quality process.

In 2018 OMPP began an initiative of determining the best process by which to provide data to CMS on the Adult Quality Measures. Meetings were held with vendor and OMPP staff to discuss which measures to prioritize for programming and reporting. In December 2019, OMPP reported (for the first time) to CMS on the Adult Quality Measures (AQM). The submitted AQM data will allow the state of Indiana and CMS to better understand and assess the quality of healthcare that adults enrolled in Medicaid receive. The AQM data is calculated following CMS instructions in the **Consolidated Implementation Guide** and the **Technical Specifications and Resource Manual**. Data is collected for enrollees in managed care and fee-for-service members. Rates were calculated across all reporting health plans for 16 HEDIS measures. Work on this project will continue with the goal of enhancing the quality of the data and number of measures for the 2020 Adult Quality Measures submission to CMS.

SECTION V. OMPP 2020 Initiatives

Standard Monitoring Compliance for 2020

Normal duties for monitoring compliance and ensuring quality healthcare is delivered to members will continue in 2020.

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 by accessing preventive health care 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 who had blindness or a disability to a coordinated care program where their multiple health needs could be coordinated. This program also includes current and former wards and foster children. In 2020 health needs screens (HNS) and comprehensive health assessments (CHAT) will continue to be monitored as pay for outcome measures and remain instrumental in identifying individual member needs, coordinating care, improving quality outcomes and maintaining consistency of care for these vulnerable members.

Right Choices Program (RCP)

The primary aim of the Right Choices Program is to assist Risk Based Managed Care (RBMC) and Fee for Service (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, 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 such as, multiple Emergency Room visits, pharmacy visits and physician visits that are not medically necessary. The program's design is to assist RCP enrollees by creating a medical home to support the member in obtaining the appropriate care at the right time in the right place.

For 2020 the focus of the Right Choices Program will include a monthly analysis of pharmacy claims identifying those members who have utilized opioid and controlled substances at a rate higher than the standard mean. This information will be uploaded into a single portal that can be accessed by MCE and OMPP staff as needed for review and analysis of Medicaid member usage.

Initiatives for 2020

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

Reimbursement and Financial Reporting

OMPP will continue to work with the MCEs in 2020 to research, identify and remediate contractual and financial barriers that limit access to care. One identified barrier is the fact that specialty provider costs can be higher than MCE reimbursement rates. This may act as a disincentive for specialty providers to contract with the MCEs and provide needed services as well as supports to Medicaid members. OMPP will work to provide effective contractual remedies for this identified barrier.

Policy Governance

The OMPP Policy and Program Development Section 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 Health Coverage Programs 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. This process will be reengineered to improve automation and communication with stakeholders.

Monitoring and Reporting Quality

The OMPP Quality and Outcomes staff works collaboratively with internal stakeholders (e.g., functional sections outside of Quality & Outcomes) and the MCEs to improve the oversight and reporting processes by ensuring that all contracted health plans are measuring, calculating and reporting in the same manner. Quality team staff reviewed the health plans' proposed 2020 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 and Outcomes Section will continue to collaborate to identify areas needing improvement, such as pharmacy and program integrity, 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 2020.

In 2020 OMPP will continue to monitor services to pregnant HIP women and the subsequent birth outcomes using the same metrics as previously used in HHW. OMPP will continue to use this data to not only identify HIP quality initiatives in 2020 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.

For 2019 Indiana has developed a broader strategy for infant mortality aimed at implementing a "Levels of Care" program to ensure that the highest-risk babies are delivered at hospitals with the facilities to meet the needs of the mother and baby. This strategy will be a collaboration between FSSA and ISDH. This is just one of the many initiatives aimed at meeting Indiana's goal of becoming the best state in the Midwest for curbing infant mortality by 2024.

In 2019 OMPP began work with the Indiana State Department of Health (ISDH), the Indiana Family and Social Services Administration (FSSA) and the Indiana Department of Child Services (DCS) on the OB Navigator Program. This initiative will build a network of services and supports for moms and babies with a goal of creating healthier outcomes for both. The goal of this program is to identify Medicaid members early in their pregnancies and connect them with an OB navigator – a home visitor who provides personalized guidance and support to the woman during her pregnancy and continuing through at least the first six to 12 months after her baby's birth. OMPP collaboration efforts have included making changes to the presumptive eligibility application to inform women about the program and establishing a data feed between ISDH and FSSA containing the demographic information on pregnant women identified through presumptive eligibility. OMPP collaboration continues through 2020, with OMPP acting as a liaison between the program and the MCEs and providing quality expertise.

In December of 2019, CMS selected Indiana's Family and Social Services Agency as one of ten states to be awarded a five-year $50,000,000 Maternal Opioid Misuse (MOM) Model grant. For this grant OMPP will serve as a liaison between FSSA and the MCEs and will provide quality expertise. The MOM model was developed to improve the quality of care and reduce expenditures for pregnant and postpartum women with Opioid Use Disorder (OUD) as well as their infants, increase access to treatments and create sustainable coverage and payment strategies that support ongoing coordination and integration of care. The MOM Model provides the opportunity for healthcare providers to improve care for mothers and infants affected by the opioid crisis. The model is aimed at promoting more health plan care coordination and integration of care. By supporting the coordination of clinical care and integration of others services critical for health, wellbeing, and recovery, the MOM Model has the potential to improve quality of care and reduce the cost of providing medical care to mothers and infants a like. Indiana will use these grant funds over the next five years to transition into the new model of care, and then fully implement the plan.

Smoking Cessation

The Indiana Health Coverage Programs (IHCP) has enhanced its coverage of tobacco cessation drug treatment through the pharmacy benefit. Effective March 1, 2019 prior authorizations will no longer be required for exceeding 180 days of tobacco cessation therapy. Other enhancements to the program include; allowance of preferred agents, including Chantix, to be used as first-line therapy and the ability to use Chantix concurrently with other nicotine replacement therapy. The goal of the program is to significantly improve the health of Medicaid members and to reduce the disease and economic burden that tobacco use places on them.

OMPP will continue to work closely with the ISDH Indiana Tobacco Quitline. The Indiana Tobacco Quitline is a free phone-based counseling service that helps Indiana smokers quit. OMPP in collaboration with ISDH, has facilitated increased quality of the monthly Quitline reports provided to the MCEs. OMPP and ISDH meet monthly to discuss any issues and trends with the reporting data. This partnership has resulted in a greatly increased accuracy of the reports being submitted to the MCEs, allowing for enhancement of their smoking cessation programs. The MCEs provided detailed information on their smoking cessation initiatives and incentive programs during the December, 2019 Quality Strategy Committee meeting. In turn ISDH presented the details of their new vaping initiative to all attendees at

this same meeting. OMPP and ISDH will continue this close and beneficial collaboration through 2020 with the continuation of monthly meetings between representatives from the two agencies.

Community Health Workers

On May 31, 2018 OMPP adopted a policy allowing Medicaid reimbursement for the use of community health workers (CHW). CHWs will be used to provide diagnosis-related patient education for members regarding self-managing physical or mental health, in conjunction with a healthcare team. The CHW may extend education efforts associated with any physical or mental health concern that a member may encounter. The CHW will also assist in the facilitation of cultural brokering between a member and the member's healthcare team allowing them to act as a facilitator between a Medicaid member and a provider when cultural factors (such as language or socioeconomic status) become a barrier to properly understanding treatment options or treatment plans. CHWs may also provide the service of health promotion education to a member on behalf of the healthcare team to prevent chronic illness. This service allows a CHW to discuss and promote healthy behaviors with a member to increase awareness and avoid the development of chronic illnesses.

MCE Alignment

A core of OMPP's updated mission is to increase efficiency and reduce administrative burden for both members and providers participating in Indiana Medicaid. In 2020 OMPP will continue to work on our strategic initiative of aligning MCE activities so provider and member experiences among the four MCEs are uniform.

In 2019 OMPP kicked off the work on this strategic initiative by aligning managed care practices around emergency department payment. Beginning April 1, 2020 each Indiana MCE must use a uniform list of diagnosis codes when determining whether a service is an emergency. The MCE may add additional codes to the list, but may not remove any diagnosis codes. As a part of this project, timeliness standards for submitting records for prudent layperson reviews were also standardized to 120 days.

Substance Use Disorder

OMPP implemented the substance use disorder (SUD) waiver in 2018 with the goal of providing a compendium of services for those members dealing with addictions to ensure they receive the right level of services when needed. Consideration of enhancements to those members receiving long term supports and services (LTSS) via various waivers continues within OMPP.

On December 20, 2019, the Indiana Family and Social Services Administration (FSSA) received federal approval for a Medicaid waiver that will offer improved access to a full continuum of care for thousands of Hoosiers suffering from serious mental illness (SMI). The waiver, now approved by the U.S. Centers for Medicare and Medicaid Services (CMS), gives Indiana Medicaid the authority to pay for acute inpatient stays in institutions for mental disease (IMDs) for individuals between the ages of 21-64 who are diagnosed with SMI. Until now, Medicaid law had significantly limited federal funding from being used for inpatient SMI treatment at any hospital, nursing facility, or other institution with more than 16 beds.

This new SMI waiver, effective January 1, 2020, is a crucial step for Indiana in reducing barriers to appropriate mental health services and increasing overall success for members transitioning back into their homes and communities. With this waiver, the State has made a significant commitment to address gaps in care and enhance its existing behavioral health infrastructure. These services are available to any Medicaid member between the ages of 21-64 with full Indiana Health Coverage Programs (IHCP) benefit

coverage, including those who are in Hoosier Healthwise, Healthy Indiana Plan (HIP), Hoosier Care Connect, or traditional Medicaid programs. This also includes those eligible for Hospital Presumptive Eligibility for Adults (aid category - MAHA) or Presumptive Eligibility for Pregnant Women (PEPW).

Adult Quality Measures

In 2018 OMPP began an initiative of determining the best process by which to provide data to CMS on the Adult Quality Measures. Meetings were held with vendor and OMPP staff to discuss which measures to prioritize for programming and reporting. In December 2019, OMPP reported (for the first time) to CMS on the Adult Quality Measures (AQM). The submitted AQM data will allow the state of Indiana and CMS to better understand and assess the quality of healthcare that adults enrolled in Medicaid receive. The AQM data is calculated following CMS instructions in the **Consolidated Implementation Guide** and the **Technical Specifications and Resource Manual**. Data is collected for enrollees in managed care and fee-for-service members. Rates were calculated across all reporting health plans for 16 HEDIS measures. Work on this project will continue with the goal of enhancing the quality of the data and number of measures for the 2020 Adult Quality Measures submission to CMS.
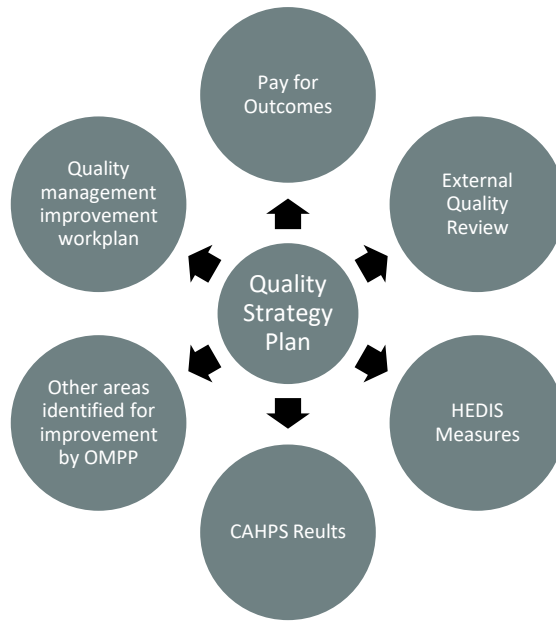
Section VI. Conclusion

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.

Indiana continues to utilize data from six primary sources in developing the Quality Strategy Plan. These six sources include Indiana's annual External Quality Review, the MCEs' HEDIS measures, the MCEs' CAHPS survey results, the Quality Management Improvement Work Plans, OMPP contractual pay for outcomes results, and any other areas identified for improvement via MCE reporting, on site meetings or other data and analytics provided to OMPP.

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 2020. 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 plan to monitor outcomes and plan for future endeavors.

The IHCP 2020 Quality Strategy Plan will be presented to the Quality Strategy Committee and will be made available through a public posting on the State website.

Diagram showing "Quality Strategy Plan" at the center, surrounded by: Pay for Outcomes, External Quality Review, HEDIS Measures, CAHPS Reults, Other areas identified for improvement by OMPP, and Quality management improvement workplan.

Appendix I: 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 (HIP) 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 Taskforce comprised of staff from across key FSSA divisions.

2014 HIP-ESP is folded into the HIP program

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

2015   Hoosier Care Connect 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 effective 1/1/17

2017   Pharmacy and Dental services carved-in for HHW

Appendix II: 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 effective 1/1/17

2017   Pharmacy and Dental services carved-in for HHW

Appendix III: 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 effective 1/1/17

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

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

2020   Gateway to Work is terminated

Appendix IV: 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 V: 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 1. Pharmacy, Dental and Vision services carve-in.

2015   Complete integration of Hoosier Care Connect occurs August 1.

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