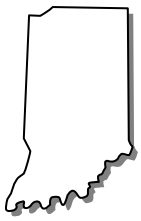
EDS Managed Care Unit



INDIANA HEALTH COVERAGE PROGRAMS

Care Management Organizations' Policies and Procedures Manual

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Revision History

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Version 1.0	March 2008	New manual	EDS Managed Care and Publications

Table of Contents

Section 1: Introduction

Overview

The *Care Management Organizations' Policies and Procedures Manual* is provided to each Care Management Organization (CMO) contracting with the Indiana Office of Medicaid Policy and Planning (OMPP) to administer services to *Care Select* members enrolled in a care management plan. The purpose of this manual is to provide an overview of the following:

- The *Care Select* program
- The CMOs' role in the *Care Select* program
- The policies and procedures specific to the CMOs' delivery of services to *Care Select* program members
- The interfaces among the CMOs, the OMPP and other contractors

This manual is organized into the following sections:

- *General Information* gives a broad understanding of the Indiana Health Coverage Programs (IHCP), including the *Care Select* program, its objectives, and components. This section also outlines the communication processes for addressing operational and policy matters.
- *Care Management Organizations* includes information about eligibility requirements, the CMOs' expected role in the *Care Select* program, and the coordination of the health plans with the fee-for-service (FFS) program.
- *Care management Services* defines covered services, non-covered services, and program requirements specific to the CMOs.
- *Member Services* details the regulations and general program expectations relating to member education and enrollment including helpline, grievance, and member-provider communication information.
- *CMO and Provider Enrollment* details the CMOs' requirements for enrollment, education, and practice standards for network providers who render services to *Care Select* members.
- *Member Eligibility and Enrollment* describes the categories of IHCP members who must enroll in *Care Select* and those who may voluntarily enroll, how the enrollment occurs, eligibility verification, disenrollment of members from the program, and the data exchange processes required for each of these events.
- *Network Development, Services, and Data* describes the requirements and processes with respect to eligible CMOs and providers, network development, enrollment processes, disenrollment processes, and reporting requirements.
- *Quality Improvement Program and Performance Reporting* is a critical aspect of care management and is described with regard to expectations, monitoring, and reporting.
- *Management Information Systems* and reporting requirements of the CMOs are described in reference to general financial reporting.
- *CMO Payment Process* mechanisms are described for payment and adjustment of administration fees.

Unless otherwise noted, mention of *Care Select* in this manual refers to the care management component of the IHCP and the areas in which the CMOs have an interest.

This manual is intended to document *Care Select* policies and procedures applied to the care management component of the program in general, and matters specific to CMOs and their roles in the program. General policies and those detailed elsewhere are referenced and not duplicated in this manual. Unless otherwise noted, technical specifications referred to in this manual are provided in the CMO orientation package described in *Section 8: CMO Enrollment and Network Development*.

The healthcare industry, and care management in particular, constantly changes to meet the demands of its patients, providers, and payers. *Care Select* is subject to many of these changes. To meet its objectives, *Care Select* is a fluid program that strives to meet the needs of its many constituents. The OMPP provides many forums – both formal and informal – designed to address the concerns of *Care Select* participants and refine its policies to reflect the input received. These policies are documented in signed, numbered Care management Policy Statements that are distributed to program participants when they are finalized. These policy statements are incorporated into updates of this manual.

CMO Orientation

When the CMO contract with the OMPP is finalized, the OMPP schedules a series of orientation sessions with the CMO to review policy and technical procedures necessary to contract administration, including interfaces with the OMPP and its contractors. The CMO identifies an implementation team to participate in the orientation, which likely includes staff from these functional areas:

- Provider network development and enrollment
- Technical and systems support
- Medical policy
- Member services and enrollment
- Quality assurance and utilization review

The OMPP designates members from its staff and contractor representatives to work with the CMO on implementation issues. During orientation, the OMPP and its *Care Select* contractors provide the CMO with a broad range of materials.

The fiscal agent provides the following:

- Claim processing edits and audits information
- The *IHCP Provider Manual* which is also available on CD-ROM or on the Web at http://www.indianamedicaid.com/
- Schedules for generation of all other information both to and from the CMO
- IHCP provider update bulletins, banner pages, and newsletters for the current year which are mailed to providers and are also available at http://www.indianamedicaid.com/
- Electronic file layouts and requirements for all data exchanges, including provider network files and member enrollment rosters, which are also available on the CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa/
- *Companion Guide for 834 MCE Benefit Enrollment and Maintenance Transaction*
- User ID and password for access to electronic files, including member enrollment rosters
- CMO enrollment information and procedures, and CMO enrollment forms which are available on the CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa/
- Health Plan primary medical provider (PMP) enrollment and disenrollment procedures; PMP enrollment and disenrollment forms are available on the CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa/

The OMPP or its designee provides the following:

- Orientation meeting schedule
- Telephone numbers for the OMPP, Maximus, and EDS contacts
- Annual IHCP report and other program summary reports
- Care management meeting schedule
- *Care Select* Provider Manual

The enrollment broker provides the following materials:

- *Care Select* member materials including the *Care Select* member handbook
- Enrollment broker script for member education and enrollment process
- In-service training opportunities

The CMO monitoring contractor provides the following materials:

- Readiness review criteria
- Quarterly reporting requirements and schedule

The medical policy contractor provides the following materials:

- Schedule for medical policy meetings

Section 2: General Information

Indiana Health Coverage Programs Overview

The IHCP is the umbrella for Medicaid and other State programs such as 590 (health benefits for institutionalized individuals), the Children's Health Insurance Program (CHIP), and Hoosier Rx. Established in 1965 by Title XIX of the *Social Security Act*, Medicaid is an entitlement program that finances medical services for certain individuals and families with low incomes and resources. Within broad federal guidelines, a state or territory retains responsibility for the following:

- Establishing its own eligibility standards for program members
- Determining the type, amount, duration, and scope of medical services offered
- Setting payment rates for services of medical providers treating eligible members
- Administering its own program or contracting with an outside entity to do the administration

Medicaid programs, funded with federal and state dollars, may vary considerably as individual states adapt the program to their unique populations. The federal government must certify states to operate a Medicaid Management Information System (MMIS) to be eligible for the full range of federal assistance. All branches of the IHCP use the same MMIS system for administration purposes. The Centers for Medicare and Medicaid Services (CMS) is the branch of the federal Department of Health and Human Services (HHS) that publishes guidelines for Medicaid, certifies an MMIS, and requires specific reporting designed to monitor each state's volume and expenditures for Medicaid. Medicaid and CHIP send state plans to the CMS for review and approval.

All states certified to operate an MMIS must offer a specific range of services to Medicaid-eligible members and organize administration of the program following published guidelines. States are mandated to provide some categories of medical services and can provide other categories as optional services to their Medicaid enrollees. The following is a list of services provided by Indiana's program including most of the optional and all of the required services that must be provided by a state's Medicaid program:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic (RHC) and federally qualified health center (FQHC) services
- Clinical laboratory services
- Radiology services
- Long-term care services
  - Nursing home
  - Intermediate care facility for members with mental retardation (ICF/MR)
  - Mental hospital care for members younger than 21 years old or older than 65 years old
  - Community residential center for members with developmental disabilities (CFR/DD)
- Home health services
- Physician services
- Family planning services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) programs
- Transportation and ambulance services

- Pharmacy services
- Dental services
- Optometry services and eye glasses
- Medical supplies
- Durable medical equipment (DME), including surgical appliances and prosthetic devices
- Emergency room treatment
- Physical therapy services
- Podiatry services
- Chiropractic services
- Community mental health rehabilitation services
- Occupational therapy services
- Respiratory therapy services
- Speech therapy services
- Audiological services and hearing aids
- Preventive health services
- Nurse practitioner services
- Nurse-midwife services
- Food supplements approved by the Food and Drug Administration (FDA)
- Psychiatric hospital services for individuals younger than 21 years old and older than 65 years old
- Psychiatric hospital services for individuals between 21 and 65 years old in psychiatric facilities of 16 beds or less
- Hospice services
- Smoking cessation

The IHCP covers certain waiver services for a limited number of qualified members under one of the Home and Community-Based Services (HCBS) waiver programs.

All IHCP coverage is subject to certain limitations that may be defined in terms of the following:

- Specific services excluded from coverage, for example, cosmetic surgery
- Limits on the frequency of services provided
- Services provided only under certain conditions, for example, prior-authorized services
- Coverage available only to certain age groups of members

There is one additional covered service available to *Care Select* PMPs. The CMO will coordinate with the *Care Select* PMPs to perform care coordination conferences to review a member's progress and care management plan. The PMPs are eligible to be reimbursed for their time at these case conferences.

Reimbursement for the *Care Select* Care Coordination Conference service requires the service be performed by the PMP assigned to the member or a nurse practitioner in the same group as the *Care Select* PMP. If a provider other than the member's *Care Select* PMP or nurse practitioner in the same group as the *Care Select* PMP bills for the service, the claim will be denied for Explanation of Benefit

code, 1050 – *The recipient is enrolled in the Care Select Program. Care Management service must be billed by the member's assigned Care Select PMP or nurse practitioner in the same group as the Care Select PMP.*

Each *Care Select* PMP is limited to two one-hour care coordination conferences per 12 rolling month period, for each *Care Select* member.

Services must be billed using HCPCS 99211 SC – Office or other outpatient visit for the evaluation and management of an established patient. *Care Select* PMPs are reimbursed $40 for each encounter.

The *Care Select* PMP may allow a Nurse Practitioner in the same group to perform the *Care Select* Care Coordination Conference service. When billing, the Nurse Practitioner must use their unique rendering provider number that is associated with the *Care Select* PMP's group number. If the Nurse Practitioner is not enrolled in the IHCP with their provider number, then the service is billed using the PMP's provider number and the SA modifier must be appended to the service.

For example, the Nurse Practitioner in the same group as the *Care Select* PMP performs the *Care Select* Care Coordination Conference service. The Nurse practitioner is not enrolled in the IHCP with their provider number. The claim is billed with the *Care Select* PMP's provider number as the rendering provider and the service is billed as 99211 SC SA.

Claims billed by a Nurse Practitioner that is enrolled with their own IHCP Provider number, but the provider number is not associated with the *Care Select* PMP's group billing number will be denied for edit 1050 – *Care Select Care Coordination Service must be billed by a Care Select PMP or a Nurse Practitioner in the same group as the Care Select PMP*.

Claims for *Care Select* Care Coordination Conference services that exceed the program limitation will be denied with Explanation of Benefit code, 6925 – *Care Select Care Coordination service is limited to 2 units of service per member, per rolling 12 months*.

State of Indiana Introduces Care Select - Care Management to Indiana Health Coverage Programs

The State of Indiana has several goals for improving the quality and comprehensive nature of care for its Indiana Health Coverage Programs (IHCP) members. Historically, the State of Indiana has classified its members based on aid category rather than by tailoring a treatment plan to each member. However, the State of Indiana is seeking to personalize and enhance the care provided by addressing members' needs holistically and by seeking input from medical providers, behavioral health experts, family members, and other caregivers. Toward that end, during the fall of 2007, the State created the Indiana *Care Select* Program, which will include comprehensive care coordination for all members not eligible for Medicare and not covered by Hoosier Healthwise, the care management portion of IHCP.

Primarily, the State of Indiana seeks to improve the quality of care and health outcomes for its IHCP members. This includes improved clinical and functional status, enhanced quality of life, improved client safety, client autonomy, adherence to treatment plans, and cost savings. Through this program, the State of Indiana will address the following concerns:

- Treatment regimens for chronic illnesses should better conform to evidence-based guidelines.
- Primary care providers should be more aware of and incorporate knowledge of functional assessments, behavioral changes, self-care strategies, and methods of addressing emotional or social distress into overall patient care.
- Care should be less fragmented and more holistic, for example, in addressing physical and behavioral health care needs and in considering medical as well as social needs, and there should be more communication across settings and providers.

- Consumers should have greater involvement in their care management.

In a *Care Select* delivery system, the OMPP pays contracted CMOs a monthly administration fee for each IHCP enrollee in the CMO's health plan. The administration fee covers the care management of the IHCP enrollees in the CMO health plan. The care of *Care Select* members enrolled in the CMO is managed by the CMO through its network of PMPs, specialists, and other providers who contract directly with the CMO.

Indiana has contractual agreements with the following entities to support and administer the care management component of the IHCP:

- Fiscal agent and premium collection vendor
- Surveillance and utilization review (SUR) contractor
- Enrollment broker
- Care Management Organizations
- Fee-for-service Prior Authorization broker
- External quality review organization

The care management component of *Care Select* is designed to meet the following goals:

- Ensure access to primary and preventive care
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

Member Choice

The *Care Select* enrollment broker and health plan provides information to aid the potential enrollee in the selection of an appropriate physician to meet the member's needs. There is emphasis on the importance of establishing and maintaining a relationship with a PMP of the member's choice. Information about the CMOs is also discussed with the member in terms of the broad impact this choice has on the access to services other than primary care. *Care Select* member education as it relates to PMP health plan selection is the responsibility of the enrollment broker. *Section 9: Member Eligibility and Enrollment* provides information about the member enrollment process.

Eligibility for *Care Select* Membership

The *Care Select* program provides health coverage to following members:

- Aged
- Blind
- Physically and mentally disabled
- Members receiving adoption assistance
- Members in the Waiver Program
- M. E. D. Works participants

The *Care Select* Program will include members enrolled in the Waiver Program. Waiver services rendered to waiver members will continue to require approval by their Waiver Case Manager and members must follow the Waiver Plan of Care. These services will not require a referral from their Indiana *Care Select* PMP. Claims submitted for non-Waiver services rendered by non-Waiver providers will require a referral from their Indiana *Care Select* PMP unless the service rendered is a self-referral service for the Indiana *Care Select* Program.

Waiver providers and Waiver Case Managers will continue to work closely together to identify and authorize waiver services for the Indiana *Care Select* Member. The prior authorization process that is currently in place for the Waiver program will be used. However, it is the expectation of the State that strong communications between the Waiver Case Manager and the Indiana *Care Select* PMP will exist in order to ensure uninterrupted care.

Members enrolled in aid categories *MA3* and *MA4* or otherwise designated as *foster children* or *wards of the court* **are eligible for Hoosier Healthwise but should not be excluded from *Care Select* if another factor makes these children ineligible for Hoosier Healthwise.**

Like other IHCP programs, eligibility and coverage are based on the member's aid category. The following IHCP members will not be covered by the *Care Select* Program:

- Members on spend-down
- Members dually eligible for Medicare and Medicaid
- Members in the Hospice Program
- Undocumented aliens
- AID to Recipient in County Homes (ARCH) Members
- Members enrolled in the 590 Program
- Members enrolled in the Breast and Cervical Cancer Treatment Services Program
- Individuals who are Qualified Medicare Beneficiaries (QMB) or Special Low Income Medicare Beneficiaries (SLMB) only (not in combination with another aid category)

Enrollment Education

During the IHCP eligibility determination process, the enrollment broker ensures that all enrollees eligible for care management receive education and written materials about the following topics:

- The importance of PMP and health plan selection
- How to access care appropriately within the program, including appropriate use of the hospital emergency room
- The importance of primary and preventive care
- The differences between care management and traditional fee-for-service (FFS) IHCP coverage
- The unique characteristics of the CMO networks

Enrollment brokers explain to potential enrollees that once they are eligible for the program, they have 30 days to choose a PMP.

Care Select encourages potential members to select a PMP who provides, through an ongoing member-PMP relationship, preventive and primary medical care, and authorization and referral for all medically necessary specialty services. The PMP must be available 24 hours a day, seven days a week, and must assume total management of the member's non-emergent medical needs. A helpline, manned

by the *Care Select* enrollment broker, is available for members to call with any problems or questions about the program. Helpline staff may refer the questions or problems to the appropriate entity for resolution.

Primary Medical Provider Eligibility in Care Select

A PMP is an IHCP enrolled physician operating in a primary care mode of practice in one of the following medical fields (provider specialty code):

- General practice (318)
- Family practice (316)
- General pediatrics (345)
- General internal medicine (344)
- Obstetrics and gynecology (328
- In addition, specialists such as cardiologists can serve as PMPs if requested by a member. The specialist must be able to provide all preliminary and preventive care services (i.e. pap test, acute care visits for viral illness) and may request to limit his/her panel

Primary care physicians in any setting are eligible to be PMPs and may serve any *Care Select* care management member within the physician's scope of practice. Physicians practicing in a group setting may enroll to service *Care Select* members as a PMP within a particular group. Group enrollment does not necessitate PMP enrollment in *Care Select.* One group can contain physicians enrolled as PMPs in the *Care Select* program and those who are not. Resident physicians in training are not eligible to serve as PMPs. All PMPs agree to be named in the *Care Select* provider listing.

Communication

Official IHCP policies are documented in the *IHCP Provider Manual* available to all providers enrolled in the IHCP and available online at http://www.indianamedicaid.com/. Supplements to this manual are distributed as needed. The following provides examples of some of the communication tools:

- CMOs must publish provider manuals.
- The *HealthWatch (EPSDT) Provider Manual*, published and distributed by EDS, is sent to providers who meet the licensing requirements and who are interested in providing EPSDT services to the IHCP population. All *Care Select* PMPs are HealthWatch providers. The *IHCP Provider Manual* contains additional information about this program.
- IHCP provider bulletins and newsletters, published and distributed by EDS, are sent to providers to give policy updates. IHCP provider bulletins, available on the IHCP Web site at www.indianamedicaid.com, are normally distributed to providers affected by the policy addressed in the bulletin. For example, a change in the pricing methodology for home healthcare services is sent to those providers enrolled in the home healthcare provider specialty. By virtue of enrollment as IHCP providers, CMO health plan providers receive these communications based on the specialty under which they are enrolled in Indiana*AIM*. Provider newsletters are mailed to all enrolled IHCP providers each month. Bulletins and newsletters are mailed to billing providers only. Specific care management bulletins and newsletters can also be accessed in the Managed Care - Care Select section of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/MCOPubs.asp

- Banner pages, published and distributed by EDS, are included with the remittance advice (RA) sent to providers who have submitted claims to EDS for adjudication. Banner page articles are brief informational paragraphs and are available on the IHCP Web site at http://www.indianamedicaid.com/. Only providers who have submitted claims adjudicated by EDS receive RAs and banner pages. Specific care management banners can also be accessed in the Managed Care - Care Select section of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/MCOPubs.asp

The IHCP E-mail Notification enables entities to subscribe to e-mail notifications for banners, bulletins, newsletters, IHCP notices, Web interChange notices, EDI notices, and Advisor FSSA Newsletters. Information regarding the IHCP E-mail Notifications is available on the IHCP Web site in the Publication section or at http://www.indianamedicaid.com/ihcp/mailing_list/sign_up.asp.

To ensure consistency in program policy and operation, establishment of communication mechanisms for clarification of existing policy and discussion about new policy issues is critical. The following briefly describes the roles of the various entities responsible for the administration of the *Care Select* program. Each CMO must establish a central contact person within its organization who is primarily responsible for maintaining the communications with other organizations to resolve daily operational problems.

Office of Medicaid Policy and Planning

The OMPP is the office within Indiana Family and Social Services Administration (IFSSA) that administers the IHCP, including *Care Select*. The OMPP has the final responsibility for *Care Select* care management program contracting, setting all program policies, and coordinating with other state and federal agencies, as required. A *Care Select* policy analyst is the CMO's liaison and primary point of contact with the OMPP.

Enrollment Broker

Maximus, the enrollment broker serves as an unbiased source for member education about all aspects of the care management and managed care programs. The enrollment broker also facilitates initial member enrollment into the programs, and performs member-initiated PMP changes and member disenrollment. CMOs also provide education to their members after enrollment in the CMO.

Fiscal Agent

EDS, the fiscal agent for the IHCP including *Care Select*, performs the premium collection for Package C, and is responsible for matters related to the development, maintenance, and operation of Indiana*AIM*. Major responsibilities include provider enrollment, claim adjudication, and payment to providers. EDS generates monthly administration fee payments and enrollment rosters to the CMOs three times a month.

Surveillance and Utilization Review

Health Care Excel, Inc. (HCE) is responsible for identifying potential overuse or fraudulent activity from program participants. CMOs must contact HCE with questions about SUR issues.

Care Management Organizations

The Care Management Organization is an entity that is a Primary Care Case Manager as defined by *42 Code of Federal Regulations (CFR) 438.2*. Please refer to *Section 3 Care Management Organizations* for additional information.

CMO Monitoring

Navigant Consulting assists the OMPP in monitoring CMO activity and performance. This ensures CMO compliance with contract requirements and performance standards.

Burns & Associates, Inc. is the external quality review organization (EQRO). The EQRO performs a reprocuring independent analysis of CMO performance in accordance with federal requirements at *42 CFR 438, Subpart E*.

Required CMO Meeting

The OMPP has an established set of meetings to discuss various aspects of the *Care Select* Care management Program. A schedule is released by the OMPP each year to identify meeting dates, times, and locations. An agenda is sent before each meeting with a copy of the previous month's meeting minutes.

The CMO must attend and participate in the following meetings:

Quality Improvement Committee

Facilitator – Navigant Consulting

Function – Attendees evaluate the effectiveness of the CMOs' QI activities. The QIC establishes standards and guidelines for the provision of care and services within the *Care Select* program.

Frequency – Monthly meetings held on the third Wednesday of the month.

IHCP Medical Policy Meeting

Facilitator – OMPP

Function – Processing of medical policies from initial evaluation through completion. Ongoing assessment of the implications of any changes to the IHCP and determination of the approach to changes. The IHCP medical policy meeting discussions encompass all IHCP medical policy decisions, including those that may or may not have an impact on the *Care Select* program.

Frequency – Quarterly

Indiana Chronic Disease Management Program (ICDMP) meetings with the OMPP (Twice monthly)

Facilitator – The OMPP

Function – Discussions regarding the ICDMP policies and procedures.

Frequency – Twice monthly

IHCP Prior Authorization/Medical Management Meeting (Monthly)

Facilitator – The OMPP Medical Policy Team

Function – Discussions regarding prior authorization and medical management policies and procedures for the *Care Select* program.

Frequency – Monthly

Drug Utilization Review Board

Facilitator – The OMPP, Drug Utilization Review (DUR) Board Chairperson

Function – The DUR board was established under *IC 12-15-35* and is responsible for oversight of the current and proposed DUR program. One of the DUR Board's duties includes the review and approval of formularies in the IHCP. See *Section 3* for more information about the DUR Board.

Frequency – Monthly

Mental Health Quality Assurance Committee

Facilitator – The OMPP Director

Function – House Enrolled Act (HEA) 1325 confers upon the Mental Health Quality Assurance Committee (MHQAC) the responsibility to make recommendations to the OMPP regarding access to behavioral health drugs through the Indiana Medicaid program. The office reports recommendations made by the committee to the DUR board. The OMPP has the ultimate responsibility for implementing any restrictions with the advice of the Committee.

Frequency – Monthly

Quarterly Review Meeting

In addition, the CMO's executive leadership must meet at least quarterly with the OMPP to review the CMO's performance, discuss the CMO's outstanding or commendable contributions, identify areas for improvement, and outline upcoming issues that may impact the CMO or Indiana *Care Select*.

Recommended Meetings

The CMO is encouraged to attend but is not required to participate in the following meetings:

IHCP Provider Workshops

Facilitator – EDS

Function – The OMPP and EDS provide Medicaid healthcare providers with information about the Medicaid program.

Frequency – Quarterly

- Accessibility of care
- Appropriateness of care

- Cost-effectiveness of care

Indiana State Medical Association Medicaid Coalition Meeting

Facilitator –Indiana State Medical Association

Function – The OMPP and EDS provide Medicaid healthcare providers with information about the Medicaid program.

Frequency – Bimonthly meetings held in January, March, May, July, September, and November.

Optional Meetings

The CMO **may** attend the following meetings:

- Medicaid Advisory Committee Meeting (Quarterly)
- Other Professional Provider Association meetings (Various)

Important Telephone Numbers

Table 2.1 lists telephone numbers for CMOs to call for general questions occurring during daily operations or in ongoing management activities. CMOs must make enrolled providers and members aware of the appropriate telephone numbers and educate them about their use. In addition to the numbers in Table 2.1, each PMP is required to have a 24-hour telephone number for members. CMOs may also provide a nurseline to assist as necessary with member questions and direct members to the PMP's office. CMOs must update EDS by sending a MCO Enrollment update form and the OMPP whenever a provider or member services telephone number is changed.

Table 2.1 – Important Telephone Numbers

Contact	Telephone Number	Hours of Operation	Description
EDS Automated Voice Response (AVR) System	1-800-738-6770 (317) 692-0819	5 a.m. to 1 a.m. Eastern Time daily	Member eligibility verification Other insurance information Benefit limits Prior authorization history
EDS Provider Enrollment	(317) 655-3240 1-877-707-5750	7:30 a.m. to 6 p.m. Eastern Time Monday – Friday	Enrollment in IHCP PMP enrollment questions
EDS Managed Care	(317) 488-5000	8 a.m. to 5 p.m. Eastern Time Monday – Friday	CMO general program or policy questions Indiana*AIM* questions Data exchange information. This number is for CMO, HCE, and the OMPP use only. It must not be given to providers or members.
EDS Third Party Liability	1-800-457-4510 (317) 488-5046	7:30 a.m. to 6 p.m. Eastern Time Monday – Friday	Previous casualty coverage Previous lien information
Care Select Helpline	1-866-963-7383	8 a.m. to 6 p.m. Eastern Time Monday – Friday 8 a.m. to noon Eastern Time Saturday	Member enrollment in *Care Select* Member PMP change requests Member education issues Member disenrollment from CMO PMP changes outside CMO network
OMPP Care management	(317) 233-8800	8 a.m. to 5 p.m. Eastern Time Monday – Friday	CMO enrollment Marketing issues CMO monitoring Program performance Care management contract procurement and evaluation
Navigant Consulting	(202) 973-2400	Regular business hours	Program monitoring and quality improvement
HCE Surveillance and Utilization Review	(317) 347-4500 Ext. 1248	Regular business hours	Identification and investigation of potential overuse or fraudulent activity from Program participants
ADVANTAGE Health Solutions SM – Traditional Medicaid Prior Authorization	1-800-269-5720	Regular business hours	Prior authorization process administration

CMOs may access http://www.indianamedicaid.com/ for additional IHCP contact telephone numbers.

CMO Member and Provider Helpline

Each CMO is required to establish and maintain a toll-free helpline for member and provider calls specific to CMO issues. *Section 6: Provider Services* provides detailed information about helpline requirements.

Section 3: Care Management Organizations

Overview

Care Management Organizations (CMOs) participating in *Care Select* collaborate with the OMPP to provide quality care to program enrollees. While the core benefits identified in the Indiana Administrative Code (IAC) are provided under the CMO health plans, the CMOs assume some of the responsibilities for enrolled members and providers that the State (or its designated contractor) performs for fee-for-service (FFS) enrolled members and providers.

The following list, while not all-inclusive, highlights the major responsibilities of CMOs:

- Management of medical care for CMO-enrolled members
- Development and maintenance of a contracted provider network,
- Education of providers and members
- Maintenance of formal provider and member grievance processes
- Maintenance of a quality improvement and quality assurance program specific to the *Care Select* population
- Submission of required performance reports to the OMPP on a regular basis

Each of the CMO responsibilities is described in greater detail throughout this manual.

Eligible CMOs

To be eligible a CMO must comply with the following:

- Be fully authorized under Indiana law to arrange or administer the full range and scope of services required under a procurement process undertaken by the State.

Participating CMOs have signed contracts with the state of Indiana and the OMPP. The OMPP selects CMOs through a competitive procurement process. Each CMO must submit a successful proposal to provide services to *Care Select* enrollees.

Each participating CMO is encouraged to attain accreditation from a recognized accrediting body such as the National Commission for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Staffing Requirements

The CMO must ensure all staff members, including subcontractor staff, have appropriate and ongoing training, education and experience to fulfill the requirements of their positions. Training should include topics such as orientation, cultural sensitivity, program updates, clinical protocols, policies and procedures compliance, computer system, and so forth. The CMO must institute mechanisms to maintain a high level of plan performance and data reporting capabilities regardless of staff vacancies or turnover. The CMO must have an effective method to address and reduce staff turnover (for example, cross training, use of temporary staff or consultants, and so forth) and processes to solicit staff feedback to improve the work environment. The CMO must maintain documentation to confirm its internal staff training, curriculum, schedules, and attendance.

The CMO must have position descriptions for the positions discussed in this section that include the responsibilities and qualifications of the position such as, but not limited to: education (for example, high school, college degree, and graduate degree), professional credentials (such as, licensure or certifications), direct work experience, and membership in professional or community associations.

The CMO must have an office in the state of Indiana from which, at a minimum, key staff members physically perform the majority of their daily duties and responsibilities, and a major portion of the plan's operations take place.

The CMO must employ key staff members listed below who are dedicated to the *Care Select* program. The key staff members include, but are not limited to the below positions. The CMO must provide at least one full-time employee (FTE) to each function listed as "dedicated". The employees filling these positions shall be solely devoted to the *Care Select* program and not to any other CMO clients or IHCP programs.

- **Chief Executive Officer** – The chief executive officer or executive director has full and final responsibility for the CMO management and compliance with all provisions of the State's contract with the CMO.
- **Chief Financial Officer** – The chief financial officer must oversee the budget and accounting systems of the CMO for the *Care Select* program. This officer must, at a minimum, be responsible for ensuring that the CMO meets the State's requirements for financial performance and its reporting.
- **Medical Director (Dedicated)** – The CMO must employ or contract the services of a medical director who is an IHCP provider. The medical director must oversee the development and implementation of the CMO's clinical practice guidelines, review any potential quality of care problems, oversee the CMO's clinical management program and programs that address special needs populations, oversee health needs assessments, serve as the CMO's medical professional interface with the CMO's PMPs and specialty providers, be the point person for the CMO's disease management program for asthma and the Indiana Chronic Disease Management Program (ICDMP), direct the quality management and utilization management programs, monitor corrective actions and other quality management, and monitor utilization management or program integrity activities. The medical director, in close coordination with other key staff members, is responsible for ensuring the medical management and quality management components of the CMO's operations are in compliance with the terms of CMO's contract with the State.
- **Psychiatrist (Dedicated)** – The Psychiatrist must coordinate with the medical director to ensure that the CMO's behavioral health management and quality management programs comply with the terms of the contract. The Psychiatrist will fulfill a role similar to the medical director, but will be focused primarily on the CMO's behavioral health program.
- **Compliance Officer (Dedicated)** – The CMO must employ a compliance officer who is dedicated full-time to the *Care Select* program. This individual is the primary liaison with the State (or its designees) to facilitate communications between the OMPP, the State's contractors, and the CMO's executive leadership and staff. This individual must maintain a current knowledge of federal and state legislation, legislative initiatives, and regulations that may impact the CMO's *Care Select* program. The OMPP must approve of the candidate who fills this position. The compliance officer, in close coordination with other key staff, has primary responsibility for ensuring all CMO functions are in compliance with the terms of the CMO's contract.
- **Care Management Manager (Dedicated) –** The CMO must employ a full-time Care Management Manager. This manager must oversee the care management program, which includes utilization management, care coordination and disease management. The care management manager must, at a minimum, be a registered nurse or other medical professional with extensive experience in providing care coordination to a variety of populations. This individual will work directly under the CMO's medical director to develop, expand and maintain the care management program. The

individual will be responsible for overseeing care management teams, care plan development and care plan implementation.

- The care management manager will be responsible for directing the activities of the utilization management staff. With direct supervision by the medical director, this manager must direct staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, continuity of care, care coordination and other clinical and medical management programs. These responsibilities extend to physical and behavioral health care and transportation services.
- This individual will work with the medical director, provider and member services managers and with State staff as necessary, to communicate to providers and members about medication management, appropriate use of generic medications, etc. The care management manager will provide input, as requested by the State, at the State's Drug Utilization Review (DUR) Board meetings and Mental Health Quality Assurance Committee, participate on the CMO's internal pharmacy therapeutics committee, and work closely with the pharmacy benefits manager (PBM) and the State's PBM team.
- **Information Systems (IS) Coordinator (Dedicated)** – The CMO must employ an IS coordinator who is dedicated full-time to the *Care Select* program. This individual oversees the CMO's Medicaid IS and serves as a liaison between the CMO and the State's fiscal agent, monitoring contractor, or other OMPP contractors about encounter data submissions and other data transmission interface and management issues. The IS coordinator, in close coordination with other key staff, is responsible for ensuring all program data transactions are in compliance with the terms of the CMO's contract with the State. The OMPP must approve of the candidate who fills this position.
- **Member Services Manager** (Dedicated) – The CMO must employ a member services manager who is dedicated full-time to the *Care Select* program. This manager must, at a minimum, be responsible for directing the activities of the CMO's member services, including, but not limited to, member helpline telephone performance; member education; outreach programs; and member materials development, approval and distribution. The manager must also serve as the primary interface with the State's fiscal agent and enrollment broker regarding such issues as member enrollment and disenrollment, member PMP changes, member eligibility, and newborn enrollment activities. This manager must provide an orientation and ongoing training for member services helpline representatives, at a minimum, to support accurately informing members of how the CMO health plan operates, availability of covered services, benefit limitations, health needs assessment (HNA) screenings, emergency services, PMP assignment, specialty provider referrals, self-referral services, preventive and enhanced services, well-child services, and member grievances and appeals procedures. The member services manager, in close coordination with other key staff members, is responsible for ensuring all of the CMO's member services operations are in compliance with the terms of the CMO's contract with the State.
- **Provider Network and Services Manager** (Dedicated) – The CMO must employ a provider services manager who is dedicated full-time to the *Care Select* program. This manager must, at a minimum, be responsible for monitoring the performance of the provider services helpline; monitoring provider recruitment, contracting and credentialing; creating and updating provider manuals, education materials, and outreach programs; providing information to the OMPP or its contractors regarding the CMO's provider network; and facilitating the provider claims dispute process. The provider services manager, in close coordination with other key staff, is responsible for ensuring all of the CMO's provider services operations are in compliance with the terms of the CMO's contract with the State.
- **Quality Management Manager (Dedicated) –** The Quality Management Manager must, at a minimum, be responsible for directing the activities of the CMO's quality management staff in monitoring and auditing the CMO's performance and health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical

quality. This Manager must assist the CMO's Compliance Officer in overseeing the activities of the CMO operations to meet the State's goal of providing health care services that improve the health status and health outcomes of Indiana *Care Select* members.

- **Prior Authorization Manager (Dedicated) –** This individual will be responsible for the coordination and achievement of the Prior Authorization (PA) business function and objectives. The PA Manager will also be responsible for setting PA goals and fulfilling the goals each year. The PA Manager shall participate in and lead discussions with the OMPP. Interfacing with providers to refine procedures for PA submissions, assisting in the development and maintenance of review criteria, developing and coordinating relevant PA activities with the State, ensuring high meeting activity attendance with the State and submitting reports on time are additional responsibilities of the PA Manager position. The PA Manager will also be responsible for developing and maintaining job descriptions and hiring and training PA staff.
- **Case Managers (Dedicated)** – The Care Management staff must include qualified case managers who are registered nurses and/or licensed practical nurses, social workers, therapists, physician assistants or other appropriately qualified individuals.

The CMO must provide written notification of anticipated vacancies of key staff within five business days of receiving the key staff person's notice to terminate employment or five business days before the vacancy occurs, whichever occurs first. Notification should be directed to the OMPP policy analyst assigned to the CMO. At the time notification is given, the CMO must present the OMPP with an interim plan to cover the responsibilities created by the key staff vacancy. Likewise, the CMO must notify the OMPP within five business days after a candidate's acceptance to fill a key staff position or five business days prior to the candidate's start date, whichever occurs first.

All key staff must be accessible to the OMPP and its other program subcontractors via voice mail and electronic mail systems. As part of its annual quality management and improvement plan, the CMO must submit to the OMPP an updated organizational chart including e-mail addresses and telephone numbers for key staff.

Drug Utilization Review Board

The Indiana DUR Board is appointed by the governor to serve in an advisory capacity to Indiana Medicaid with regard to the prescription and dispensing of drugs by Medicaid providers and the use of drugs by Medicaid members. The DUR Board is composed of representatives of the pharmacy, medical, and scientific communities and has a responsibility to establish criteria for review of both current and future drug prescription, dispensing and use for and by Medicaid members. Through the expert opinion of the DUR Board members, aided when appropriate by consultants, the DUR Board provides the OMPP with advice on matters of drug usage allowing for the appropriate and cost effective delivery of medical and pharmaceutical care. For more information about the DUR Board refer to *IC 12-15-35-46.*

The MHQAC makes recommendations to the OMPP regarding access to behavioral health drugs through the Indiana Medicaid program. The office reports recommendations made by the committee to the DUR board. The OMPP has the ultimate responsibility for implementing any restrictions based on the advice of the MHQAC.

The CMO will monitor pharmacy claims and provide input regarding suggested changes and improvements to the pharmacy preferred drug list (PDL) and/or policies and procedures to the State. The State, in turn, may present that input to the Therapy Committee and the DUR Board.

Financial Requirements

The CMO must be in compliance with all applicable insurance laws of the State of Indiana and the Federal government throughout the term of the contract. No less than 90 calendar days prior to delivering services under this contract, the CMO must obtain from an insurance company duly authorized to do business in the State of Indiana, at least the minimum coverage levels as listed below for the following types of insurance:

- Professional Liability (Malpractice) Insurance for the CMO and its Medical Director, as defined in *IC 34-18-4-1*
- Workers' Compensation Insurance
- Comprehensive Liability Insurance

No less than 30 calendar days before the policy renewal effective date, the CMO must submit to the OMPP its certificate of insurance for each renewal period for review and approval.

The CMO must maintain accounting records specifically for performance of the Indiana *Care Select* Program contract that incorporate performance and financial data of subcontractors, as appropriate. The CMO must maintain accounting records that are specific to Indiana *Care Select* Program operations. The CMO must provide documentation that its accounting records are compliant with National Association of Insurance Commissioners (NAIC) standards.

In accordance with *42 CFR 455.100-104*, the CMO must notify the OMPP of any person or corporation with 5 percent or more of ownership or controlling interest in the CMO and must submit financial statements for these individuals or corporations.

Authorized representatives or agents of the State and the Federal government must have access to the CMO's accounting records and the accounting records of its subcontractors upon reasonable notice and at reasonable times during the performance and/or retention period of this contract for purposes of review, analysis, inspection, audit and/or reproduction.

Copies of any accounting records pertaining to the contract must be made available by the CMO within 10 calendar days of receiving a written request from the State for specified records. If such original documentation is not made available as requested, the CMO must provide transportation, lodging and subsistence at no cost, for all State and/or Federal representatives to carry out their audit functions at the principal offices of the CMO or other locations of such records. FSSA and other State and Federal agencies and their respective authorized representatives or agents must have access to all accounting and financial records of any individual, partnership, firm or corporation insofar as they relate to transactions with any department, board, commission, institution or other State or Federal agency connected with the contract.

The CMO must maintain financial records pertaining to the contract for three years following the end of the Federal fiscal year during which the contract is terminated, or when all State and Federal audits of the contract have been completed, whichever is later, in accordance with *45 CFR 74.53*. Financial records should address matters of ownership, organization and operation of the CMO's financial, medical, and other record keeping systems. However, accounting records pertaining to the contract must be retained until final resolution of all pending audit questions and for one year following the termination of any litigation relating to the contract if the litigation has not terminated within the three-year period.

In addition, the OMPP requires the CMO to produce the following financial information upon request:

- Externally audited annual fiscal information
- Appropriate insurance coverage for general liability, property, workmen's compensation, medical malpractice, and fidelity bond

- Evidence of revenue sufficiency by line of business, group and program
- Budgeted revenue and spent total revenues
- Corrective action plans and implementation records of corrective action taken to remedy noncompliance with any financial requirements, if applicable

Medicaid enrollees will not be liable for the entity's debt if the entity becomes insolvent.

The CMO shall not perform any activities related to third party liability (TPL).

Subcontractors

The term "subcontract(s)" includes contractual agreements between the CMO and any entity that performs delegated activities related to the State CMO contract and any administrative entities not involved in the actual delivery of medical care. For instance, Respondents may choose to subcontract with other companies for certain administrative functions, such as prior authorization.

Although the CMO is required to build a network of providers for the Indiana *Care Select* population, those providers are not subcontractors of the CMO. Those agreements shall be formalized through the use of an Addendum to the Provider's Indiana Health Coverage Programs/Medicaid Provider Agreement. Any agreements with providers, whether subcontracts or not, must include adequate Health Insurance Portability and Accountability Act (HIPAA) language.

The OMPP must approve all subcontractors and any change in subcontractors or material change to subcontracting arrangements. All subcontracts must be approved by the OMPP prior to being signed by the subcontractor and must include acceptable HIPAA language. The State encourages the CMO to subcontract with entities that are located in the State of Indiana.

The CMO is responsible for the performance of any obligations that may result from the CMO contract. Subcontractor agreements or signed Addenda do not terminate the legal responsibility of the CMO to the State to ensure that all activities under the contract are carried out. The CMO must oversee subcontractor activities and submit an annual report on its subcontractors' compliance, corrective actions and outcomes of the CMO's monitoring activities. The CMO must similarly monitor and report about the providers which have signed Addenda to participate in the *Care Select* Program. The CMO will be held accountable for any functions and responsibilities that it delegates.

At least annually, the CMO must obtain the following information from each subcontractor and use this information to monitor the subcontractor's performance: audited financial statements including statement of revenues and expenses, balance sheet, cash flows and changes in equity/fund balance. The CMO shall make these documents available to the OMPP upon request and the OMPP will regularly review these documents during CMO site visits, which are likely to occur at least three times per year.

The CMO must comply with *42 CFR 438.230* and the following subcontracting requirements:

- The CMO must obtain the OMPP's approval before subcontracting any portion of the project's requirements. This approval shall include detailed review of any subcontractor agreements. The CMO must submit a written request and a draft subcontract to the OMPP at least 60 calendar days prior to the use of a subcontractor. The CMO shall obtain the OMPP's approval of the subcontract before using it with any subcontractors. If the CMO makes subsequent changes to the duties included in its subcontracts, it must notify the OMPP 60 calendar days prior to the revised contract effective date and submit the amendment for review and approval. The OMPP must approve changes before the CMO modifies any previously approved subcontracts.
- The CMO must evaluate prospective subcontractors' abilities to perform delegated activities prior to contracting with the subcontractor to perform services associated with Indiana *Care Select*.

- The CMO must have a written agreement in place that specifies the subcontractor's responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is inadequate. The written agreement must be in compliance with all State of Indiana statutes, and will be subject to the provisions thereof. The subcontract cannot extend beyond the term of the State's contract with the CMO.
- The CMO must collect performance and financial data from its subcontractors and monitor delegated performance on an ongoing basis and conduct formal, periodic and random reviews, as directed by the OMPP. The CMO shall monitor subcontractor performance against the requirements of the False Claims Act. The CMO must incorporate all subcontractors' data into the CMO's performance and financial data for a comprehensive evaluation of the CMO's performance compliance and identify areas for its subcontractors' improvement when appropriate. The CMO must take corrective action if deficiencies are identified during the review.
- All subcontractors must fulfill all State and Federal requirements appropriate to the services or activities delegated under the subcontract. In addition, all subcontractors must fulfill the requirements of the State's contract with the CMO (and any relevant amendments) that are appropriate to any service or activity delegated under the subcontract.
- The CMO must comply with all subcontract requirements specified in *42 CFR 438.230*. All subcontracts, provider contracts, agreements or other arrangements by which the CMO intends to deliver services required under this RFS, whether or not characterized as a subcontract under this RFS, are subject to review and approval by the OMPP and must be sufficient to assure the fulfillment of the requirements of *42 CFR 434.6*. The OMPP may waive its right to review subcontracts, provider contracts, agreements or other arrangements. Such waiver shall not constitute a waiver of any subcontract requirement. In accordance with *IC 12-15-30-5(b)*, subcontract agreements for Indiana *Care Select* Program business terminate when the CMO's contract with the State terminates.
- The CMO must have policies and procedures addressing auditing and monitoring subcontractors' data, data submissions and performance. The CMO must integrate subcontractors' financial and performance data (as appropriate) into the CMO's information system to accurately and completely report CMO performance and confirm contract compliance.
- The OMPP reserves the right to audit the CMO's subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. The OMPP may require corrective actions and will assess liquidated damages, as specified in Section 8.0, for non-compliance with reporting requirements and performance standards.
- If the CMO uses subcontractors to provide direct services to members, the subcontractors must meet the same requirements as the CMO, and the CMO must demonstrate its oversight and monitoring of the subcontractor's compliance with these requirements. The CMO 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.

Reporting Transactions with Parties of Interest

The CMO, if not federally qualified, must disclose to the OMPP information on certain types of transactions they have with a "party of interest" as defined in the *Public Health Service Act* (See *§§1903(m)(2)(A)(viii) and 1903(m)(4)* of the Act).

Definition of *A Party of Interest* – As defined in *§1318(b) of the Public Health Service Act*, a party of interest is:

- *Any director, officer, partner, or employee responsible for management or administration of an HMO and HIO; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note,*

or other interest secured by, and valuing more than 5% of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

- *Any organization in which a staff member who is a director, officer or partner; has directly or indirectly a beneficial interest of more than 5% of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the HMO;*
- *Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or*
- *Any spouse, child, or parent of an individual described in the above bulleted subsections 1, 2, or 3.*

Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include:

- *Any sale, exchange or lease of any property between the HMO and a party in interest;*
- *Any lending of money or other extension of credit between the HMO and a party in interest; and*
- *Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.*

The information which must be disclosed in the transactions listed in subsection B between a CMO and a party in interest includes:

- *The name of the party in interest for each transaction;*
- *A description of each transaction and the quantity or units involved;*
- *The accrued dollar value of each transaction during the fiscal year; and*
- *Justification of the reasonableness of each transaction.*

The above information on business transactions must be accompanied by a consolidated financial statement for the CMO and the party in interest.

If the contract is an initial contract with the OMPP, but the CMO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. If the contract is being renewed or extended, the CMO must disclose information on business transactions which occurred during the prior contract period. The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the CMO's business transactions must be reported.

Debarred Individuals

In accordance with *42 CFR 438.610*, the CMO must not knowingly have a relationship with the following:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under *Executive Order No. 12549* or under guidelines implementing *Executive Order No. 12549*
- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in this chapter

The relationships include directors, officers, or partners of the CMO, persons with beneficial ownership of 5 percent or more of the CMO's equity, or persons with an employment, consulting or

other arrangement with the CMO for the provision of items and services that are significant and material to the CMO's obligations under its contract with the State.

In accordance with *42 CFR 438.610*, if the OMPP finds that the CMO is in violation of this regulation, the OMPP notifies the secretary of noncompliance and determines if the agreement is to continue.

Section 4: Care Management

Overview

The State has created the *Care Select program* to improve the current *Medicaid Select* Primary Care Case Management (PCCM) and fee-for-service programs to better meet the needs of the target population. For example:

- Treatment regimens for chronic illnesses should better conform to evidence-based guidelines.
- Primary care providers should become more aware of and incorporate knowledge of functional assessments, behavioral changes, self-care strategies, and methods of addressing emotional or social distress into overall patient care.
- Care should be less fragmented and more holistic (for example, in addressing physical and behavioral health care needs and in considering both medical as well as social needs), and there should be more communication across settings and providers.
- Consumers should have greater involvement in their care management.

The State's goals for the care management program include:

- More effectively tailor benefits to the individual's and population's needs by using evidence-based medicine, best practices and practice-based evidence to manage services by duration, scope and severity
- Improve the quality of care and health outcomes for the Indiana *Care Select* Program population
- Manage the growth of health care costs for the Indiana *Care Select* Program population
- Appropriate utilization of community resources and reduced duplication of resources
- Accessible and safe home environment.
- Appropriate and accessible health care
- Increased understanding regarding medical conditions, treatments, and medications
- Reduced ER visits and avoidable hospitalizations
- More effective and ongoing health promotion and disease prevention activities
- Integration of the member and their family within the community
- Cost savings

Quality-based outcomes of care coordination include indicators such as: improved functional status, improved clinical status, enhanced quality of life, client satisfaction, adherence to the treatment plan, improved client safety, cost savings, and client autonomy.

The CMO will provide care management for its membership, under the leadership of its Medical Director. Through care management, the CMO will identify the needs and risks of its members, identify services members are currently receiving, identify members' unmet needs, stratify members into care levels, serve as a coordinator to link members to services, ensure that members receive the appropriate care in the appropriate setting by the appropriate providers, and ensure that members receive holistic health care. The CMO will provide care management services that work to maximize function and independence while also recognizing an individual's right to self-determination. More detail about these steps can be found in the following sections.

Care Management Process Steps

The CMO will develop and use a multidisciplinary team to manage the care of the complex Indiana *Care Select* population. While the care management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health care provided by multiple providers in all care settings, including the home, clinic, hospital, sub-acute and long-term care institutions, at times.

The CMO will apply systems, science, incentives and information to improve medical practice and help care management program members manage physical and behavioral health care more effectively with the goal of improving patient health status and reducing the need for expensive medical services.

The CMO will design and implement care management services that are dynamic and change as members' needs change. The CMO will address the medical psychological, functional and social domains of health care for its membership. The CMO will be responsible for linking the member to the services that will address these four domains and for coordinating care, as needed, between these services.

Care management is an umbrella term that encompasses the following four components:

- Care coordination, member/population risk assessment and stratification
- Disease management
- Utilization management
- The monitoring of case management services, which are not directly performed by the CMO

The program requirements for each of these three components are described in the following subsection, beginning with care coordination.

Care Coordination

Care coordination refers to coordination of health and other services provided to Indiana *Care Select* members. Through care coordination, the CMO will proactively assist all members to improve their health outcomes and will prioritize members who are at risk for an acute or catastrophic episode in the future and, as such, provide care coordination services as a preventive measure. The CMO will provide comprehensive care coordination services that are tailored to the individual, rely on sound medical practices, and include Medicaid-covered services.

Once a Medicaid recipient is identified as being eligible for the Indiana *Care Select* program, the State's enrollment broker and/or fiscal agent will enroll the recipient by assigning them to a PMP. Once the member is enrolled in the Indiana *Care Select* program, the CMO must assess the member's PMP assignment and health care needs and develop, implement, reassess, monitor and evaluate the member's care plan. These steps are described below.

Member Assessment

Within 30 days of being notified of the member's enrollment, the CMO will review the member's PMP assignment with the member and relevant caregivers, and assist with a PMP change if necessary. The CMO will also conduct an initial screening to identify the member's immediate physical and/or behavioral health care needs, as well as the need for care management and care coordination. The initial screening will be conducted in person, by phone or by mail. The initial screening will be followed by stratification, a detailed assessment, and ongoing care coordination and management as appropriate. These activities are summarized in the table below.

Table 4.1 – Member Assessment

	Description	Timing
Initial Assessment	• Identify immediate physical and/or behavioral health needs • Determine need for care coordination and management • Conduct comprehensive review of clinical history	Within 30 days of new member enrollment
Stratification	Perform stratification based on initial assessment and historical claims data	Immediately following initial assessment and within 60 days of assignment
Detailed Assessment	• Determine clinical, psychosocial, functional and financial needs • Gather information regarding level and type of existing care management • Review information to identify member's care strengths, needs and available resources	As needed
Care Coordination and Management	• Utilize claims data, information gathered in screenings, medical records and other sources to ensure care coordination and management • Identify gaps in members' care and communicate them to PMPs	Ongoing

During the initial screening, the CMO will review the member's claims history, identify any access or accommodation needs, language barriers, or other factors that might indicate that the member requires additional assistance. The initial screening shall also identify members who have complex or serious medical conditions that require an expedited appointment with an appropriate provider. The initial screening will ensure that members who are in ongoing treatment receive assistance in accessing appropriate care in order to avoid disruptions.

The initial assessment must include a comprehensive review of important, relevant clinical information such as the provider's assessment of condition and severity of illness, treatment history and outcomes, other diseases, illnesses and health conditions as well as the member's psychosocial, support and treatment needs. The CMO will use the Minimum Data Set for Home Care (MDS-HC) assessment suite plus any other screening tool of the CMO's choice, as long as the tool is approved by the OMPP.

The screening tool may differ for children/adolescents vs. adults. Once the State has finalized it, the CMO will use the Child and Adolescent Needs and Strength (CANS) assessment process to assess current or future behavioral health needs and strengths of children and adolescents and support an outcomes-based quality management process. The results of CANS should inform the child's treatment plan, provide level of care decision support, serve as an outcome measurement, and facilitate communication between agencies. Several pilot programs in child-service systems in Indiana have already implemented CANS. Once the State finalizes the CANS tool, the CMO will be required to adopt the assessment process.

A similar tool called the ANSA, or Adult Needs and Strength Assessment, is being developed by FSSA. The tool will be ready in July 2008, and at that time, the CMO should adopt it for assessments of adults.

Based on the results of the initial screening and mining of historical claims data, the CMO will stratify its membership into various subpopulations and initial classifications of Level 1 through Level 4 care. Before the contract's effective date, the CMO will propose to the OMPP a stratification methodology, which shall include a "rush" designation for members with immediate needs. The stratification plan must be approved by the OMPP before any stratification begins.

Based on that initial stratification, the CMO will determine a timeframe for and conduct a more detailed health needs assessment for each member in order to further identify what care management services are appropriate. The assessment will be comprehensive and identify clinical, psychosocial, functional and financial needs of the participant. The CMO will gather information about the level and type of existing care and/or case management services that the member may already be receiving, for example, through a waiver program or a CMHC. The CMO will use an assessment tool and the health needs assessment will be conducted by a care manager employed by the CMO. The CMO will collect and review medical and educational information, as well as family and caregiver input to identify the member's care strengths, health needs and available resources. A clinician on the CMO's care management team will review the findings of the health needs assessment and provide the findings to the member's PMP as well as his/her behavioral health care provider, if appropriate.

The CMO will use claims data when available, data collected during the initial screenings, the follow up health assessment, data from medical records when available, and other sources, to ensure that the care for Indiana *Care Select* members is adequately coordinated and appropriately managed. For example, through data analysis and predictive modeling, the CMO will identify members who are at the highest risk for hospitalization or relapse, or high cost and/or high utilization in the future. The CMO will also identify gaps in the member's current treatment approach, and communicate those findings to the member's PMP.

Care Plans and Levels of Care

After the initial assessment, the CMO will assign members to a care level, develop a care plan for each member, and facilitate and coordinate the holistic care of each member according to his or her needs The CMO will assist the member, the family and the PMP to develop a care plan with specific objectives, goals and action protocols to meet identified needs. The CMO will initiate and facilitate specific activities, interventions and protocols that lead to accomplishing the goals set forth in the care plan. The care plan will include, at a minimum:

- Clinical history
- Diagnosis(es)
- Functional and/or cognitive status
- Mental health status
- Level of care management (1 through 4)
- Clearly identified, member-centered, and measurable short-term goals and objectives
- Clearly identified, member-centered, and measurable long-term goals and objectives
- Key milestones toward meeting short-term and long-term goals and objectives
- Immediate service needs
- An assigned PMP

- Member self-management goals
- Use of services not covered by IHCP
- Barriers to care
- Follow-up schedule
- Family member/caregiver/facilitator resources and contact information
- Assigned case manager and/or disease manager
- Psychosocial support resources
- Local community resources
- Assessment of progress, including input from family, if appropriate
- Accommodation needs (for example, special appointment times, alternative formats) and auxiliary aids and services
- An assigned care manager

When developing the care plan, in addition to working with a multidisciplinary team of qualified health care professionals, the CMO must ensure that there is a mechanism for members and their families and advocates to be actively involved in care plan development. If a member's PMP declines to participate in the care management team, the CMO must ensure that the care management plan is provided to the member's PMP. The CMO will develop a process for reviewing and updating the care plans with members on an as-needed basis, but no less often than annually.

Services called for in the care plan will be coordinated by the CMO's care management staff, in consultation with any other case managers already assigned to a member by another entity (for instance, by a waiver program, county or a treatment facility). The CMO's care coordinators must be licensed physician assistants, registered nurses, therapists or social workers and have training, expertise and experience in providing case management and care coordination services for individuals represented in each of the subpopulations in the Indiana *Care Select* Program, including individuals with behavioral health needs and developmental disabilities. The CMO's care coordinators will work in partnership with PMPs and other caregivers to ensure that Indiana *Care Select* members' overall care is coordinated and well managed. Each member will have an assigned care manager, and each of the CMO's care managers may be assigned to multiple members.

Care plans will call for, and the CMO will use, a variety of "low touch" and "high touch" interventions and approaches –member education only, face-to-face visits, in-home visits, and telephonic outreach. Each CMO must submit a proposed care plan and indicate which interventions and approaches would be used for each case study.

Care plans shall indicate a member's current level of care (level 1 through level 4). Members may move between groups over time as their needs change, so the CMO shall develop a protocol for re-evaluating members periodically to determine if their present care levels are adequate. The care management classification system below may be modified if the CMO receives written approval from the OMPP.

Level 1 Care Management Services

Level 1 service shall be provided to all Indiana *Care Select* members. Through Level 1 services, the CMO will assist individuals in gaining access to and having a better understanding of available medical, social, educational and community services. The CMO will provide information, resources and referrals as needed to all members, their families and health care providers, as requested. Level 1 services shall include policies and procedures that encourage all new members to have a PMP visit

within 60 calendar days of the member's effective date of enrollment and ongoing member outreach as indicated for the entire population.

Level 1 services shall address each member's medical and health concerns, specific medical information, and available community resources. Level 1 service will typically result in brief, short-term encounters. The CMO will reach out to members and providers during the initial assessment period as well as on an ongoing basis, in person and through written notification where appropriate.

Level 2 Care Management Services

Level 2 care management services include all services provided under Level 1. Additionally, the CMO will provide members requiring Level 2 services with more guidance and support due to less self-efficacy, changes in status, or transitions (changes in location). Initially, until otherwise indicated by claims data or contact with the member and the member's caregivers and PMPs, the CMO will provide Level 2 services to all people with developmental disabilities enrolled in the DD waiver, on the DD waiver waiting list (and enrolled in Medicaid) or in a non-state-run ICFMR. The CMO will provide detailed needs and functional assessment of Level 2 members and approximately 12 in-person contacts per year.

The CMO will use a multi-disciplinary team (skilled in nursing, social work and mental health with knowledge of local community resources) to implement protocol-driven care modules for Level 2 members that include action steps to be followed when needs are identified. This team is responsible for the initial assessment and on-going re-assessment and evaluation of Level 2 enrollees. The CMO must evaluate all members determined to need Level 2 care management services during a home visit where the CMO can assess the member's environment and available resources.

The CMO will engage the member's PMP in care management through ongoing, direct interaction between the PMP and the multidisciplinary care management team. This involvement will include semi-annual care conferences based on the member's assessment and evaluation. The CMO will offer to travel to the PMP's office to conduct the care conference, or conduct it via teleconference, at the PMP's option.

One week prior to each care conference, the CMO will send the PMP a list of the PMP's members under care management. Each care management conference may cover only some of the members on the list and will last as long as necessary for the Care Management team to discuss the member's progress and the care management plan. The State will create care coordination codes through which PMPs may be reimbursed for their time at these care conferences. See Attachment H for the State's care coordination rates, which are based on an expectation of two one-hour care conferences per year for each Indiana *Care Select* Program member. PMP participation in care conferences will be billed to the State's fiscal agent.

Other standard protocols that the CMO will assess, plan, implement, re-assess and evaluate for members needing Level 2 services are:

- Pain
- Trouble sleeping
- Anxiety/depression
- Medications – poly-pharmacy and gaps in prescription refills
- Skin
- Bowel/bladder
- Transitions
- Health Maintenance – preventive care

- Health Maintenance – chronic disease management
- Mobility
- Nutrition
- Advance care planning
- Caregiver burden
- Oral health
- Avoiding unwanted pregnancy
- Preventing choking from inappropriate supervision with eating
- Appropriate gait evaluation and adaptive equipment use to prevent fractures

Level 3 Care Management Services

Level 3 care management services include all elements of Level 1 and Level 2 services. Additionally, the CMO will provide high levels of support to members who are determined to require Level 3 Care Management Services, defined by high risk issues such as significant deterioration in health status or ongoing lack of self-management skills due to personal issues, cognitive impairment or other mental illness, or lack of social supports, or multiple co-morbidities. The CMO will have frequent contact with Level 3 members and will involve additional expertise as needed through developmental disabilities specialists, pharmacologic experts, and other urgent management specialists. The CMO should be prepared for Level 3 members and their caregivers to have volatile healthcare needs, including a need for immediate respite, medical advice or additional home health care.

The CMO will provide care management through "curbside" consultation services that facilitate engaging PMPs, maximizing PMPs' ability to manage disease, minimizing PMP use of unnecessary referrals and reducing the need for hospitalization and ER utilization.

Level 4 Care Management Services

Members with Level 4 needs shall receive the highest level of care management provided in the Indiana *Care Select* program. Level 4 services will include all elements of Level 1, 2, and 3 care management, and will be provided to members who require the most support and, generally, are in a crisis situation where immediate additional support is needed to prevent hospitalizations, long-term care or poor outcomes. Contact with these individuals is expected to be immediate, frequent and intense.

Monitoring

Care managers must regularly and routinely consult with both the member's physical and behavioral health providers to facilitate the sharing of clinical information and the development and maintenance of a coordinated physical health and behavioral health treatment plan for the member. The CMO will gather information about the care plan's activities, interventions, and services to determine the plan's effectiveness in reaching desired goals and outcomes, and provide feedback to the primary care physician, family and others involved in the care. CMOs must explain how they will determine and communicate the plan's effectiveness to individual members and overall to the OMPP.

Reassessment and Evaluation

The CMO will reassess a member's risk factors and care level at least annually or when an indication arises such as a claim from a new provider or a report from a provider or caregiver about a change in

condition. The CMO will evaluate the overall effectiveness of each care management plan to achieve positive outcomes for families and improve the system of care for individuals in the Indiana *Care Select* program. The CMO will conduct activity at regularly scheduled team reviews with members of the multidisciplinary care management team, and shall modify care plans as necessary via feedback from protocols and other recommendations from members, families, primary care physicians and other providers. On a regular basis (at least quarterly), the CMO shall report the overall success of the care management program to the OMPP in a format that the OMPP shall approve.

The CMO must develop procedures to monitor and assess its effectiveness in delivering quality health care to its Indiana *Care Select* Program members. The CMO must submit performance data related to its quality of care management, medical necessity determinations and utilization management in a manner consistent with the OMPP reporting templates. The State reserves the right to add additional reporting requirements once the implementation roll out begins and to audit the CMO's quality of care coordination, utilization management and medical necessity determination process at anytime.

The next subsections provide case management information specific to some of the subpopulations enrolled in *Care Select.*

Care Management for Members with Behavioral Health Care Needs

The individuals in the Indiana *Care Select* program will have significant behavioral health care challenges – both mental health and substance abuse conditions. The CMO will manage the behavioral health care needs of its membership. In doing so, the CMO will:

- Provide care that addresses the needs of Indiana *Care Select* Program members in a more holistic manner
- Increase communication between the PMP, the CMO and the behavioral health care provider
- Better manage utilization of behavioral health care services

The CMO must employ or contract with care coordinators and case managers with training, expertise and experience in providing case management services for members receiving behavioral health services.

The CMO will manage behavioral health services provided to its membership through hospitals, offices, clinics, CMHCs, in homes, at school and other locations, as appropriate. A continuum of services, as indicated by the behavioral health care needs of enrollees, shall be available to members. These services must include crisis intervention services. CMOs must explain how they will provide these services during and after business hours. For instance, will the CMO operate a 24-hour behavioral health crisis line? Will it combine this line with a 24-hour nurse triage line? Will other services be available instead?

The CMO must allow members to self-refer to any behavioral health care provider in the CMO's network without a referral from the PMP or CMO authorization. In addition, members may self refer to any IHCP-enrolled psychiatrist, as set forth in the self-referral section of this manual, although the CMO should encourage its members to use psychiatrists within its provider network.

The CMO will also ensure that behavioral health crisis services are available to members within no more than a 45 minute drive of every member in rural areas, and within a 30 minute drive of members outside the rural areas. The CMO will connect members to CMHCs, as appropriate.

At a minimum, the CMO must provide care management services for any member at risk for inpatient psychiatric or substance abuse hospitalization, and for members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than 180 days following that inpatient hospitalization. Care managers must contact members during an inpatient hospitalization, or

immediately upon receiving notification of a member's inpatient behavioral health hospitalization, and must schedule an outpatient follow-up appointment to occur no later than seven days following the inpatient behavioral health hospitalization discharge.

Care management services beyond Level 1 (for example, Level 2, 3. or 4) must be provided to all members identified as having serious mental illness. The CMO will be responsible for identifying these individuals using claims data and the diagnoses of behavioral health care providers, which in turn should be based on the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), currently IV. During the early stages of the Indiana *Care Select* Program, the CMO shall develop clinical definitions and assessment tools to identify those members who are seriously mentally ill, and incorporate these tools into initial member assessments.

The CMO shall design a process to identify when a member seeks (or should seek) hospitalization or emergency treatment for behavioral health issues, including substance abuse. With the appropriate consent, case managers must notify the PMP and behavioral health providers when hospitalization or emergency behavioral health treatment occurs. Care managers must provide this notification within five days of the hospital admission or emergency treatment.

Care managers must also monitor members receiving behavioral health services to ensure that the member is expediently linked to an appropriate behavioral health provider, and that the member's access to appropriate behavioral health drugs is not interrupted. The case manager must monitor whether the member is receiving appropriate services and whether the member is at risk of over-or under-utilizing services.

Care managers must regularly and routinely consult with both the member's physical and behavioral health providers to facilitate the sharing of clinical information, and the development and maintenance of a coordinated physical health and behavioral health treatment plan for the member. The CMO will share member medical data with physical and behavioral health providers and coordinate care for all members receiving both physical and behavioral health services, to the extent permitted by law and in accordance with the member's consent. The CMO must require every provider contracted with the CMO, including behavioral health providers, to ask and encourage members to sign a consent that permits release of substance abuse treatment information to the CMO and to the PMP or behavioral health provider, if applicable.

The CMO must, on at least a quarterly basis, send a comprehensive behavioral health profile for members with behavioral health needs to the respective PMP. The behavioral health profile will list the physical and behavioral health treatment received by that member during the previous reporting period.

Information sharing is especially important for effective care coordination for members with behavioral health needs. As such, the CMO will mandate that its behavioral health care network providers notify the CMO within five days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications, etc. to the CMO and the member's PMP. Disclosure of mental health records by the provider to the CMO and to the PMP is permissible under HIPAA and State law *IC 16-39-2-6(a*) without consent of the patient because it is for treatment. However, consent from the patient is necessary for substance abuse records.

For each member receiving behavioral health treatment, the CMO will contractually require behavioral health providers (including CMHCs – see below) to document and share the following information with the CMO and PMP initially and whenever there are any changes to the following items:

- A written summary of each member's treatment plan
- Primary and secondary diagnoses
- Findings from assessments
- Medication prescribed

- Any other relevant information

The CMO will also work with behavioral health care providers to increase the rates at which individuals with serious mental illnesses are screened for chemical dependence conditions. The CMO will ensure that members discharged from inpatient hospitals for behavioral health care conditions receive a follow up visit with their behavioral health care provider within seven days of discharge.

Many of the CMO's members will receive services through the thirty-one community mental health centers (CMHCs) in the State of Indiana. The CMO will coordinate with and include in its network the CMHCs that meet its credentialing requirements and performance standards so that the CMO can better manage physical and behavioral health care, including the services being provided through these centers. The CMO will establish mechanisms to ensure that individuals seeking services through the CMHCs are also receiving the appropriate primary health care services from medical care providers.

At the time they are enrolled in Indiana *Care Select*, members may be receiving case management services through the CMHCs. As such, the CMO will work with the member and CMHC to determine where and how the member should continue to receive case management services. For example, the CMO may allow the member or the member's PMP to decide whether the member will receive care coordination and case management services from the CMO, from the CMHC, or both. In all cases, the CMHC and CMO should work closely together to ensure the member receives appropriate services that are not duplicated.

Through the fiscal agent, the CMO will have access to detailed claims data through Business Objects for services provided to members through CMHCs. The CMO will use this data to assess and compare services being rendered among CMHCs and will provide this information to the CMHCs.

The CMO will work with CMHCs and other behavioral health care providers and members to use evidence-based guidelines that will help members work towards recovery.

Care Management for the Developmentally Disabled

Medicaid members on a developmental disability waiver will be included in the *Care Select* program. In providing care management services for individuals with developmental disabilities, the CMO will address the framework illustrated in the figure below, which was developed by the World Health Organization. This framework encompasses the complexity of health conditions and contextual factors on healthy "functioning" (bodily functions, activities and participation) rather than on disability. This new framework shifts the focus beyond the historical model of pathology and limitations to achieving optimal functioning as a goal for everyone. In addition, this model recognizes the important tenets of family-centered, community-based care and planned care.

The CMO will empower individuals with developmental disabilities to reach their optimum level of wellness, self-management and functional capability by:

- **Prevention and/or early treatment of secondary conditions** – For example, decubiti in people with cerebral palsy or urinary tract infections in people with spina bifida.
- **Decreasing preventable chronic conditions** – For example, adults with disabilities are at increased risk to have inadequate emotional support and to lack regular physical activity. They remain at the same or greater risk as the general population to be overweight or obese and also to use tobacco. They are at increased risk of cardiovascular disease, arthritis and chronic pain.
- **Improving clinical preventive services** – For example, adults and children with disabilities are at increased risk to lack routine dental care and women's health preventive services. People with disabilities often require additional preventive or guideline recommended screenings and services (for example, thyroid screening for individuals with Down Syndrome or flu shots for individuals with chronicobstructive pulmonary disease).

- **Planning beyond the physical needs of the person with disabilities to improve health and quality of life** – For example, functioning, activities and participation in work and school. People with disabilities not only need education about their conditions, but also *activities* to acquire life skills to manage their own care and opportunities to *participate* in their communities to foster healthy physical, mental and social lifestyles.

In many cases, developmentally disabled members will be receiving these services from the waiver provider. However, the CMO will monitor and coordinate this care and provide care management services to individuals with developmental disabilities through four levels of services.

The State recognizes concerns from members, providers and advocates regarding avoiding redundancy in case management services, especially for members with developmental disabilities. As such, for persons with developmental disabilities, the CMO will use the results of its initial screening to make a determination about the type of care management the developmentally disabled member should receive and will share this information with all necessary providers and case managers. If appropriate, the CMO may recommend that the member continue to work with his existing waiver providers, and not directly with the CMO. However, the CMO will monitor all members' care and periodically reassess the care plans.

Care Management for Members in Other Waiver Programs

The State of Indiana currently has seven waiver programs with approximately 13,000 total waiver recipients. The State is in the process of evaluating its waiver programs and considering options for restructuring its waivers. As such, the State expects the CMO to work cooperatively with the State and its waiver programs as these programs continue to be assessed, revised and possibly restructured.

Regardless, waiver recipients will be enrolled in the Indiana *Care Select* Program. Many of these recipients are already receiving case management services through their waiver program. As such, the CMO will be responsible for managing the non-waiver services provided through the State plan and eliminating duplication of services between the Indiana *Care Select* Program and the waiver programs.

Waiver case managers are typically social workers and are primarily responsible for brokering in-home services and developing a plan of care for waiver services. Waiver case managers also monitor the waiver service plan and review and revise the plan as appropriate. For members who already receive case management services through a waiver program, the member's waiver program case manager will continue to provide case management services for the member. In this case, the CMO's role will be one of assessment and care coordination, or care management at the level indicated.

When the Indiana *Care Select* Program member is also receiving case management services through a waiver program, the CMO and member will assess whether or not waiver case management services are sufficiently meeting the member's needs. If not, the CMO may also provide care management services (for example, for more clinically focused services). The CMO will also serve as a link between the waiver program and the member's health care providers to ensure that members are receiving holistic and coordinated health care services.

In addition to a waiver program for the developmentally disabled, the State has a waiver for the aging population that is primarily administered through 16 Area Agencies on Aging (AAAs) located throughout the State. The AAAs conduct assessments to determine whether an individual should be admitted to a long-term nursing facility, but as the Indiana *Care Select* Program is implemented, the CMO will take on this responsibility.

The CMO will work closely with the AAAs in several areas, and as such, will establish business agreements which must include HIPAA compliance language, with each of the 16 AAAs. The CMO will work with the AAAs to ensure that each individual is placed in an appropriate care setting –

whether a long-term nursing home or a community setting – and, if the latter, that the appropriate resources are available to support the member.

The CMO will be required to work with and coordinate efforts, as necessary, with Indiana OPTIONS. IndianaOPTIONS is implemented through FSSA's Division of Aging with direct services delivered through the Area Agencies on Aging. For more information about IndianaOPTIONS, please refer to http://www.LTCOPTIONS.in.gov.

The AAAs also provide case management to waiver participants. Again, the CMO will not duplicate services already being provided to its members who are in waiver programs. Instead, the CMO will work closely with AAAs to ensure that the various health care and waiver providers serving the member are sharing needed information about the member's physical and behavioral health care needs, available resources, care plan, and so forth.

The CMO will also serve as a resource to the AAAs and provide information about the medical needs of waiver recipients as well as the medical services being rendered to waiver participants. The CMO will develop a mechanism or process to keep all waiver recipients' medical care providers informed of the various waiver services the recipients receive, and the purpose of those services.

Section 5: Disease Management Call Center

Program Overview

The second component of the care management program is the disease management call center, an integral part of the Indiana Chronic Disease Management Program (ICDMP). The CMO will provide disease management services that are population-based and target specific disease states via telephonic interventions as designed by the OMPP under legislative mandate, *IC 12-15-12-19*.

As part of the initial member assessment, the CMO shall determine whether an Indiana *Care Select* Program member meets the specifications for inclusion in the ICDMP, a legislatively mandated and defined program.

The CMO will be required to incorporate and maintain the ICDMP call center structure, policies and procedures. At a minimum, the CMO will retain the following characteristics of the current ICDMP program:

- Working with the State to link the Indiana Care Select Program with the ICDMP
- Meeting with the OMPP at least twice monthly for purposes of reporting and monitoring of the disease management program
- Maintaining a ICDMP call center
- Using ICDMP selection and stratification models as provided by the State
- Using ICDMP call scripts as provided by the State
- Using ICDMP educational materials as provided by the State

The CMO's staffing responsibility will be to assign sufficient and knowledgeable staff capable of contacting members who are newly assigned to the ICDMP and educating members about the program. This may require several attempts and multiple outgoing calls per member.

The State will contract with the Regenstrief Institute or a similar organization to complete an annual evaluation of the program. The CMO contractor will be required to provide information and work with the Regenstrief Institute in accordance with evaluation methodologies. Please visit www.indianacdmprogram.com for more information.

The CMO must maintain the following disease management programs:

- Diabetes
- Pediatric asthma
- Congestive heart failure (CHF)
- Cardiovascular disease (CVD)
- The co-morbidity of diabetes and hypertension
- The co-morbidities and/or combinations of any of these disease states

All Indiana *Care Select* members shall be eligible for these disease management programs, and the CMO must report at least quarterly to the OMPP regarding the monitoring, work load, efficacy and other performance-based measures for the call center disease management programs. The reporting format shall be approved by the OMPP. In addition, the OMPP reserves the right to require the CMO to assist in the development of disease management programs for additional conditions, such as chronic obstructive pulmonary disease, or others, in the future. The OMPP will provide three months'

advance notice to the CMO if the OMPP decides to add new diseases to the disease management program requirements. As the ICDMP is a legislative mandate, other disease states may also be guided by changes in legislation.

If the CMO chooses to enhance or provide disease management programs in addition to the aforementioned disease states, the CMO may recommend such changes to the OMPP through the following steps:

- Substantiate the reasons for initiating such programs
- Secure the OMPP's approval for implementing the disease management program(s)
- Partner with the OMPP to develop the overall package of the disease management program
- Provide quarterly updates documenting the efficacy and results of those additional disease management programs

Any additional educational materials, changes to the call scripts, or other modifications to any aspect of the ICDMP shall be approved by the OMPP before being implemented to members. The OMPP maintains the overall program administration for the ICDMP; and, thus, shall maintain the ability to modify the program and approve or deny the CMO's recommendations.

General Requirements for the ICDMP Call Center

The CMOs shall:

1. Obtain and maintain the current Indiana Chronic Disease Management (ICDMP) toll free number to:

a) a) Serve as an information line, receiving in-bound calls from members, providers, and Nurse Care Managers.

b) b) Serve as message center for members and care coordinators.

The ICDMP has a 1-866 number that will be transferred to the CMO vendor for the ICDMP call center. All members in the ICDMP have access to the number. The ICDMP call center serves to take incoming calls for members and transfer any messages to the ICDMP administration of other ICDMP contractors. The Chronic Disease Management System (CDMS) system also has a component which allows call center staff to send internet messages to the nurse care management personnel.

2. Interact with members

a) Via inbound calls from members, answer questions, provide information about the program, assist in communication between members and their Nurse Care Managers.

b) Via outbound calls to members, according to daily task lists provided by the CDMS program tool or a tool designed by the CMO, conduct assessments of program members utilizing the screening survey provided in the CDMS tool.

c) Assist members in care coordination based on results of the assessment and other relevant information.

3. Interact with doctor's offices to request medical records via inbound or outbound calls and send/receive member updates.

4. Interact with ICDMP Nurse Care Managers to:

a) Coordinate and communicate, as needed.

b) Support Nurse Care Managers by making outbound calls, as needed.

5. Train call center staff in the use of the CDMS computer software tool and appropriate interaction with members of the ICDMP.
6. Enter data in the CDMS Program tool or CMO designed tool in real time.
7. Maintain call center performance.
8. Maintain qualified call center staff sufficient to manage the expected call volume.
9. Maintain the appropriate number of call center supervisors.
10. Have a registered nurse available to handle medical-related questions from members and doctor's offices.
11. Prepare and deliver to the OMPP monthly monitoring reports, as directed by the OMPP, by the fifteenth of every month for the previous month's activities.
12. Coordinate activities with ICDMP care management partners.
13. Meet bi-weekly with the OMPP, or as requested by the OMPP.

Software and Data Requirements for the ICDMP Call Center

The CMO can:

1. Obtain needed access to the CDMS computer software tool. The CDMS server is hosted and maintained by the State. The CDMS system was purchased and is maintained by the State. CDMS users do not need a license, but a completed user agreement and internet access is needed to access the system.
2. Have appropriate and sufficient information technology staff trained and dedicated to support the CDMS software program, and to serve as the level one help desk for Nurse Care Managers (NCMs), providers, and others.
3. Coordinate with ICDMP evaluation contractor regarding software and system compatibility.
4. Accept data transfers from EDS and the Regenstrief Institute.
5. Produce monthly monitoring reports of enrollments, call center statistics and performance standards.
6. Provide Internet capability to ICDMP call center representatives in order to validate information, such as Medicaid enrollment status and current phone number and or address.

Physician and Member Outreach

The CMO shall develop and distribute to members written materials to provide information about the ICDMP services:

- Upon a member's agreement to participate in the ICDMP,
- Upon request by a member, provider or Nurse Care Manager, or
- Upon request of the OMPP

The CMO shall outreach to IHCP physicians via site visits and mailings to inform them about the ICDMP and encourage their participation.

ICDMP Help Desk Requirements

The CMO shall:

1. Maintain help desk staff appropriate to the requirements of this paragraph, trained specifically on CDMS, its technical functions, Indiana-specific program features and data conventions
2. Receive and log all help desk calls for assistance in the use of CDMS from the ICDMP Nurse Care Manager Network
3. Perform and document preliminary diagnosis of the reported problem
4. Provide assistance to the Nurse Care Managers for issues related to CDMS application software and data relationships, and Indiana-specific program features and data conventions (for example, Level 1)
5. Escalate calls requiring more technical expertise or advanced application knowledge in the following ways or as directed by the State (for example, Level 2)

a) Refer connectivity issues to the DoIT Help Desk.

b) For urgent/emergent calls requiring Level 2 assistance, the Contractor may page the appropriate Level 2 Help Desk staff, if necessary.

c) Refer problems related to the Nurse Care Manager's internal system back to the Nurse Care Manager's technology staff.

d) Refer all other calls to the ISDH Help Desk.

6. Help Desk Performance Measures:

a) Level 1 assistance must be provided within 4 business hours of the call.

b) The Contractor shall provide the OMPP with CDMS Help Desk reports, as defined by the 15th of each month for the previous month.

Section 6: Care Select Services

Covered Services in Care Select

Services covered by CMOs and reimbursed by fee-for-service payments for members enrolled in CMO health plans must be furnished in an amount, duration, and scope that is no less than those IHCP-covered services detailed in *405 IAC 5*, in accordance with *42 CFR 438.210*. Detailed explanations of Medicaid-covered services and limitations are cited in *405 IAC 5*, CHIP (Package C) in *407 IAC 3*.

The following lists broad categories of services provided by the CMO network in a CMO arrangement with the OMPP:

- Physician services
  - Primary care services
  - Preventive health services (including vaccinations added to the periodicity schedule but not yet available through the Vaccines for Children program)
  - Therapeutic and rehabilitative services
  - Specialty care services
- Hospital services
  - Inpatient care
  - Outpatient services
  - Therapy services
  - Laboratory and X-ray services
  - Diagnostic studies
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
  - Initial and periodic screenings
  - Diagnosis and treatment
- Home health services
  - Physical, occupational, and respiratory therapy
  - Speech pathology
  - Renal dialysis
- Pharmacy services
  - Legend drugs
  - Non-legend drugs (selected over-the-counter drugs) as identified in the OMPP over-the-counter formulary
  - Insulin, nutritional and food supplements, and infant formulas
- Medical supplies and equipment
  - Medical supplies and durable medical equipment
  - Braces and orthopedic shoes
  - Prosthetic devices
  - Hearing aids
- Transportation services
  - Emergency transportation
  - Non-emergency transportation
  - Transportation to and from services provided by the CMO
  - Transportation to and from services excluded from CMO capitation but covered by IHCP under fee-for-service (FFS), otherwise known as carved out services
- Dental Services

- Diabetes self management services
- Pregnancy care coordination
- Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) targeted case management services
- Smoking cessation services
- Behavioral health services, such as mental health, substance abuse, and chemical dependency services
- Special provisions for specific types of service, coverage and payment policies apply to some services and providers, include the following; and are discussed later in this section
  - Emergency services
  - Out-of-plan services
  - Out-of-area services
  - Self-referral services
  - FQHC and RHC services
  - Hospital extended stay for children investigated by protective services
  - Services related to carved out services
  - Short term placements in long-term care facilities
  - Continuity of care
  - Women, Infants, and Children program (WIC) infant formula

Emergency Services and Post-Stabilization Care Services

CMOs are responsible for providing 24-hour emergency care for *Care Select* members. The CMO must allow enrollees to obtain emergency services outside the CMO health plan regardless of whether the CMO referred the enrollee to the provider that furnished the services.

CMOs must allow emergency services without requiring authorization for such services, in accordance with the federal *Balanced Budget Act of 1997* (*BBA*), Medicaid Managed Care rules (*42 CFR Part 438*), and *House Enrolled Act 1872* (*IC 12-15-12*). CMOs and the fiscal agent are responsible for covering and reimbursing emergency services, including medically necessary screening services provided to members who present themselves to an emergency department with an emergency medical condition.

The criteria used to define an emergency medical condition must be consistent with the prudent layperson standard and in compliance with all applicable state and federal requirements. CMOs can approve coverage on the basis of a code such as an International Classification of Diseases, 9th Revision, and Clinical Modification (ICD-9-CM) code. However, payment for emergency services cannot be denied only on the basis of codes. The determination of whether the prudent layperson standard is met is made on a case-by-case basis.

In accordance with *42 CFR 438.114* and *IC 12-15-12*., the CMO may not determine what constitutes an emergency on the basis of lists of diagnosis codes or symptoms. The CMO may not deny payment for treatment obtained when an enrollee had an emergency medical condition, even if the outcome, in absence of immediate medical attention, would not have been those specified in the definition of an emergency medical condition.

The IC definition is: As used in this chapter, "emergency medical condition" means a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent lay person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of:

a) The individual; or

b) In the case of a pregnant woman, the woman or her unborn child;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Emergency services must be available 24- hours a day, seven days a week subject to the "prudent layperson" standard of an emergency medical condition, as defined in *42 CFR 438.114* and *IC 12-15-12*.

CMOs are responsible for post-stabilization care services for their members under the following conditions:

1. The services are pre-approved by a representative of the member's CMO;
2. The services are not pre-approved but are administered to maintain the enrollee's stabilized condition within one hour of a request for pre-approval of further post-stabilization care services; or
3. The services are not pre-approved but are administered to maintain, improve, or resolve the enrollee's stabilized condition if any of the following occur:

a) The CMO representative does not respond to a request for pre-approval within one hour

b) The CMO representative cannot be contacted

c) The CMO representative and the treating physician cannot reach an agreement concerning the enrollee's care, and a physician representing the CMO is not available for consultation.

If the situation described in 3.c above exists, the CMO provides the member's treating physician an opportunity to consult a physician representing the CMO. The treating physician may continue to care for the member until a physician representing the CMO is reached or until one of the following criteria is met:

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
- A plan physician assumes responsibility for the member's care through transfer.
- The CMO and treating physician reach an agreement concerning the member's care.
- The member is discharged.

Out-of-State Services

The fiscal agent will pay for services rendered by out of state providers, such as urgent or emergent care while a member is traveling outside Indiana. The fiscal agent will reimburse these services, even without authorization from the CMO.

Out-of-Network Services

The CMO will educate its members about the benefits of using in-network providers, such as enhanced care coordination. When building its network, the CMO should advise PMPs that the State's fiscal agent will pay claims for all authorized, routine care provided to its members by out-of-network providers. The fiscal agent will reimburse any out-of-network provider's claim for authorized services provided to *Care Select* Program members at the lesser of the following:

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

- The established IHCP reimbursement rates that exist for participating IHCP providers at the time the service was rendered.

In accordance with *42 CFR 438.206(b)(4)*, the CMO, in its role of approving PA requests, must authorize (and the fiscal agent must reimburse) out-of-network care if the CMO's provider network is unable to provide necessary medical services to a particular member. Emergency care does not require PA, but claims for these services will be suspended for medical review. The CMO must authorize all services in a timely manner. The State's fiscal agent will make all emergency room claims data available to the CMO. The CMO is responsible for incorporating the ER claims into its care management plans for members, including outreach to members about appropriate ER use, informing PMPs and behavioral health providers of emergency visits.

Self-Referral Services

Federal and state regulations allow members access to certain services outside the health plan in which they are enrolled without a referral. *Care Select* members can receive self-referral services from any IHCP-enrolled provider qualified to provide the service, whether or not the provider belongs to the same health plan as the member. The following self-referral services do not require a referral from the member's PMP or authorization from the CMO:

- Members may access **emergency services** as defined in the *42 CFR 438* and *IC 12-15-12* on a self-referral basis as described under *Emergency Services* in this section. To be reimbursed by *Care Select*, the facility must be enrolled in the IHCP.
- Members may access dental services from any IHCP enrolled dental provider qualified to render the service.
- Members may access pharmacy services from any IHCP enrolled pharmacy provider.
- Members may access **family planning services** from any IHCP-enrolled provider qualified to render the service. Family planning services under Federal regulation *42 CFR 431.51(b)(2)* require a freedom of choice of providers and access to family planning services and supplies. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy including, but not limited to, birth control pills. Indiana *Care Select* Program members may not be restricted in choice of a family planning service provider. Family planning services are defined by procedure and diagnosis code combinations detailed in a supplement to the *IHCP Provider Manual.*

  The CMO must allow its members to obtain birth control pills and other family planning services and supplies on a self-referral basis. The OMPP recognizes the need for appropriate management of prescription medication in the interest of the member's health; however, the OMPP also recognizes the importance of removing barriers to family planning services. To reduce potential barriers to obtaining birth control pills and other family planning products, the State's PBM will, at a minimum, ensure that members can access to up to a 90 calendar day supply of birth control pills and other family planning products at one time per member, if prescribed. The CMO shall defer to this PBM requirement when coordinating with the PBM for pharmacy utilization management.
- **Chiropractic services** are IHCP-covered services rendered by a IHCP provider enrolled with a specialty 150 (chiropractor) and practicing within the scope of the chiropractic license as defined in *IC 25-10-1-1* and *846 IAC 1-1*.
- **Podiatric services** are IHCP-covered services rendered by a IHCP provider enrolled with a specialty 140 (podiatrist) and practicing within the scope the medical license as defined in *IC 25-22.5* (Doctor of Medicine or Doctor of Osteopathy) or *IC 25-29* (Doctor of Podiatric Medicine).
- **Psychiatric services** are IHCP-covered services rendered by a provider enrolled with a specialty 339 (psychiatrist) and practicing within the scope of the medical license as defined in *IC 25-22.5*.

- **Behavioral Health Services**, such as mental health, substance abuse, and chemical dependency services are included in the *Care Select* program. The CMO mental health providers to which the member may self-refer within the health plan are:
  - Outpatient mental health clinics
  - Community mental health clinics
  - Psychiatrists
  - Psychologists
  - Certified psychologists
  - Health services providers in psychology
  - 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

  As stated in *405 IAC 5-20-8*, reimbursement is available to the physician or health services provider in psychology (HSPP)-directed outpatient mental health services for group, family, and individual psychotherapy when services are provided by one of the following mid-level practitioners.
  - Academy of Certified Social Workers (ACSW)
  - Certified Clinical Social Worker (CCSW)
  - Advanced practice nurses under *IC 25-23-1-1(b)(3),* credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
  - Certified psychologist
  - Licensed Clinical Social Worker (LCSW)
  - Licensed independent practice school psychologists
  - Licensed mental health counselor
  - Licensed marriage and family therapist
  - Licensed psychiatric and mental health clinical nurse specialist
  - Psychologist with a basic certificate
  - A person holding a master's degree in social work, marital and family therapy, or mental health counseling.
  - RN with a master's degree in nursing with a major in psychiatric and mental health nursing from an accredited school of nursing

  These mid-level practitioners may not be separately enrolled as individual providers to receive direct reimbursement. Mid-level practitioners can be employed by an outpatient mental health facility, clinic, physician, or HSPP enrolled in the IHCP. Reimbursement is available for services provided by mid-level practitioners in an outpatient mental health facility when services are supervised by a physician or HSPP. Services rendered by mid-level practitioners must be billed using the rendering provider number of the supervising practitioner and the billing provider number of the outpatient mental health clinic or facility. Please see the *IHCP Provider Manual* for additional information about the claim billing policy for mid-level practitioners.

- CMO members can seek most **vision care services** on a self-referral basis from IHCP providers enrolled with vision care specialties 180 (optometrist), 190 (optician), or 330 (ophthalmologist) and practicing within the scope of their licenses. The following ranges of Current Procedural Terminology (CPT®) codes define vision-related surgeries:
  - 65091-65114 – Removal of eye and related procedures
  - 65125-65175 – Ocular implants and related procedures
  - 65205-65265 – Removal of foreign body from eye (unless billed with an emergency diagnosis code)
  - 65270-65290 – Repair of laceration and related procedures

  - 65400-66999 – Procedures on anterior segment including cornea, anterior chamber, anterior sclera, iris, lens, and cataract removal
  - 67005-67299 – Procedures on posterior segment including vitreous, retina, sclera
  - 67311-37999 – Procedures on ocular adnexa including orbit, eyelids, brow, and related procedures
  - 68020-68899 – Conjunctiva and related procedures

- **HIV/AIDS targeted case management services** are limited to no more than 60 hours per quarter.
- **HIV/AIDS Care Coordination** services are billed using the primary diagnosis code 042 – HIV/AIDS and the national Healthcare Common Procedure Code System (HCPCS) procedure code G9012. The CMO is expected to work with the HIV/AIDS care coordinator to avoid duplication of services with any case management services provided by the CMO. HIV/AIDS care coordination claims are not subject to care management edits; therefore, there is no requirement for a PMP's certification code and provider number on the paper *CMS-1500* claim form or the 837P transaction. Additional information about this waiver program, authorized by *42 USC 1396n(g)* and administered by the Indiana State Department of Health (ISDH), is located in the *IHCP Provider Manual*.

  HIV and AIDS care coordination is a specialized form of case management for members with HIV infection. Care coordination consists of goal-oriented activities that locate or create, facilitate access to, coordinate, and monitor the full range of HIV-related health and human services. The purpose is to encourage the cost-effective use of medical and community resources and to promote the well being of the individual while assuring the individual's freedom of choice. To assure freedom of choice, the individual signs a *Freedom of Choice/Intent to Participate Form* acknowledging an understanding of the services provided and identifying the chosen care coordination provider. Care coordination services are those that assist Medicaid-eligible people in the targeted group to access needed medical, psychological, social, educational, and other services.
- **Diabetes Self-Management Training Services** are available to *Care Select* members on a self-referral basis from any chiropractor, podiatrist, optometrist, or psychiatrist who has had specialized training in the management of diabetes.

  The CMO must include diabetes self-management services when the member obtains the services from IHCP self-referral providers. However, *IC 27-8-14.5-6* also provides that claims for diabetes self-management may be reimbursed when member seeks diabetes self-management services from providers other than providers designated as IHCP self-referral providers. The statute also recognizes that eye care and podiatry, which may include diabetes self-management services, are self-referral services. The CMO shall ensure that any members identified as seeking diabetes self-management services obtain adequate diabetes care. The CMO must not restrict members to any IHCP-eligible diabetes self-management providers. Specific information about this benefit is provided in Indiana Medicaid Update *E98-05* and *405 IAC 5-36*

- **Immunizations** are self-referral to any IHCP-enrolled provider. Immunizations are covered regardless of where they are received. For example, members may receive immunizations at county health departments, and the health department may bill the fiscal agent for the immunization administration fee.

The following ancillary services are allowed as self referral and do not require *Care Select* PMP referral:

> *Note, A complete list of provider types and specialties, including descriptions and enrollment criteria is listed in Chapter 4 of the IHCP Provider Manual.*

- Emergency Services as indicated by the primary diagnosis code on the claim
- Lab – provider specialties 280 and 281

- Radiology – provider specialties 290 and 291
- Anesthesia – provider specialty 311
- Transportation – provider specialties 260 through 266
- Durable Medical Equipment (DME) and Home Medical Equipment (HME) providers
- Home health services – provider specialty 050

The following outpatient therapy services:

- Physical – provider specialty 170
- Occupational – provider specialty 171
- Respiratory – provider specialty 172
- Speech – provider specialty 173

The following Provider Type and IHCP Programs are also considered self referral services:

- School Corporations
- First Steps
- Medical Review Team (MRT)
- Pre-Admission Screening/Resident Review (PASRR)

Note	*Although the two-digit PMP certification code is not required for the non-emergency outpatient hospital services, the eight-digit PMP license number is required for claim reimbursement. These services include outpatient non-emergency ER visits, as well as radiology, pathology, and laboratory, when performed in an outpatient hospital setting. The PMP license number should be provided on the UB-04 claim form when submitting claims for such services on behalf of Indiana Care Select Providers. Details regarding completion of the UB-04 claim form can be found in Chapter 8 of the IHCP Provider Manual.*

Services Related to Self-Referral Services

The CMO must include self-referral providers in its health plan. The CMO and PMPs will encourage members to seek the services of the self-referral providers contracted in the CMO's health plan, but the CMO cannot require that the members receive such services from health plan providers. When members choose to receive self-referred services from IHCP enrolled self-referral providers who are not part of the CMO's health plan, the fiscal agent will still be responsible for payment to these providers up to the applicable benefit limits and at Medicaid rates. Members may not self-refer to a provider who is not enrolled in IHCP.

The CMO will have access to self-referral claims information, and should incorporate information about the use of these services into the care management program analysis and member assessments.

Federally Qualified Health Centers and Rural Health Clinics

CMO contracts on behalf of the State with the federally qualified health centers (FQHCs) and rural health clinics (RHCs) to ensure that FQHCs and RHCs are reimbursed for services at a rate comparable to other providers and sufficient enough to operate economically viable and efficient facilities.

The OMPP provides a supplemental payment, at least quarterly, to the FQHC or RHC to bring reimbursement up to 100 percent of reasonable costs based on data provided by the FQHC or RHC. To calculate the supplemental payment, the amount paid by the fiscal agent directly to the FQHC or RHC for services provided to CMO members is subtracted from 100 percent of their reasonable costs.

Annually, the fiscal agent must submit to the OMPP the amount paid to each FQHC or RHC for services provided to CMO members, so that the OMPP can perform the annual reconciliation. The results of the reconciliation determines whether additional payments are made to the clinic or if recoupment is needed.

The CMO must identify for the State all the financial incentives offered to the FQHC. All incentives accrued during the contract period relating to the cost of providing FQHC-covered or RHC-covered services to CMO members must be included along with any FFS in the determination of the amount of direct reimbursement paid by the CMO to the FQHC or RHC. Specifics about the FQHC and RHC reports are in the *CMO Reporting Manual.*

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

Indiana's EPSDT program is called HealthWatch and it includes all IHCP-covered preventive, diagnostic and treatment services, as well as other prior-authorized treatment services that the EPSDT screening provider determines to be medically necessary. Through HealthWatch, the CMO will ensure that children enrolled in Indiana *Care Select* Program receive age-appropriate comprehensive, preventive services. (See the *IHCP HealthWatch EPSDT Provider Manual* for details regarding components and recommended frequency of HealthWatch screenings.)

The CMO will work with pre-natal clinics and other providers to educate pregnant women about the importance of EPSDT screenings and encourage them to schedule preventive visits for their infants. The CMO's care management staff will ensure that all children in Indiana *Care Select* Program between nine months and six years of age are tested for lead poisoning.

The CMO will ensure that children with elevated lead levels are identified, their PMPs are notified, and they receive the recommended follow-up treatment.

Transportation Services

The CMO will be responsible for arranging transportation services for its membership. The CMO will ensure that transportation services are provided through Indiana *Care Select* Program in the appropriate amount, duration and scope. At present, the State does not use a transportation broker, so the CMO will be responsible for developing and maintaining a transportation provider network and authorizing services; however, the State may decide to implement a transportation broker program over the course of its contract with CMO. In this case, the CMO will no longer be responsible for maintaining a transportation provider network. Transportation vendors will continue to submit claims to the State's fiscal agent. However, the CMO will work with any transportation broker(s) to ensure that Indiana *Care Select* members have access to transportation services.

The CMO will coordinate these services with transportation services that may be provided through waiver providers to ensure that transportation services are not duplicated or billed to the wrong program.

Pharmacy Services

The State's Pharmacy Benefit Manager (PBM) will administer the pharmacy benefit (including conducting prior authorization and entering those decisions directly into Indiana*AIM*) and the State's

fiscal agent pay pharmacy claims. The State's preferred drug list (PDL) is utilized for Indiana *Care Select* Program members. The CMO will receive the PBM's data and/or analysis about the Indiana *Care Select* population's use or appropriateness for the restricted card program (which controls access to certain pharmaceuticals by individuals with abnormal use patterns) and coordinate with the PBM as necessary to identify the appropriate PMP, hospital, and pharmacy to which a *Care Select* member should be restricted. At a minimum, information about a member's restricted card status shall be incorporated into the CMO's care plans.

The CMO will monitor pharmacy claims, provide input regarding suggested changes and improvements to the pharmacy PDL and/or policies and procedures to the State, and the State, in turn, may present that input to the Therapy Committee and the DUR Board.

The CMO will be expected to generate savings from pharmacy services by accessing and analyzing pharmacy claims data. Using these data, the CMO will coordinate with the State's PBM to reduce pharmacy costs through various strategies, such as examining and increasing the dispensing rate of generic medications or encouraging its provider network to prescribe a generic medication within a class before automatically prescribing a brand drug. The CMO will also utilize pharmacy data to ensure that members are refilling drugs appropriately and provide outreach to members that are not in compliance. The CMO should target specific populations, such as members with mental health issues and with specific disease states. The CMO will manage this benefit through monitoring actual pharmacy utilization, member compliance with taking prescribed medications, and assisting members with medication management.

IHCP-Covered Services Excluded from Care Select

Broad categories of service, covered by the IHCP but excluded from *Care Select*, are payable as FFS claims by the fiscal agent. If a care management member becomes eligible for any of these services the member is disenrolled from care management. Services excluded from care management include:

- Long-term institutional care
- Hospice care
- Psychiatric treatment in a State hospital
- Dual Eligibles

CMO members who qualify for long-term institutional care, hospice care, or waiver services are disenrolled from their *Care Select* care management plan according to the member disenrollment criteria outlined in *Section 9: Member Eligibility and Enrollment*. CMOs must note that it is possible for a member's Indiana Pre-Admission Screening/Pre-Admission Screening and Resident Review (IPAS/PASRR) process to be under way (but not yet complete) when the member is linked to a CMO.

Short-Term Placements in Long-Term Care Facilities

A CMO may allow its enrolled members to receive services in a nursing or long-term-care (LTC) facility on a short-term basis (no more than 30 days) if this setting is more cost-effective than other options and if the member can obtain the care and services needed.

If the short-term stay is extended beyond 30 days, the screening must be completed within 25 days after the end of the short-term stay (except as specified for Pre-Admission Screening and Resident Review cases). A member approved for long-term nursing facility placement is disenrolled from the *Care Select* care management plan and converted to FFS eligibility in the IHCP at the time the appropriate level of care (LOC) information is entered in Indiana*AIM*. The CMO plays a critical role in

monitoring its members who are receiving care in a nursing facility and helping coordinate the transition to long-term care. See information about pending LOC in this section.

An important responsibility of the nursing facility is to complete the *Physician Certification of Long Term Care Service, Form 450B,* indicating that the member has entered the nursing facility..

Continuity of Care

The Indiana *Care Select* Program is committed to providing continuity of care for members as they transition among various IHCP programs such as fee-for-service and Hoosier Healthwise. CMOs may receive member enrollments, through member selection or auto-assignment, for patients who have ongoing medical care provided by hospitals, specialists, or ancillary providers. The CMO must have mechanisms in place to ensure the continuity of care and coordination of medically necessary health care services for its Indiana *Care Select* Program members.

For members newly enrolled with the CMO, the CMO must ensure that an ongoing course of treatment is not interrupted or delayed due to the change to new providers, and that medical record information is transferred to new providers within 20 business days of the CMO's request. If the new member's previous provider decides not to participate in *Care Select*, the CMO must work with the non-network providers to facilitate the transfer of medical record information to the member's new Indiana *Care Select* provider. The CMO will respect services that have already been authorized by the State or its PA vendor for up to 30 days after the member is enrolled in the Indiana *Care Select* program

Some examples of the need for special consideration include, but are not limited to, the following:

- Transitions from the current Medicaid Select program to the *Care Select* program
- Transitions from fee-for-service to *Care Select*
- Members who are hospitalized on the effective date of *Care Select*
- Members who have a prior authorization issued by another *Care Select* health plan that is still open on the effective date with the new *Care Select* health plan
- Transitions for members who become dual eligible for Medicare and IHCP
- Members undergoing the Indiana Pre-Admission Screening/Pre-Admission Screening and Resident Review (IPAS/PASRR) process for long-term care placement
- Members who are receiving behavioral health services, especially for those members who have received prior authorization for behavioral health drugs from their previous CMO or through fee-for-service.
- The CMO arranges for covered services provided to newborn children of CMO members from the newborn's date of birth. EDS cannot control when newborn eligibility is transmitted from the State's eligibility system, Indiana Client Eligibility System (ICES), to Indiana*AIM*. There may be delays of several weeks to several months before EDS can send newborn eligibility to CMOs due to delays in transmissions from ICES to Indiana*AIM*. Therefore, CMOs must be aware of pregnant mothers enrolled in their health plan.
- Hospital transfers, if the member has changed health plans during an inpatient stay, is treated as a new admission.
- Transitions and explanations of benefit changes for members recently disenrolled from the Indiana *Care Select* Program

One of the CMO's last interactions with disenrolled members should be communicating basic information about the member's new health care options, including where to go for more information

In situations such as PMP disenrollment, the CMO must facilitate continuity of care with other PMPs. When receiving members from Hoosier Healthwise or another IHCP program or private health plan, the CMO must honor previous PAs for a minimum of 30 calendar days.

The CMO will be responsible for ensuring a smooth transition after the member has been disenrolled from the Indiana *Care Select* Program whenever the member disenrollment occurs during an inpatient stay. The CMO must coordinate discharge plans with the member's new medical provider if known.

The State aims to ensure that no member is discharged from inpatient services and admitted to a nursing home or other treatment setting inappropriately when the individual would more appropriately receive care in a less restrictive and more appropriate setting, such as through home- and community-based services. To achieve the State's objective, the CMO must have a process in place to establish and coordinate a care plan prior to discharge for members who are ready to be discharged from an inpatient hospital or nursing home. The CMO must track the implementation of this care plan. The CMO will be required to work with and coordinate efforts, as necessary, with IndianaOPTIONS. IndianaOPTIONS is implemented through FSSA's Division of Aging with direct services delivered through the Area Agencies on Aging. For more information about IndianaOPTIONS, please refer to http://www.LTCOPTIONS.in.gov.

Continuity of Care for Members Receiving Behavioral Health Care

The following procedures and requirements apply specifically to those members receiving behavioral health care under the Indiana *Care Select* program. To ensure appropriate continuity of care, CMO staff must monitor the care of a member receiving behavioral health services to ensure that medical records, treatment plans and other pertinent medical information follows members transitioning providers for any reason. The care manager must notify the PMP of the member's previous mental health treatment, and must offer to provide to the new provider the member's treatment plan, if available, and consultation with the member's previous treating provider. The CMO must coordinate information regarding prior authorized services for members in transition.

The CMO must require that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven business days from the date of the member's discharge. If a member misses an outpatient follow-up or continuing treatment, the CMO must ensure that a behavioral health care provider or the CMO's behavioral health care manager contacts that member within three business days of the missed appointment.

Care Select Members Pending Level of Care Determination

The LTC facility, such as nursing facility, community residential facility for the developmentally disabled (CRF/DD), or intermediate care facility for the mentally retarded (ICF/MR) where an IHCP member is treated must verify the patient's IHCP eligibility and healthcare program when the patient is admitted or screened, to determine whether the individual is currently enrolled in a care management program. The facility must contact the *Care Select* health plan responsible for the patient's care.

If the eligibility information indicates that the patient is enrolled in *Care Select*, the LTC provider must contact the CMO identified by the EVS. The provider must verify the patient's IHCP eligibility, not only upon admission and screening, but again on the first and 15th of every month thereafter because the member may switch from FFS Medicaid to a care management health plan.

If a care management member is undergoing screening for admission to an IHCP-certified LTC or nursing facility, the facility must complete the LOC paperwork and submit it to the appropriate agency. During the time that the facility or appropriate agency is processing the paperwork, the member may be auto-assigned to a PMP in a care management plan. It is not until the LOC determination is entered

into Indiana*AIM* that care management enrollment is blocked or care management disenrollment occurs. Additional information about this process can be found in Chapter 14 of the *IHCP Provider Manual*. Chapter 14, Section 12 covers the care management related issues.

If the facility determines that a patient is enrolled in a *Care Select* CMO, the provider must notify the CMO within 72 hours. If the provider fails to verify an IHCP member's coverage or fails to contact the CMO within 72 hours of admission, the provider is responsible for any charges incurred until the *Care Select* member is disenrolled from the CMO. When the provider notifies the CMO within 72 hours of admission, the CMO is liable for charges up to 60 days. If the provider fails to complete the paperwork for the appropriate LOC determination and the member is still enrolled in *Care Select* after two months, the claims submitted to EDS are denied payment.

Provision of Enhanced Services

In conjunction with the provision of covered services, CMOs are strongly encouraged to provide programs and benefits intended to enhance the general health and well being of members and provide greater access to care. Wellness programs available to the CMO's commercial population must be made available to its *Care Select* enrollees. The CMO is encouraged to provide enhanced services, such as health education classes, that target the IHCP population specifically. The CMO must inform the OMPP at least four weeks prior to implementation or provision of any enhanced services. The OMPP reviews these enhanced services and the CMO must receive the OMPP approval prior to implementation. The enhanced services must comply with the marketing and other relevant guidelines provided in this manual. Any type of incentives used to market an outreach or education program must be approved in advance by the State, and they cannot have a retail value of more than $10 individually. The annual maximum for member gifts or incentives is $50 per member. Under no circumstances are monetary incentives to be offered or used.

Member Financial Responsibility

Co-payments

Certain services such as transportation, non-emergency use of the emergency room, and pharmacy may be subject to a member co-payment. Pregnant women and children are not subject to co-payment requirements and cannot be charged any co-payments or other cost-sharing fees. Providers can not refuse to see members based on the member's inability to pay the co-payment.

Charging Care Select Members for Services Rendered

IHCP providers are prohibited from billing an IHCP member or the member's family for any amount billed but not paid by IHCP for a covered service. Providers must accept IHCP reimbursement as payment in full for the services rendered.

There are limited instances in which a provider can charge an IHCP member for services. Services not covered by the IHCP, such as cosmetic procedures or services that have been denied through the prior authorization process, can be billed to the member if the provider receives and retains the member's signed statement accepting financial responsibility for the services. This statement must be specific about the services to be billed; must be signed by the member prior to receiving the services; and must be retained as documentation in the patient's medical record. *Section 8: CMO and Provider Enrollment Services* gives additional information about member billing.

Chapter 4, Section 5 of the *IHCP Provider Manual* contains additional information about member billing.

Section 7: Member Services

Restricted Card Program

Member utilization review identifies members who use IHCP services more extensively than their peers. The Restricted Card Program (RCP) is designed to monitor member utilization and, when appropriate, implement restrictions for those members who would benefit from increased care coordination. Members in the RCP transitioned to the CMOs beginning with the central region phase-in on November 1, 2007. The next CMO phase-in, to include the entire State of Indiana will not occur until March 1, 2008. These RCP members will be assigned to ADVANTAGE Health Solutions as the *Care Select* Traditional Medicaid vendor.

Because there will be multiple vendors performing RCP, providers must verify member eligibility to determine to which CMO the member belongs. The Eligibility Verification Systems (EVS) that are available to the provider community will provide specific information regarding the member's CMO and PMP assignment.

Providers should continue the same process for RCP care and referrals. Information regarding the RCP can be found in the *IHCP Provider Manual, Chapter 13, Member Utilization Review Process*.

Member Information Materials

The CMO must establish policies and procedures to ensure that materials are accurate in content, accurate in translation, relevant to language or alternate formats, and do not defraud, mislead, or confuse the member. The CMO must develop and include a CMO-designated inventory control number on all member promotional, education, or outreach materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate the OMPP's review and approval of member materials and document its receipt and approval of original and revised documents. The CMO must keep a log of all member materials used during the year. The CMO must also submit its member handbook to the OMPP annually for review. The *CMO Reporting Manual* details the member materials reporting requirements.

The CMO must submit all marketing, promotional, educational, and outreach materials to the OMPP for review and approval at least 30 calendar days prior to expected use and distribution. The CMO must receive the OMPP's approval to use or display the *Care Select* logo each time the CMO wishes to do so (for example, the CMO should not assume the OMPP's approval for use of the logo based on any previous approvals). The CMO must receive approval from the OMPP prior to distribution or use of materials. The OMPP reserves the right to assess liquidated damages or other remedies for the CMO's non-compliance in the use or distribution of any non-approved member materials.

The CMO must produce member materials and may only distribute member materials approved by the OMPP and compliant with *42 CFR 438.10*. The CMO must provide information for use in member education and enrollment, upon request by the State or the State's designee. This information may include, but is not limited to, the following:

- A provider directory listing the CMO's providers in its network and identifying each provider's specialty, service location(s), hours of operation, telephone numbers, public transportation access, and other demographic information in accordance with *42 CFR 438.10(f)(6)(i)*
- CMO member bulletins or newsletters issued not fewer than four times a year that provide updates related to covered services or access to providers

- Updated policies and procedures specific to the *Care Select* population
- CMO telephone system scripts and commercials-on-hold
- CMO-distributed literature about all health or wellness programs that the CMO offers
- CMO's marketing and promotional brochures and posters
- A member handbook that describes the terms and nature of services offered by the CMO and contact information including the CMO's Internet Web site address

General Information Requirements

The CMO must make written information available in English and Spanish and other prevalent non-English language, as identified by the OMPP, upon the member's request. The CMO must identify additional languages that are prevalent among members. The CMO must inform members that information is available upon request in alternative formats and how to obtain alternative formats. The OMPP defines alternative formats as Braille, large font letters, audiotape, prevalent languages, and verbal explanation of written materials.

To the extent possible, written materials must not exceed a fifth grade reading level. The CMO must provide notification to its members of the *Care Select*-covered services that the CMO does not elect to cover on the basis of moral or religious grounds and guidelines for how and where to obtain those services, in accordance with *42 CFR 438.102.* The CMO must provide this information to the member before and during enrollment and within 90 calendar days after adopting the policy with respect to any particular service. The CMO must inform the members that, upon the member's request, the CMO provides information on the structure and operation of the CMO and, in accordance with *42 CFR 438.6(h),* provides information on the CMO's provider incentive plans.

The CMO is responsible for developing and maintaining member education programs designed to provide the members with clear, concise, and accurate information about the CMO's program, the CMO's network, and the *Care Select* program. The State encourages the CMO to incorporate community advocates, support agencies, health departments, other governmental agencies, and public health associations in its outreach and member education programs. The State encourages the CMO to develop community partnerships with these types of organizations to promote health and wellness within its *Care Select* membership.

The CMO's educational activities and services should also address the special needs of specific *Care Select* subpopulations (such as, pregnant women, newborns, early childhood, at-risk members, and children with special needs) and its general membership. The CMO must demonstrate how these educational interventions reduce barriers to healthcare for members. The CMO must review its education and outreach program activities in the annual *Quality Management and Improvement Plan Summary Report.*

Web Site

The CMO must provide a user-friendly Internet Web site in an OMPP-approved format (currently Bobby™ format) to ensure compliance with existing accessibility guidelines that is available to members, providers and the community within six months of the effective date of the CMO's contract with the State. More information about the Bobby format is available at: http://bobby.watchfire.com/bobby/html/en/index.jsp. The OMPP must preapprove the CMO's Web site information and graphic presentations. The Web site information must be accurate and current, culturally appropriate, written for understanding at a fifth grade reading level, and available in English and Spanish. The CMO must inform members that information is available upon request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the Web site

must avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The CMO must date each Web page, change the date with each revision, and allow users access to print the information. Such Web site information should include, but not be limited to, the following:

- The CMO's provider network identifying each provider's specialty, service location(s), hours of operation, telephone numbers, public transportation access, and other demographic information. The CMO must update the online provider network information monthly at a minimum.
- The CMO's contact information for member inquiries, member grievances, or appeals
- The CMO's member services telephone number, telecommunications device for the deaf (TDD) number, hours of operation, and after-hours access numbers
- The CMO's wellness and prevention programs or prenatal services (particularly if these are enhanced beyond standard *Care Select* coverage)
- Information about the CMO's nurse care hotline (if applicable)
- A description of the CMO's care management program, including case management services and chronic disease management programs
- The member's rights and responsibilities
- The member handbook
- The HIPAA privacy statement
- A list and brief description of each of the CMO's member and provider outreach and education materials
- The executive summary of CMO's *Annual Quality Management and Improvement Program Plan Summary Report*

Handbook

Upon enrollment in the CMO program, the CMO must provide members with a handbook containing written policy that includes information on the following:

- Rights and responsibilities of the members
- Benefits and services included and excluded as a member of the CMO program and how to obtain them
- Special benefit provisions (for example, co-payments, deductibles, limits, or rejection of claims) that may apply to services.
- Procedures for accessing in-network services
- Procedures for obtaining out-of-area services
- Provisions for 24-hour access to care, including emergency care
- Standards and expectations to receive preventive health services
- CMO policy on referrals to specialty care
- Procedures for notifying members affected by termination or change in any benefits, services, or service delivery sites
- Procedures for appealing decisions adversely affecting the members' coverage, benefits, or relationship with the CMO
- Procedures for changing PMPs

- Procedures for changing plans within *Care Select*
- Procedures for making complaints, filing grievances, and recommending changes in policies and services
- Information about advance directives

Education, Outreach, and Marketing Materials

All education, outreach, and marketing materials must meet the following guidelines:

- The State must approve all education and outreach materials, including materials of CMO subcontractors, prior to distribution.
- All materials must be on health and wellness issues pertaining to the *Care Select* program.
- The OMPP must review and approve any materials that use the *Care Select* logo prior to distribution, for each material use. The CMO must cooperate with the OMPP to identify which materials require the program logo. The OMPP's decision on use of the logo is final.
- All brochures, presentation materials, and information packets must follow the standards established by the OMPP. All materials must be written at a fifth grade reading level or lower and be culturally appropriate. Materials submitted to the State for approval must indicate the measurement used to assess the reading level (such as, SMOG, Fog, or other method) and must have the reading level indicated.
- Any educational, outreach, or marketing materials must be distributed within the entire service area specified by the CMO and approved by the OMPP.
- Marketing materials cannot contain any false or misleading information and must be approved by the OMPP before distribution.
- Literature about health and wellness promotion programs offered by the CMO is encouraged.

The OMPP does not approve materials if it determines that the content is inaccurate, misleading, or otherwise misrepresents the program. It does not approve materials if they do not directly deal with healthcare issues. The materials must be culturally sensitive to the population groups served by the CMO.

The contents of education, outreach, and marketing materials must not refer to or identify the addressee as a *Care Select* or Medicaid enrollee and must include, at a minimum:

- Information about how the individual can receive additional information or contact a CMO representative with questions
- Information about who to call if a member is hearing impaired or needs an interpreter

The CMO must provide the OMPP written notification immediately upon discovery of an alleged or suspected marketing violation by marketing representatives. Upon notification, the OMPP investigates with the CMO's cooperation. The CMO must take appropriate action and is subject to loss or restriction of enrollment, marketing privileges, or other suitable remedy.

The CMO must submit to the OMPP a member materials distribution plan quarterly. All member outreach, marketing and education materials, as well as any form letters that are sent to members (for example, notification or welcome letters, annual notices, etc.) must be submitted to the OMPP for approval prior to distribution and in accordance with the OMPP policy. In addition, the CMO must notify the OMPP of any changes to that work plan that occur throughout the year.

Member Education

Pre-enrollment

In accordance with *42 CFR 438.10 (e)*, the enrollment broker must provide the following CMO information, at a minimum, to the member prior to the selection of the PMP and the enrollment in the CMO network:

- List of PMPs, specialists, and hospitals within the *Care Select* network produced and distributed by the enrollment broker. This list must include general information, including area of specialty, telephone number, practice limitations, whether new patients are currently being accepted, and any restrictions on the scope of practice (for example, non-English language spoken)
- CMO-specific information such as service area cost sharing, enhanced services, wellness programs, and so forth

Post-enrollment

The CMO is responsible for the development and maintenance of member education and outreach programs. These programs are designed to provide the member with information about the CMO's services. CMO member bulletins or newsletters specific to the *Care Select* population are to be issued not fewer than three times a year. These publications must provide updates related to covered services, access to providers, and updated policies and procedures. The CMO is encouraged to provide literature about health and wellness programs offered by the CMO. The OMPP must review and approve newsletters prior to distribution like other education and outreach materials.

A CMO's educational activities and services must focus on the special needs of its *Care Select* population. CMOs must demonstrate how these educational interventions would reduce barriers to healthcare for members.

CMOs must make post-enrollment information available to members. This information includes but is not limited to the following:

- Summary of IHCP-included and -excluded benefits and services, and any enhanced services available in the CMO network
- Statement that most necessary healthcare services, except long-term institutional care, hospice care, behavioral health services provided by Psychiatric Residential Treatment Facility (PRTF), community mental health rehabilitation option (MRO) services, dental services, First Step services, and services provided by a school corporation enrolled in the IHCP with provider specialty 120 as part of a student's Individualized Education Plan (IEP) are provided through the CMO and must be obtained through the CMO facilities or providers
- Statement that all self-referral services (services rendered for the treatment of an emergency, family planning services, chiropractic services, podiatric services, eye care services other than eye surgeries, human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) targeted case management, and diabetes self-management services) can be obtained either in or out of the CMO network. *Section 6:Care Select Services* contains additional information about self-referral services.
- Description of the CMO's 24-hour access to emergency care procedures
- Information about member's rights and responsibilities under the CMO's plan, including participation in member satisfaction surveys
- Information about grievance procedures and the rights of a member with respect to the filing of a grievance

- Information about the member's right to change PMPs and the procedures for disenrollment from the CMO
- Information about preventive health programs or enhanced services offered by the CMO

Member Grievance Procedures

At a minimum, the grievance system includes a grievance process, an appeal process, expedited review procedures and access to the State's fair hearing system. The grievance system must comply with *42 CFR 438, Subpart F*, and must include all the elements outlined in the grievance and appeal requirements in the *Appendix C Care Select, Grievance, and Appeal Process*. The member must exhaust the CMO's appeals process prior to filing an appeal with FSSA.

As the CMO will not be responsible for paying claims, but will be authorizing or denying authorization requests, the CMO will be responsible for addressing grievances and appeals related to authorization requests. The term *action*, as defined in *42 CFR 438.400(b)*, includes:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Failure to provide services in a timely manner, as defined by the State; or
- Failure of a CMO to act within the required timeframes.

The CMO must notify the requesting provider, and give the member written notice, of any decision by the CMO to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of *42 CFR 438.404*, except that the notice to the provider need not be in writing.

In accordance with *42 CFR 438.102*, the CMO must not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member.

A grievance is defined as an expression of dissatisfaction about any matter other than an "action."

An enrollee can file a grievance with the CMO. An enrollee may file a grievance either orally or in writing. A provider may file a grievance if the State permits the provider to act as the enrollee's authorized representative.

The CMO must dispose of each grievance and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes not to exceed 90 days from the day the CMO receives the grievance.

The State will establish the method CMOs will use to notify an enrollee of the disposition of a grievance.

CMO Member Helpline

The CMO must maintain a statewide toll-free telephone helpline for members with questions, concerns, or complaints. The CMO must staff the member services helpline to provide sufficient live voice access to its members during (at a minimum) a 10-hour business day in the Eastern time zone, Monday through Friday. The member services helpline must offer language translation services for

members whose primary language is not English and must offer telephone-automated messaging in English and Spanish. A member services messaging option must be available after business hours in English and Spanish and member services staff must respond to all member messages by the end of the next business day.

The CMO must provide twenty-four hour oral interpreter services either through interpreters or telephone services. For example, the CMO must provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members, oral interpreters and signers.

The CMO must maintain a system for tracking and reporting the number and type of members' calls and inquiries it receives during business hours and non-business hours. The CMO must monitor its member services helpline service and report its telephone service performance to the OMPP each month as described in the *CMO Reporting Manual*.

The CMO's member services helpline staff must be prepared to respond to member concerns or issues including, but not limited to the following:

- Access to healthcare services
- Identification or explanation of covered services
- Special healthcare needs
- Disease management services
- Behavioral health
- Care management
- Procedures for submitting a member grievance or appeal
- Potential fraud or abuse
- Changing PMPs
- Quality of care

Upon a member's enrollment in the CMO, the CMO must inform the member about the member services helpline. The CMO should encourage its members to call the CMO member services helpline as the first resource for answers to questions or concerns about *Care Select*, PMP issues, benefits, CMO policies, and so forth.

Nurse Care Hotline

The CMO may have a nurse triage telephone service for members to receive medical advice twenty-four-hours-a-day/seven-days-a-week from trained medical professionals. If the CMO implements one, members would be strongly encouraged by the CMO to contact the nurse care line before going to the ER. This resource will be a primary source of averting inappropriate ER utilization. The CMO will inform its members of this available resource and will encourage its members to use it in order to promote appropriate care in the appropriate setting at the appropriate time.

Member to Provider Communications

The CMO must not prohibit or restrict a healthcare professional from advising a member about his or her health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the *Care Select* program, as long as the professional is acting within his or her lawful scope of practice. This provision does not require the CMO to provide coverage for a counseling or referral service if the CMO objects to the service on moral or religious grounds.

In accordance with *42 CFR 438.102(a)*, the CMO must allow health professionals to advise the member on alternative treatments that may be self-administered and provide the member with any information needed to decide among relevant treatment options. Health professionals are free to advise members on the risks, benefits, and consequences of treatment or non-treatment.

The CMO must not prohibit health professionals from advising members of their right to participate in decisions regarding their health, including the right to refuse treatment and express preferences for future treatment methods. The CMO may not take punitive action against a provider who requests an expedited resolution or supports a member's appeal.

Marketing

Marketing Activities

The OMPP permits and encourages the CMO and its subcontractors to promote their services to the general community, but forbids direct outreach or direct marketing to potential *Care Select* care management members and *Care Select* enrollees who are not the CMO's members. In accordance with *42 CFR 438.104*, the CMO cannot conduct, directly or indirectly, door-to-door, telephone or other cold-call marketing enrollment practices. The CMO may not directly outreach or market to a *Care Select* enrollee prior to the enrollee becoming a member in the CMO's program.

The prohibition on CMO outreach to *Care Select* care management members applies equally to enrollees who apply for the program at a Division of Family Resources (DFR) office or at any other outstation location. The CMO may not offer gifts, incentives, or other financial or non-financial inducements greater than $10 for each individual and $50 per year, per individual. The CMO is subject to penalties under the *Social Security Act Section 1128A(a)(5)* about inducements, remunerations, and gifts to Medicaid and Package C members. The CMO must comply with all marketing provisions in *42 CFR 438.104*, and federal and state regulations about inducements and must itemize its marketing gifts, incentives, and other financial inducements annually in the *Quality Management and Improvement Plan Summary Report.*

The CMO must submit a member materials distribution plan to the OMPP quarterly. All member outreach, marketing, and education materials must be submitted to the OMPP for approval prior to distribution and in accordance with the OMPP policy. Any outreach and marketing activities (written and oral) must be presented and conducted in an easily understood manner and format, at a fifth grade reading level, and must not be misleading or designed to confuse or defraud members or potential members. Examples of false or misleading statements include, but are not limited to:

- Any assertion or statement that the member or potential member must enroll in the CMO to obtain benefits or to avoid losing benefits
- Any assertion or statement that the CMO is endorsed by the Centers for Medicare & Medicaid Services (CMS), the federal or state government, or a similar entity

The CMO cannot entice a potential member to join the CMO by offering the sale of any other type of insurance as a bonus for enrollment, and the CMO must ensure that a potential member can make his or her own decision as to whether to enroll.

The CMO may provide (at its own cost, including any costs related to mailing) an informational brochure or flyer to the State's enrollment broker for distribution to potential *Care Select* enrollees at the time of PMP selection. The CMO may submit poster-sized (11" X 17") promotional materials to the OMPP for approval. Upon the OMPP's approval, the CMO can make these posters available to the local county office of the Division of Family Resources (DFR) and enrollment centers for display in an area where *Care Select* application or member enrollment occurs. Each local county Office of Family

Resources (OFR) and enrollment center may display these promotional materials at its discretion. The CMO may display these same promotional materials at community health fairs or other outreach activities. The OMPP must pre-approve all promotional and informational brochures or flyers and all graphics prior to display or distribution.

If the CMO wishes to use the *Care Select* logo, the CMO must request approval from the OMPP for each desired use. Any approval given for logo use is specific to the use requested, and shall not be interpreted as a blanket approval.

Section 8: CMO and Provider Enrollment

Overview

All CMOs must have an executed contract on file with the Indiana Family and Social Services Administration (IFSSA) and submit completed CMO enrollment information to the fiscal agent. The CMO is required to provide education and enrollment services for their healthcare provider network. The CMO must obtain approval from the OMPP prior to distribution of all provider materials.

All providers rendering services to *Care Select* members in a care management organization (CMO) health plan must be enrolled in the IHCP, including out-of-state providers. Providers must also agree to comply with all IHCP regulations and State standards for access to care and quality of services. On behalf of the State, the CMO must request the provider to sign the *Care Select* addendum to order to participate in the *Care Select* program.

The CMO, through its network of PMPs and other providers, is responsible for providing or authorizing reimbursement of most primary and preventive care services. These services include:

- Physician services
- Hospital inpatient and outpatient services
- Ancillary services, including but not limited to, behavior health services, pharmacy, X-ray, laboratory, and radiology, therapies, HealthWatch early periodic screening diagnosis and treatment (EPSDT), audiology, home healthcare, and DME and supplies.

CMO Enrollment

After the execution of a contract between Indiana Family and Social Services Administration (IFSSA) and the CMO, the IFSSA submits a written request to the fiscal agent (EDS) to enroll the CMO in Indiana*AIM*.

The CMOs are required to complete the *CMO Care Select Enrollment Form* and *CMO Supplemental Contact Information Enrollment Form.* These forms are submitted to the fiscal agent's care management manager. The *CMO Care Select Enrollment Form* includes the CMO name, address, contact name, telephone number, CMO regions, electronic funds transfer (EFT) information, update authorizations contact information, CMO contact information, financial contact information, and tax information. The *CMO Supplemental Contact Information Enrollment Form* is utilized to inform the fiscal agent of additional addresses and phone numbers for supplemental functions not included in the *Care Select* CMO Enrollment Form. If changes occur to the above enrollment information, the CMO must complete the *CMO Care Select Enrollment Update Form* and submit to the fiscal agent

The *CMO Care Select Enrollment Form*, *CMO Supplemental Contact Information Enrollment Form*, and the *CMO Care Select Enrollment Update Form* can be found in the CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa/.

On verification of the required information, EDS enrolls the CMO in Indiana*AIM* and sends confirmation letters to the IFSSA and the CMO. The letters contain the CMO's unique identification number comprised of 10 digits, for example, 9999999999. The 10th digit denotes the region of the state in which the CMO is enrolled. If the CMO is enrolled in more than one region, the ID number remains the same, with only the 10th digit character changing for each service region. For example, if

the CMO is enrolled in regions 1 and 2, the ID numbers would be 9999999991 and 9999999992. The numeric region identifiers are listed in Table 8.1.

Table 8.1 – CMO Region Identifiers and Name

Region Identifier	Region Name
1	Northwest
2	North Central
3	Northeast
4	West Central
5	Central
6	East Central
7	Southwest
8	Southeast
9	Out of State/IFSSA

Provider Education and Outreach Activities

The CMO must educate its contracted providers, including behavioral health providers, about provider requirements and responsibilities, the CMO's prior authorization policies and procedures, clinical protocols, member's rights and responsibilities, claim dispute resolution process, pay-for-performance programs and any other information relevant to improving the services provided to the CMO's *Care Select* members.

The CMO is responsible for ensuring that its provider network is trained about and is aware of the cultural diversity of the Indiana *Care Select* Program population and competent in respectfully and effectively interacting with individuals with varying racial, ethnic and linguistic differences.

The CMO will educate its provider network about the following items:

- The care management process
- The various types of chronic conditions and disabilities prevalent among the Indiana *Care Select* program members
- The various screening and assessment tools used in the Indiana *Care Select* program, including the MDS-HC suite and CANS once it is finalized
- Awareness of personal prejudices
- Legal obligations to comply with the Americans with Disabilities Act (ADA)
- Scope of benefits
- Definitions and concepts such as communication access, medical equipment access, physical access and access to programs
- The types of barriers that adults with physical, sensory, communications disabilities, developmental or mental health needs face in the health care industry and the resulting access and accommodation needs

The CMO must submit all promotional, training, educational, and outreach materials to the OMPP for review and approval at least 30 calendar days prior to use and distribution. The CMO must develop and include a CMO-designated inventory control number on all provider material with a date issued or

date revised clearly marked to facilitate the OMPP's review and approval process. Upon the OMPP's approval, the CMO may distribute provider materials to the provider community.

Provider Credentialing and Recredentialing Policies and Procedures

The following subsections dealing with credentialing and recredentialing are a summary of current National Committee for Quality Assurance (NCQA) standards. CMOs must refer to the NCQA standards for further detail.

Credentialing

The CMO must have credentialing procedures to determine whether physicians and other healthcare professionals under contract with the CMO are licensed by the State and are qualified to deliver healthcare services.

The CMO must have written policies and procedures for credentialing healthcare professionals it employs and with whom it contracts. The CMO must have documented plans to periodically review and revise policies and procedures. If the CMO contracts with a hospital that conducts the CMO's credentialing activity, the CMO must have access to the hospital credentialing files. At minimum, the CMO must obtain and review verification of the following:

- A current valid license to practice
- Status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility
- Current and valid Drug Enforcement Administration (DEA) or controlled substance registration (CSR) certificate, as applicable (DEA certificates are not applicable to chiropractic settings)
- Proof of graduation from medical school and completion of a residency, or board certification for medical doctors (MDs) and doctors in osteopathy (DOs), as applicable since the last time the provider was credentialed or recredentialed
- Proof of graduation from chiropractic college for doctors of chiropractic medicine (DC)
- Proof of graduation from podiatry school and completion of residency program for doctors in podiatric medicine (DPMs)
- Work history that includes a minimum of five years on the curriculum vitae (the CMO is not required to verify work histories)
- Current, adequate malpractice insurance according to the CMO's policies
- History detailing any pending professional liability claims and claims resulting in settlements or judgments paid by or on behalf of the practitioner
- Proof of board certification if the practitioner states being board certified
- Verification of IHCP enrollment. If group enrollment, verify that the provider is linked appropriately to the group, and verify that the provider is enrolled at the appropriate service locations

The credentialing policies and procedures must specify the professional criteria required to participate in the CMO. Each practitioner file must contain sufficient documentation to demonstrate that these criteria are evaluated. Primary sources used by the CMO to verify credentialing information must be

included in its policies and can include use of external agencies such as county medical societies, hospital associations, or private verification services.

Mechanisms for Credentialing and Recredentialing

The CMO must document the mechanism for credentialing and recredentialing MDs, DOs, DPMs, and DCs that fall under the CMO's scope of authority and action, and with whom it contracts or employs to treat members outside the inpatient setting. This documentation includes but is not limited to the following:

- The scope of practitioners covered
- The criteria and the primary source verification of information used to meet these criteria
- The process used to make decisions
- The extent of any delegated credentialing or recredentialing arrangements

Policies and procedures must specify the requirements and the process used to evaluate practitioners. Selection decisions must be based on the network needs of the CMO and practitioners' qualifications. Selection decisions cannot be based solely on a practitioner's membership in another organization, such as a hospital or medical group.

Policies and procedures must include physicians and other licensed independent practitioners who are subject to these policies, and criteria to reach a decision.

The CMO must have a process in place for receiving advice from participating practitioners in credentialing and recredentialing to ensure that procedures are followed consistently. CMOs must seek practitioner expertise on current practice in the medical community and advice on modifying the criteria, as appropriate. This expertise can be obtained from a committee with participating practitioner representation or from consultation with participating practitioners.

Participating practitioners must complete an application for membership on such a committee. Through the application process, the practitioner discloses information about health status and any history of issues with licensure or privileges that may require additional follow-up. A signed attestation statement on the application ensures that the practitioner has completed it in good faith.

Before making a credentialing decision, the CMO must have the following information on the practitioner:

- Information from the National Practitioner Data Bank (NPDB). NPDB is not applicable to chiropractors and podiatrists
- Information about sanctions or limitations on licensure from the State Board of Medical Examiners, Federation of State Medical Boards, or the Department of Professional Regulations, if available
- Information from the State Board of Chiropractic Examiners or the Federation of Chiropractic Licensing Boards
- Information from the State Board of Podiatric Examiners
- Previous sanction activity by Medicare and the IHCP

Evidence indicating that the CMO has obtained information from the previously designated organizations must be included in the credentialing file.

Credentialing – Initial Visit

The CMO credentialing process must include an initial visit to the offices of all potential primary medical providers including all obstetricians and gynecologists (OB/GYNs). There must be a structured review that evaluates the site against the CMO standards. The initial site visit must also include documentation of the evaluation of the medical record-keeping practices at each site to ensure conformity with the maintenance of medical records. *Section 7: Member Services* outlines this documentation.

Recredentialing

The CMO must have a formal recredentialing process that verifies the credentialing information subject to change over time. The recredentialing process must be organized to verify the information through a primary source on the current standing of items listed in this section, such as member complaints, quality reviews, utilization management, and member satisfaction. The description of the recredentialing process must include data from at least three of the following six sources:

- Member complaints
- Quality reviews (practice-specific)
- Utilization management (profile of utilization)
- Member satisfaction (practice-specific)
- Medical record review
- Practice site reviews

The recredentialing evaluation process must use this data as objective evidence in the reappraisal of professional performance, judgment, and clinical competence. There must be evidence that the CMO has taken action based on the data. Examples of action taken include continuation in the CMO, required participation in continuing education, required supervision, a clear plan for improvement with the practitioner, evidence of changes in the scope of practice, or termination of the practitioner from the CMO.

Recredentialing Practice Site Visit

The CMO must conduct an on-site visit at the time of recredentialing to determine if there have been any changes in the facility, equipment, staffing, or medical record-keeping practices that would affect the quality of care or services provided to members of the CMO. Primary medical providers, OB/GYNs, and other high-volume specialists must be included in this site visit. The CMO is responsible for determining which high-volume specialists are subject to this visit, based on its own experience with the specialist.

Altering Conditions of Provider Participation

CMOs must have plans for developing and implementing policies and procedures for altering conditions of a provider's participation with the CMO due to issues of quality of care and service. These policies and procedures need to specify actions the CMO may take before terminating the provider's participation with the CMO. Policies and procedures must have mechanisms in place for reporting serious quality deficiencies to the OMPP that could result in a provider's suspension or termination. These policies and procedures must specify how reporting occurs and the individual staff members responsible for reporting deficiencies.

The policies and procedures must include a well-defined appeals process for instances in which the CMO decides to alter the provider's condition of participation because of quality of care or service issues. The CMO must ensure providers are aware of the appeals process. Policies and procedures must include mechanisms to ensure that providers are treated fairly and uniformly.

Credentialing Provider Healthcare Delivery Organizations

The CMO must have policies and procedures for credentialing healthcare delivery organizations, including but not limited to, hospitals, home health agencies, freestanding surgical centers, laboratories, and subcontracted networks of providers.

Every three years after the initial contract the CMO must confirm the following:

- That the organizations are in good standing with state and federal regulatory bodies
- That the organizations have been reviewed and approved by an accreditation body before contracting with the CMO
- That the organizations conform to the previously mentioned requirements

The CMO must also develop standards of participation and assess these providers accordingly if the provider has not received accreditation.

Clinical Laboratory Improvement Amendments

CMOs must arrange for laboratory services only through those laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.

Provider Service Locations

PMPs can designate any number of service locations that accept *Care Select* assignments.

> *Note: Physicians must be IHCP enrolled at these service locations before they can designate them as PMP service locations.*

Physicians can download IHCP applications from the IHCP Web site at http://www.indianamedicaid.com/ihcp/index.asp. CMOs must verify that the physician is IHCP enrolled prior to submitting a PMP enrollment to the EDS Managed Care enrollment specialist. PMPs can treat *Care Select* members at any enrolled service location, but receive member enrollment or auto-assignment at only two locations. PMPs participating in a CMO can have service locations in any Indiana county that the CMO's state contract allows.

Out-of-State Providers

To enhance access to primary care in areas with an inadequate number of PMPs, the OMPP permits out-of-state PMPs to enroll in the program in areas where limited access has been identified. PMPs with out-of-state service locations are available for voluntary selection by members.

Out-of-state providers are allowed to be PMPs; however, auto-assignments occur to those with the Indiana Family and Social Services Administration (IFSSA) out-of-state designations. Other out-of-state PMPs only receive self selections. The IFSSA out-of-state designations are defined in *405 IAC 5-5-2* and are delineated as cities that reside outside the state of Indiana, excluded from out-of-state prior

authorization (PA) requirements and required to follow in-state PA requirements. The cities defined as IFSSA out-of-state designations are as follows:

- Danville, Illinois
- Watseka, Illinois
- Louisville, Kentucky
- Owensboro, Kentucky
- Sturgis, Michigan
- Cincinnati, Ohio
- Hamilton, Ohio
- Oxford, Ohio
- Chicago, Illinois (Effective July 1, 2006)

Residency Programs

To promote long-term relationships for *Care Select* members, physicians practicing in group residency programs are not eligible to enroll as PMPs in the *Care Select* program. The frequent turnover of physicians in a residency program disrupts the continuity of care essential to a care management program. Residents can provide care to *Care Select* members only if the residency program's faculty physicians are participating PMPs and are enrolled in Indiana*AIM* in the same billing group as the resident physicians. The PMP or faculty physician retains responsibility for the care provided to *Care Select* patients and must provide oversight to the resident physician consistent with the residency program's stated procedures.

Care Select members are linked to the supervising physician as the PMP of record and the IHCP eligibility systems provide that doctor's name as the PMP on the eligibility verification system (EVS).

School-based Clinics

Some *Care Select* members are eligible for and receive medical services in a school-based clinic. These clinics typically have funding sources other than IHCP, and do not bill IHCP for the services they provide. For school-based clinics to bill for services provided to *Care Select* enrollees, the clinics must be IHCP-enrolled providers. Clinics that expect reimbursement must obtain CMO authorization prior to providing services. Services provided in a school-based clinic are usually limited to EPSDT, immunizations, or other primary care and preventive services.

School corporations can also provide IHCP-covered services to students as part of an individualized education plan (IEP). All claims for services provided to *Care Select* members as part of an IEP that are billed by provider specialty 120 – school corporation are billed to the fiscal agent. The OMPP strongly encourages CMOs to collaborate with school-based programs in the delivery of care to their members and to encourage their PMPs to assist in the coordination of medical services.

Pre-enrollment Provider Education

The CMOs can educate physicians interested in becoming PMPs about the *Care Select* program through face-to-face training sessions, brochures, and videos. The OMPP must approve prior to distribution all education and outreach materials designed for distribution to physicians interested in becoming PMPs.

Prior to enrolling PMPs in the CMO program, CMOs are encouraged to educate providers about the following:

- *Care Select* program goals
- Member PMP selection and PMP change process
- Practice requirements of a PMP, including the following:
  - Panel size limits
  - On-site availability requirements
  - 24-hour access standards
  - Provider disenrollment
  - Preventive health standards and requirements
  - Referral standards (for example, referrals for continuity of care)
- Quality improvement requirements (including EPSDT)
- Self-referral services
- Billing and reimbursement practices
- Covered and excluded services and referral practices
- Other relevant CMO-specific information

> *Note: All prospective PMPs must first be enrolled in the IHCP at the service location at which they want to be enrolled as PMPs. CMOs must verify IHCP enrollment with prospective PMPs prior to submitting PMP enrollment through the Web interChange. If the prospective PMP is not IHCP enrolled, the CMO must tell the physician to contact EDS for an enrollment application, or the physician (or physician's group) can download the appropriate application from the Web site at http://www.indianamedicaid.com/ihcp/index.asp.*

Post-Enrollment Provider Education

As part of the enrollment process for network PMPs, the CMO must educate PMPs about the following:

- *How PMPs are notified about panels* – EDS provides member enrollment roster information to the member's contracted network PMPs. The CMO can retrieve a complete list of enrolled members (Enrollment Roster 834) with PMP assignments from EDS. Enrollment rosters are described in *Section 9: Member Eligibility and Enrollment.*
- *Universally accepted standards of preventive and other care* – These standards are determined by the CMO. CMOs are strongly encouraged to employ the practice standards provided later in this section. The *Care Select* Program updates these practice standards as needed.
- *Medical records retention and availability* – This information is described in this section.
- *PMP authorization requirements* – This information is described in this section.
- *IHCP-covered services* – This information is described in *Section 6: Care Select Services*.
- *Provider claims dispute* – These procedures are developed by the CMO. Minimum requirements are described later in this section.
- *Provider helpline* – CMOs must offer a telephone helpline to providers. The CMO must report provider helpline performance statistics as described in the *CMO Reporting Manual.* The CMO

helpline staff must be prepared to respond to provider concerns including, but not limited to the following:
  - Enrollment and disenrollment from the CMO
  - Covered services
  - Self-referral services
  - Provider network development as described in *Section 10: Network Development, Services and Data* of this manual
  - Quality improvement requirements as described in *Section 14: Quality Improvement Program and Performance Reporting* of this manual
  - Billing requirements
  - Eligibility issues
  - Preventive health standards and requirements (including EPSDT)

- *Reassignment of a member to another PMP* – This process, as initiated by the provider, is described in *Section 9: Member Eligibility and Enrollment*.

Provider Enrollment

The CMO components of *Care Select* are subprograms of IHCP. As such, participating providers must be IHCP-enrolled. The CMO is responsible for ensuring that all of its providers are IHCP-enrolled at the service location where they wish to participate as a PMP. The CMO is also responsible for ensuring that there are sufficient providers to adequately serve the enrolled members.

Provider enrollment activities are governed by the following criteria:

- CMO provider outreach personnel assume responsibility for education of providers enrolled in the CMO. State-contracted provider personnel from the enrollment broker or the fiscal agent can also provide general information about the *Care Select* program and all of its health plans.
- Once enrolled in the IHCP, PMPs contract with the CMOs for their health plans. PMPs are allowed to enroll with multiple CMOs and maintain member enrollment in each CMO.
- PMPs determine the maximum panel limits of *Care Select* members for each CMO. The OMPP monitors each CMO's PMP network to evaluate its member-to-PMP ratio on at least a quarterly basis.
- If a PMP disenrolls from *Care Select* or disenrolls as an IHCP provider entirely, CMOs must ensure that members continue to receive care until another PMP is chosen or assigned. Further information about PMP disenrollment is contained in this section.

Indiana Health Coverage Programs Provider Enrollment Processing

To participate as a PMP or specialist in the *Care Select* program, a provider must be enrolled as an IHCP provider. A provider is enrolled in the IHCP when all of the following conditions have been met:

- The provider is duly licensed, registered, or certified by the appropriate professional regulatory agency pursuant to State or federal law, or otherwise authorized by the IFSSA.
- The provider has completed, signed, and returned an IHCP Provider Agreement and any other forms required by the IHCP.
- The provider has been assigned an IHCP provider number and reported their NPI in accordance with the mandatory NPI reporting requirements.
- Physicians must be actively enrolled at the service location where they wish to practice as a PMP prior to enrolling as a PMP at that location.

There are two types of IHCP providers:

- Billing providers (sole proprietorship, group)
  - A *sole proprietorship* is a provider who owns a practice location where he or she is the sole practitioner performing services with an unshared tax ID number.
  - A *group* is a business entity that owns one or more service locations where providers are employed or contracted to perform professional services on behalf of the business entity.
- Group members (rendering providers)
  - A *group member* is a rendering provider who is employed or contracted to render services to IHCP members. Group members cannot have a billing service location in Indiana*AIM*. All services are billed using the group's IHCP ID number.

The IHCP provider enrollment procedures are designed to ensure timely, accurate, and efficient processing of provider enrollment applications. This procedural base is the focus of provider participation and is critical for accurate claims processing. It is the CMO's responsibility to ensure that any health plan providers delivering services to members in the *Care Select* program are enrolled as IHCP providers. Providers complete the initial enrollment by completing the *Indiana Health Coverage Programs Provider Agreement* and submitting it by U.S. Mail to:

EDS Provider Enrollment Unit
P.O. Box 7263
Indianapolis, IN 46207-7263

Detailed information about compiling the provider enrollment application and agreement is found in the *IHCP Provider Manual* on the Web site at http://www.indianamedicaid.com/ihcp/index.asp. Providers may download enrollment applications from this Web site. Providers may also contact Customer Assistance by telephone at 1-800-577-1278 or (317) 655-3240 to request enrollment applications and to obtain answers to questions about provider enrollment in the IHCP.

After completing IHCP enrollment, PMPs enroll with the OMPP through the CMO to participate in a CMO health plan.

CMO PMP Enrollments and Updates

The CMOs have the ability to submit individual PMP enrollments for their health plans through the **Web interChange > PMP Enrollment**.

The CMOs also have the ability to update the existing PMP's scope of practice, panel hold status, and panel size information. Panel size and network updates require an effective date that is a future date, in other words at least one day after the date of entry. Updates to the panel size are viewable the day after data entry or when the change becomes effective. Updates to the panel hold and scope of practice information are processed the day the update is completed in PMP Update using the Web interChange and are viewable in Web interChange > Provider Profile.

Access Web interChange from the Indiana Health Coverage Programs Web site at https://interchange.indianamedicaid.com/Administrative/logon.aspx. All CMOs must enroll in Web interChange as a group administrator and establish a user ID and password to access the Web interChange. The CMO group administrator has the ability to assign users and enable users with the appropriate access. For information on how to enroll, review the Help section of the Web interChange Logon page or the *IHCP Provider Manual, Chapter 3*.

After logging into the Web interChange, the user must click the **Provider Profile** link. The user has the option to view the provider profile, enroll a PMP, update PMP information, view a list of the EDS provider field consultants, and download the PMP Enrollment and Update forms and other program enrollment forms. Only users that are assigned access to the PMP Enrollment Membership task will

see the *Enroll a PMP, Update PMP,* or the *PMP Enrollment and Update Forms* section on the provider profile menu. The user also has access to Help text to assist them with the processes for PMP enrollment and update.

The CMO must complete the selection process by entering the NPI or IHCP group or billing ID, selecting a service location and if group provider, selecting the applicable rendering provider. After the selection process is accomplished, the CMO must enter the 24-hour telephone number, scope of practice information, panel size. Once the CMO data entry is complete and has passed the system cross editing, the CMO must click the **Submit** button. A confirmation Web page appears with the statement that the PMP enrollment has been successfully submitted and the request has been processed. The window also includes the submission date, enrollment date, CMO name, provider number, group number and alpha service location ID. To confirm the enrollment has been accepted, the CMO can view the PMP enrollment information in the Provider Profile.

The following paragraphs outline the paper enrollment process that can be used if system issues prevent PMP enrollment through Web interChange.

Paper File Submission

The form for enrolling a PMP in the CMO health plan may be found in the Web interChange-PMP Enrollment page, and the IHCP Web site at the *Care Select* CMO Question and Answer Web page at http://www.indianamedicaid.com/ihcp/CMO/qa/.

CMOs submit enrollment forms to the EDS Managed Care Unit as indicated on the enrollment form or faxed to attention of Managed Care enrollment at (317) 488-5020. The following procedure has been implemented to allow the EDS Managed Care Unit to readily identify the submission as one belonging to a CMO, and to provide the CMO with a means of confirmation that the enrollments have been processed:

- On receipt of the CMO's PMP enrollment forms, the EDS PMP enrollment coordinator enters the data into Indiana*AIM*, verifying the following information:
  - Valid IHCP numbers
  - IHCP eligibility
  - Valid PMP provider type and specialty
  - Valid IHCP service location
  - Valid group and individual relationships
  - Number of PMP service locations
  - Acceptable panel size
- The EDS PMP enrollment coordinator confirms the disposition of the enrollments by sending an e-mail confirmation to the submitter.

Because PMP enrollment to the CMO health plan is a manual process, no exception reports are generated.

Care Select Provider Addendums

On behalf of the State, the CMOs are required to obtain a signed *Care Select* provider addendum for each provider that is enrolled into the *Care Select* program. The addendums should include the original signature of the provider. The original signature page of the addendum must be forwarded to the fiscal agent for storage and future auditing inquiries. A copy of the addendum can be found in the forms section of the IHCP Web site – Managed Care – Care Select and the CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa/.

The CMO should mail or submit a batched packet of addendums weekly to the following:

EDS
950 N. Meridian Street, #1150
Indianapolis, IN 46204-4288
Attention: EDS Provider Enrollment unit.

The packet should include an attention line that states **Attention: EDS Provider Enrollment**. Each addendum should include the provider's name and the NPI and/or legacy provider number used in the Web PMP enrollment or ancillary provider file process. The provider numbers will assist in the correct identification of the *Care Select* provider.

Twice a month, the managed care unit will conduct audits to ensure that the addendums have been received for each provider enrolled into the *Care Select* program.

Changes to PMP Scope of Practice

PMPs may request changes to their scope of practice information by contacting their affiliated CMOs. The scope of practice information includes the following:

- Admit Privileges – Options: Relationship or Privileges
- Delivery Privileges – Options: Yes or No
- Age Restrictions – Options: None, 0-2 years of age, 0-12 years of age, 0-17 years of age, 0-20 years of age, 13-17 years of age, 13-20 years of age, 21 years of age and older, 3 years of age and older, 17 years of age and older, 13 years of age and older
- 24-Hour Telephone Number and Extension
- Accept Obstetrics – Options: Yes or No
- Accepts All Women – Options: Yes or No
- Panel Size
- Panel Size Hold
- Panel Size Hold Removal
- Gender – Options: Male, Female, Male/Female

On receipt of a change request from a PMP, the CMO can perform a change through the **Web interChange** > **Provider Profile** > **Update a PMP**. If the Web interChange is not available, the CMO can submit the *Managed Care PMP Panel Size/Panel Hold Request Form* to the fiscal agent PMP enrollment specialist who updates the PMP's record in Indiana*AIM* to reflect the change.

Panel Size

A PMP designates the desired panel size as part of the PMP enrollment process. The panel size is the number of *Care Select* members a PMP agrees to accept. The individual PMP may determine the maximum.

PMPs who request an increase to their panel size must maintain acceptable quality and access standards such as the following: 24-hour availability, appointment access times, quality, and timely healthcare provision consistent with established community standards of care, minimal number of member complaints, and so forth.

The panel size includes only *Care Select* enrollees and does not include IHCP enrollees in other programs. Physicians treating children with special healthcare needs are subject to the same panel size requirements as other PMPs. The program maintains the requirement that only individual physicians, and not physician groups, enroll as PMPs. The panel size is applicable to the PMP and not to the individual service locations at which a PMP may practice. The panel of a PMP enrolled with two *Care Select* service locations is a combination of the patients assigned to each location. For example, if a PMP is enrolled with a panel size of 500 and has two active service locations, the members assigned to the PMP are spread across the two locations.

The panel size applies to an individual PMP and may not be shared among a group of PMPs. Because *Care Select* members are assigned to a specific PMP and not to a group, a group practice cannot opt to share a panel of 600 members assigned to the group. A billing group of four PMPs could each enroll with a panel of 150 members and provide services to members assigned to other group members.

Changes to Panel Sizes for Currently Enrolled PMPs

Currently, enrolled **PMPs can increase their panel size** at any time by submitting a written request to the CMO. On receipt of a panel size increase request from a PMP, the CMO should submit the panel size update with the effective date of the new panel size through the PMP Update process located in the **Web interChange> Provider Profile > Update**. If Web interChange is not available, the CMO can submit the *Managed Care PMP Panel Size/Panel Hold Request Form* to the fiscal agent's provider enrollment specialist who updates the PMP's record in Indiana*AIM* to reflect the change. This form is located in the *Care Select* CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa.

PMPs can also request a decrease in their panel size at any time by making a written request to the CMO. However, the panel size does not drop below the number of currently enrolled members assigned to the PMP's panel. When a PMP submits a request to lower its panel size, members are not removed from the PMP's panel. CMOs must understand this and communicate this to PMPs who request panel size decreases. On receipt of a panel size reduction request from a PMP, the CMO submits the panel size update with the effective date of the new panel size through the PMP Update process in the **Web interChange>Provider Profile>Update a PMP**. The panel size updates are processed immediately and are viewable in the Web Provider Profile.

If Web interChange is not available, the CMO can submit the *Managed Care Network PMP Panel Size/Panel Hold Request Form* to the fiscal agent PMP enrollment specialist who updates the PMP's record in Indiana*AIM* to reflect the change.

Panel Full Updates

The minimum increment can be relaxed, allowing a PMP with a full panel to add members as follows:

- The enrollee has a previously established relationship with the PMP as determined by the enrollment broker's established criteria.
- The enrollee's family member (identified by case number) selects the PMP.
- Both the member and the PMP are in agreement with the request.

The enrollment broker controls requests to add to full panels. After the enrollment broker confirms that a request meets the criteria outlined, the broker coordinates the request with the fiscal agent's PMP enrollment coordinator. When the enrollment has been entered in Indiana*AIM*, the enrollment broker notifies the CMO of the addition to the PMP's panel.

Panel Hold Requests

A PMP can request a panel hold to prevent new assignments to the practice by selection or default auto-assignment. CMOs must educate their PMPs that a panel hold does not stop assignment of members with the same case ID or members who have had a previous relationship with the PMP (auto assignment's case ID and previous PMP logic). Panel hold requests are usually granted in situations expected to be temporary, and are not to be used as a means to manipulate a PMP's panel with regard to a specific member assignment. The reasons for a panel hold request are documented and monitored to maintain the program's integrity for access reporting and to ensure adequate openings to accommodate new *Care Select* enrollees who self-select or are auto-assigned to a PMP within the program.

On receipt of a request to place a PMP's panel on hold, the CMO submits the panel hold update through the PMP Update process located in the **Web interChange> Provider Profile > Update a PMP**. The panel hold update will be effective the day the submission was completed. If Web interChange is not available, the CMO can submit the *Managed Care PMP Panel Size/Panel Hold Request Form* to the fiscal agent's provider enrollment specialist who updates the PMP's record in Indiana*AIM* to reflect the change.

Reasons for Granting a PMP Panel Hold Request

The following are examples of acceptable reasons for granting a PMP panel hold request:

- PMP has a personal situation such as maternity leave or short-term disability
- PMP is temporarily unable to accept new assignments for professional reasons such as moving practice location
- PMP is taking a temporary leave of absence from the practice
- CMO is researching contractual issues with the PMP, such as quality of care issues or other concerns identified by the program

Temporary Removal of an Approved Panel Hold

PMPs with an approved panel hold can request to have the hold temporarily removed to have a family member of a current patient added to the PMP's panel. Implementation of this procedure is time-sensitive to prevent auto-assignments while the panel hold is temporarily removed and replaced. Because this requires a manual intervention of the Panel Hold the CMOs must be aware of the following processing requirements:

1. The CMO forwards the member enrollment request to a PMP with a panel hold to the enrollment broker for special processing.
2. The enrollment broker receives a member enrollment request with notification from a PMP that the member is being added to its panel.
3. The enrollment broker contacts the CMO.
4. The CMO removes the panel hold and notifies the enrollment broker when the action is completed.
5. The enrollment broker enrolls the approved *Care Select* member to the PMP as requested and immediately notifies CMO when the enrollment is complete.
6. The CMO replaces the PMP panel hold.

This process must be completed in one day to avoid the possibility of unintended assignments to the PMP during the time the panel hold was removed.

Exceptions to the Panel Hold Request

CMOs and PMPs must understand that the panel hold request prevents self-selection or most auto-assignment of new members. PMPs with a panel hold continue to appear on provider lists from which potential *Care Select* members make a PMP selection. Except for members with a previous relationship with the PMP in the *Care Select* program or the family member (identified by a common case number) of a current panel member, new members are not assigned during the temporary panel hold period. Again, it is important for CMOs to communicate this to their PMPs.

Provider Disenrollment

A PMP can be disenrolled from the *Care Select* program for various reasons. The PMP disenrollment process was designed to provide continuing care for *Care Select* members whose PMPs leave the *Care Select* program and are no longer available to its members. A timing guide for this process is contained in *Appendix B : PMP Disenrollment Timeline*.

Overview of PMP Disenrollment Reasons

Disenrollment processes are designed to accommodate *Care Select* members when the PMP becomes unavailable due to immediate, unforeseen reasons such as death or loss of license. When a PMP disenrolls for such a reason, the members assigned to that PMP are auto-assigned to another PMP to allow continuous access to healthcare in the *Care Select* program.

Other disenrollment processes are designed to allow an orderly transition of care for *Care Select* members assigned to a PMP who becomes unavailable due to retirement, a move to a different network, or other circumstances that can be planned. When a member is linked to a PMP who disenrolls for such reasons, the CMO may notify the members of the pending disenrollment and encourage them to select another PMP prior to the date the current PMP becomes unavailable. The new assignment is processed as a PMP change and submitted to the enrollment broker for entry into Indiana*AIM*.

PMP disenrollments fall into two general categories:

- Disenrollment without re-enrollment occurs in circumstances where the PMP disenrolls (or is disenrolled) from his or her current *Care Select* health plan and is not available to members in a different *Care Select* health plan. Examples include the PMP's death, loss of license, retirement, relocation out of a *Care Select* service area, disenrollment from the *Care Select* program for any other reason, or IHCP provider enrollment termination. Members linked to a PMP that is disenrolled without re-enrollment are usually notified to self-select a new PMP within the CMO and are linked through a manual assignment process by the enrollment broker.
- Disenrollment with re-enrollment allows an orderly transition of *Care Select* members assigned to a PMP from one *Care Select* network or service location to the same PMP in a different *Care Select* network or service location. When a PMP disenrolls and re-enrolls, members linked to that PMP are usually auto-assigned to the same PMP in a different network or service location.

Submitting the PMP Disenrollment Request

CMOs are responsible for submitting PMP disenrollments to EDS for processing in Indiana*AIM*. The disenrollment request includes the following information submitted on the transmittal forms in the *Care Select* CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa:

- CMO name and region.

- PMP name, individual and group provider numbers, and service locations (alpha code).
- Signed letter from the PMP or PMP's representative stating the intent to disenroll and the reason for the disenrollment (except in the case of the PMP's death or if the PMP is unavailable to obtain a signature, such as, if he or she moved and did not leave contact information). The signed letter from the PMP should contain a requested effective date. If the PMP declines to provide the disenrollment reason in writing, the CMO can provide it in a cover letter requesting the disenrollment.
- Signature of the authorized CMO representative.
- Notification of whether disenrollment notification letters must be suppressed.

The detailed PMP disenrollment processes indicate whether or not letters are automatically generated due to the disenrollment reason. There may be instances in which EDS determines that a letter to a *Care Select* member should be suppressed. For example, if a PMP disenrolls from one service location, but is available to *Care Select* members at a different location with the same address as result of change in ownership of a group practice.

A CMO can decide to use the automated PMP disenrollment process for a circumstance that differs from the intention of the original design. Some instances can require immediate reassignment of the members to another PMP. For example, a PMP may fail to meet the network standards during recredentialing or other review processes. If the CMO does not have sufficient time to notify the PMP's members of disenrollment, the CMO can submit a disenrollment request, causing the members to be immediately auto-assigned to available PMPs in their network.

It is incumbent upon the CMOs to fully understand the PMP disenrollment process and to use it within the *Care Select* program's stated policies and philosophy of providing access, continuity and quality care to its membership. The following pages provide detailed information about the PMP disenrollment reasons and the result of each. The designations described here are to illustrate how the Managed Care Unit and Indiana*AIM* process PMP disenrollments. CMOs and the enrollment broker need only identify the disenrollment scenario. EDS assigns the appropriate disenrollment reason code based on the scenario provided.

PMP Disenrollment without Re-enrollment from the CMO

A PMP can disenroll from a *Care Select* CMO, or from the *Care Select* program entirely. Examples of disenrollment without re-enrollment include the following:

- PMP's individual or group IHCP eligibility is terminated due to death, loss of license, or disability
- PMP's specialty changes to a non-primary care specialty
- PMP's enrollment within a group is terminated
- PMP's service location is no longer active
- Provider is moving the practice out of the CMO service area
- Provider closes the practice due to retirement or other reason

In these situations, the PMP gives some prior notice to the CMO, allowing for a transition of the patient panel to another PMP within the CMO's network. After the CMO becomes aware of a PMP's intent to disenroll from the CMO health plan or the *Care Select* program, the CMO does the following:

- Immediately notifies EDS in writing of the PMP's intent to disenroll
- Facilitates member assignments to other PMPs within the network
- Forwards member PMP changes to the enrollment broker for processing in Indiana*AIM*

- **Must provide** EDS with written notice specifying the projected end date by five working days prior to the 24th of the month prior to the month in which the disenrollment is effective. The disenrollment notice, submitted on the disenrollment request form, includes the following:
  - CMO name
  - PMP name
  - Provider individual and group ID numbers
  - Service locations
  - Signed letter from the PMP stating the intent to disenroll, including the disenrollment reason and effective date
  - Signature of the authorized CMO representative.
  - CMO cover letter with disenrollment reason. (While a signed letter from the PMP is required, except in the case of death, the CMO can provide the disenrollment reason in a cover letter with the disenrollment request if the PMP declines to specify the reasons for disenrollment in the signed letter.)

CMOs can write a customized letter to the members of a disenrolling PMP to provide information about the PMP's departure from the health plan and information about the selection and transition to a new PMP. The OMPP must first approve all customized letters. On receipt of notification from the CMO of the PMP's intent to disenroll, EDS does the following:

- Enters disenrollment pending on the Indiana*AIM* provider file. This begins the disenrollment process, prevents the PMP from receiving any new member assignments, and suppresses the provider's name from future PMP listings.
- Confirms that the disenrollment has been processed with the requestor
- Initiates the systematic entry of the PMP disenrollment date in Indiana*AIM*.
- Generates confirmation letters to members who have chosen a new PMP as shown in Member and PMP Correspondence of the *Care Select* CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa.
- Sends a PMP disenrollment confirmation letter to the PMP as shown in Member and PMP Correspondence of the *Care Select* CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa.
- Sends the PMP disenrollment confirmation letter to the CMO as shown in Member and PMP Correspondence of the *Care Select* CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa.
- The disenrollment without re-enrollment of a PMP from a CMO health plan requires the CMO to facilitate the assignment of the PMP's patients to other network PMPs if the PMP is not otherwise available in the *Care Select* network. The CMO is responsible for all members assigned to a disenrolling PMP until another PMP selection has been made.

PMP Disenrollment with Re-enrollment from the CMO

Disenrollment with re-enrollment of a PMP from the *Care Select* program may be required. This precludes the provider from continuing patient care during the period after the member is notified and before the member selects another PMP. During this transition period, the member will be considered a Traditional Medicaid member and be able to obtain services from any enrolled IHCP provider. PMP disenrollments with re-enrollment are processed if the disenrolling PMP is available to members in a different *Care Select* network. Some reasons for a PMP disenrollment with re-enrollment include:

- PMP disenrolls from a group location to open an individual practice location or disenrolls from an individual practice location to join a group
- PMP disenrolls from one group and enrolls with another group

- PMP disenrolls from one CMO health plan and enrolls with another CMO health plan

The CMO initiates the disenrollment process for PMP disenrollments as described previously. Physicians requiring disenrollment are identified by the CMO with a letter from the PMP stating intent to disenroll from the CMO health plan. CMOs submit the request for PMP disenrollments to the fiscal agent (EDS) using the appropriate *Managed Care Disenrollment Request Form* provided in *Care Select* CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa.

On notification of a disenrollment, EDS immediately does the following:

- Verifies the disenrollment reason and, if appropriate, enters a disenrollment pending status in the provider file in Indiana*AIM* to suppress the PMP's name from PMP listings and prevent further member assignments
- Approves the disenrollment effective the last day of the month if notice is received at least five working days before the 24th of the month. Disenrollments approved after the 24th of a month are effective the last day of the following month with the CMO maintaining responsibility for the PMP's panel until all members are reassigned
- Reenrolls PMP to the new relationship as noted above
- Notifies members with a letter of the update to their PMP. This letter may also instruct members to call the CMO member services hotline to select another PMP. The Member and PMP Correspondence letters can be found in the *Care Select* CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa.
- Notifies the PMP with a letter outlining the change
- Auto-assigns members to new PMP within the CMO's health plan (if possible) who have not been reassigned by the 25th day of the month in which the disenrollment occurs if the disenrolled PMP is not available to members in the *Care Select* program
- Auto-assigns members to the same PMP at the new service location, or new health plan, if applicable
- Generates PMP confirmation letters to members who have been auto-assigned or have made a PMP change

For a PMP disenrollment from the *Care Select* program, the CMO continues to provide care to assigned members through the PMP's group practice or another PMP until the members have selected another PMP or have been auto-assigned.

IHCP Disenrollment and PMP Disenrollment

If EDS Provider Enrollment receives an IHCP disenrollment request from an individual provider (a billing provider or dual provider) or from a group requesting disenrollment for one of its members (a service provider), and the provider is a PMP, Provider Enrollment does not process the disenrollment until the PMP disenrolls from care management.

PMP Panel Transfer Requests

Policy

It is the OMPP's policy to allow a *Care Select* PMP or the CMO to request the transfer of the PMP panel to another PMP in the event that the current PMP is unable or unwilling to continue providing service to those members assigned to him or her.

The OMPP approves these requests if the current PMP requests the panel transfer and the members are better served by establishing a new PMP at the same location or one within the CMO health plan. These requests are approved if the request comes from the CMO only if the PMP is not available to make the request on his or her own behalf (for example, due to death or relocation).

These requests must be submitted to the enrollment broker for review and approval before the PMP changes are processed into Indiana*AIM*. The enrollment broker confirms that the PMP is no longer available to members at a new location or health plan. When the review is complete and approval granted, the enrollment broker notifies the requesting CMO and EDS that the request has been approved. EDS suppresses the member notification letters about the PMP disenrollment and the member receives the proper Indiana*AIM*-generated letter advising of the PMP change. If the request is not granted, the enrollment broker notifies the CMO of the denial and the reasons for it.

The CMO submits the PMP changes to the enrollment broker using the appropriate form and the proper change reason code.

Procedure

All parties understand that the member may make another selection if they are not satisfied with the selection made by the current PMP or CMO.

The following are the circumstances under which a panel transfer can be requested and the procedures to be followed.

PMP Request

- The PMP signs a letter to request a panel transfer. This letter includes the reason why he or she is no longer willing or able to serve as a PMP. The letter should also name a specific PMP or PMPs who should receive assignment of the current PMP's members.

> *Note: The PMP must sign the letter. An office staff member should not sign because of the potential for a conflict of interest. For example, the PMP may be leaving a group practice and opening a solo practice. Both the PMP and the group may want to keep the members. However, because members are linked to a PMP and not a group, members should follow the PMP to the new location. In some cases, the PMP may choose to transfer his or her members because the new practice location is a considerable distance from the current location.*

- The CMO must send the enrollment broker the CMO's *PMP letter and a Panel Transfer Request Form* by no later than the 15th of the month for a disenrollment to be effective at the end of that month.
- The enrollment broker reviews the documentation and either approves or denies the request. The enrollment broker generally completes and approves or denies the request and communicates the decision within 48 hours. However, if it receives insufficient or questionable documentation, it may take longer to process the request because the enrollment broker must attempt to confirm the request and the fact that the PMP does wish for his or her panel to be transferred.
- When the request is approved, the enrollment broker sends an e-mail notification of the approval to the requesting CMO and EDS.
- When the request is denied, the enrollment broker sends an e-mail notification to the requesting CMO. This e-mail outlines the reasons for the denial.
- The enrollment broker submits a written notification of approval or denial to the CMO.

- This approval document ***must*** accompany the disenrollment paperwork the CMO sends EDS. This approval form confirms that EDS should suppress the member notification letters of the PMP's disenrollment.
- Upon receiving approval, the CMO should submit the PMP changes to the enrollment broker on the appropriate form with the appropriate change reason code for processing into Indiana*AIM*.
- Members receive system-generated letters informing them of their new PMP assignment.

Plan Request

- The CMO signs a letter to request a panel transfer. This letter should include the reason the PMP is no longer willing or able to serve as a PMP and why the PMP is not making the request. An appropriate reason could include death, serious illness or relocation with no forwarding address or phone number. The letter should also name a specific PMP or PMPs who should receive assignment of the current PMP's members. The CMO forwards the PMP letter and a *Panel Transfer Request Form* to the enrollment broker no later than the 15th of the month for a disenrollment to be effective at the end of that month.
- The enrollment broker reviews the documentation and either approves or denies the request. The enrollment broker generally completes and approves or denies the request and communicates the decision within 48 hours. However, if the enrollment broker receives insufficient or questionable documentation, it may take longer to process the request because the enrollment broker must attempt to confirm the request and the fact that the PMP wishes his or her panel to be transferred.
- The enrollment broker submits a written notification of approval or denial to the CMO. The approval document ***must*** accompany the disenrollment paperwork that the CMO sends to EDS. This approval form confirms whether EDS should suppress the member notification letters of the PMP's disenrollment.
- Upon receiving approval, the CMO should submit the PMP changes to the enrollment broker on the appropriate form with the appropriate change reason code for processing into Indiana*AIM*.
- As determined by the approval process, members will receive system-generated letters informing them of the new PMP assignment.

Maintenance of Medical Records

The CMO must ensure that its participating providers maintain medical and other records of all medical services provided to enrollees by the CMO and its providers for seven years, in accordance with *Indiana Code* (*IC) 16-39-7-1*. The CMO medical records standards must be consistent to the extent feasible, with NCQA accreditation standards for medical records. The records must at least be legible and must include the following:

- Patient identification information (patient name or identification number) on each written page or electronic file record
- Personal biographical data
- Entry date
- Provider identification
- Allergies
- Past medical history
- Immunizations
- Medical information

- Consultations
- Referrals
- Medical conditions and health maintenance concerns
- Written instructions for a living will or durable power of attorney for healthcare when the patient is incapacitated and has such a document
- A record of outpatient and emergency care
- Specialist referrals
- Ancillary care
- Diagnostic tests and findings
- Prescriptions for medications
- Inpatient discharge summaries
- Histories and physicals, including a list of smoking and chemical dependencies
- EPSDT services

Providers must maintain medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Health records must be legible, signed, dated, and maintained for at least seven years as required by *IC 16-39-7-1*. Confidentiality of protected health information (PHI) must be maintained in accordance with HIPAA.

The State (or its contractor) must have access to medical records for medical record reviews. In accordance with *Indiana Administrative Code (IAC) 405 IAC 1-5-1*, the PMP must retain all records relating to the provision of CMO services for at least seven years from the date of record creation. The PMP must transfer, at the request of the OMPP or the CMO, a summary or copy of the member's medical records to another PMP if the member is reassigned.

Any physician receiving payments from the IHCP for rendered services may not charge an IHCP member for medical record copying or transfer. Federal regulation *42C.F.R.447.15* states that providers participating in Medicaid must accept the State's reimbursement as payment in full (except that providers may charge for deductibles, co-insurance, and co-payments).

CMO Communications with Providers

The CMO must establish policies and procedures to maintain frequent communications and provide information to its provider network. As required by the *Code of Federal Regulations (CFR) 42 CFR 438.207(c)*, the CMO must notify the State of significant changes that may affect a procedure at least 30 calendar days prior to notifying its provider network of the changes. The CMO must give providers 45 calendar days advance notice (per *IC 12-15-13-6*) of significant changes that may affect the providers' procedures such as changes in subcontractors. The CMO must post a notice of the changes on its Web site to inform both network and out-of-network providers and make payment policies available to non-contracted providers upon request.

In accordance with *42 CFR 438.102*, the CMO must not prohibit, or otherwise restrict, a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of a member. The CMO must develop and maintain a user-friendly Web site for network and out-of-network providers within three months of the effective date of the CMO's contract with the State. The OMPP must preapprove the CMO's Web site information and graphic presentations. The CMO may choose to develop a separate provider Web site or incorporate it into the home page of the member

Web site. The provider Web site may have secured information available to network providers but must, at a minimum, have the following information available to all providers:

- CMO's contact information
- *CMO Provider Manual* and forms
- CMO bulletins or newsletters issued not fewer than four times a year that provide updates related to provider services, and updated policies and procedures specific to the *Care Select* population
- The State's preferred drug list
- Claim submission information such as, but not limited to, the State's submission and processing requirements, paper and electronic submission procedures, emergency room auto-pay lists and frequently asked questions
- Prior authorization procedures
- Appeal procedures
- PMP and specialty network listings
- Links to the State's Web site for general IHCP or *Care Select* information
- HIPAA privacy policy and procedures
- Must refer questions regarding claims payment or denial to the State's fiscal agent.

The CMO must maintain a toll-free telephone helpline for all providers with questions, concerns, or complaints. The CMO must staff the telephone provider helpline with personnel trained to accurately address provider issues during (at a minimum) a 10-hour business day, Monday through Friday. The CMO must maintain a system for tracking and reporting the number and type of providers' calls and inquiries. The CMO must monitor its provider helpline and report its telephone service performance to the OMPP as described in the *CMO Reporting Manual.*

The fiscal agent sponsors quarterly workshops throughout the state and an annual seminar for all IHCP providers. The CMO must participate in the quarterly regional workshops that are held in its service areas and the annual provider seminars.

An appropriate representative must be available to make formal presentations and respond to questions during the scheduled time(s). The OMPP also encourages CMOs to set up an information booth with a representative available during the annual seminar.

Practice Standards

Universally Accepted Practice Standards

There must be evidence that the CMO further enhances quality of service to their *Care Select* members by requiring PMPs to adhere to nationally accepted standards or guidelines for preventive care for pregnant women, infants, children, adolescents, and adults.

The CMO must use or develop preventive health guidelines based on reasonable medical evidence and national guidelines. Guidelines adopted by the CMO must include those endorsed by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the American Society of Internal Medicine (ASIM), the American College of Physicians (ACP), the American College of Obstetrics and Gynecology (ACOG), the U.S. Preventive Services Task Force, the American College of Surgeons, the National Cancer Institute (NCI), and the American Cancer Society. The CMO must provide evidence that it reviews the guidelines and scientific literature to be

incorporated into the CMO preventive health guidelines. Guidelines must be shared with the CMO's Quality Improvement Committee (QIC) and subcommittees, if any, and must include provider participation. The QIC and subcommittees must have an opportunity to review, comment on, and make modifications reasonable for local practices.

The guidelines must include the full spectrum of the *Care Select* population enrolled in the CMO. Primary and secondary prevention must be addressed for populations identified as being high risk. Practice guidelines must include areas of study, methodology, indicators, analysis, plans for corrective action, follow-up, and assessment of effectiveness.

The CMO must provide evidence that supports how it shares preventive health guidelines with CMO providers, including new and existing providers. There must also be evidence that the CMO has plans for sharing new guidelines and revisions to guidelines. Communications can include provider newsletters, mailings, and provider manuals.

The CMO must establish mechanisms to monitor and review provider compliance and consistency in following preventive care guidelines. Barriers must be identified.

CMOs must publicize to members the availability of preventive health services, guidelines for these services, and the recommended frequency or conditions under which prevention activities are required. CMOs may inform members through member newsletters, member orientation packets, member handbooks, and targeted mailings.

> *Note: Additional evidence-based clinical practice guideline information is available at the National Clinical Guidelines Web site at http://www.guidelines.gov/.*

Early and Periodic Screening, Diagnosis, and Treatment Program

The federally established EPSDT program, known as HealthWatch in Indiana, is part of the IHCP and was established in 1967. The HealthWatch program is a children's preventive healthcare program providing initial and periodic examinations and medically necessary follow-up care. The program objectives are to improve the overall health of infants, children, and adolescents through early detection and treatment of medical conditions. These efforts can reduce the risk of more costly treatment or hospitalization that can occur when detection of a medical problem is delayed.

This program is available to eligible children from birth through 20 years of age on a voluntary basis. Any medical provider enrolled in the IHCP is eligible to offer HealthWatch screenings for IHCP-enrolled infants, children, and adolescents. Medical providers can offer EPSDT services to new and existing IHCP patients. If the provider participates in the *Care Select* care management program as a PMP, the provider **must** participate in HealthWatch and offer or arrange for the full range of EPSDT screenings, recommended immunizations, and follow-up care for members in the applicable age ranges.

To meet standards for preventive child healthcare, the State requires adherence to guidelines developed by the American Academy of Pediatrics (AAP). The AAP publishes a schedule of recommendations for screening components, frequency for screenings, and immunizations started in infancy. There is also an accelerated screening and immunization schedule for children older than 2 years old who have not already received the recommended screenings or immunizations. For additional information, refer to the HealthWatch Recommended Screening Techniques and Referral Standards in the *IHCP Provider Manual* and the *HealthWatch/EPSDT Provider Manual*.

CMOs are responsible for ensuring that members receive EPSDT services. The OMPP conducts ongoing studies for this designated focus area to measure results and monitor CMO compliance with this area of critical importance to *Care Select* program members.

Prenatal and Pregnancy-Related Care

The OMPP has implemented pregnancy-related standards of care that are applied to members in all of the IHCP. CMOs must consider these as minimum standards for their *Care Select* enrollees. These standards of care are based on the American College of Obstetricians and Gynecologists (ACOG)-recommended policies that include prenatal, delivery, and postpartum care. In general, the IHCP provides coverage for 14 prenatal and two postpartum care visits, which ideally occur throughout a low-risk pregnancy as follows:

- First trimester – three visits
- Second trimester – three visits
- Third trimester – eight visits
- Postpartum – two visits within eight weeks of delivery

The program does not place limits on the number of prenatal visits reimbursed for a member identified with a complicating condition that causes her to be a medically high-risk patient. The IHCP reimburses for appropriate laboratory tests and screenings during the pregnancy and two postpartum visits.

These standards, including diagnoses designated as high-risk and recommended laboratory tests and screenings, are described in detail in the *IHCP Provider Manual*.

Members who enroll with a CMO, either voluntarily or by auto-assignment, in the third trimester of pregnancy must be given particular attention about continuity of prenatal care. CMOs must make a financial arrangement with an out-of-network provider to continue care through the pregnancy if the member does not wish to change doctors in the late stages of a pregnancy. *Section 4: Care Select Services* lists CMO requirements for continuity of prenatal care.

Future Standards

CMOs are expected to add detailed practice standards for other patient conditions including the following:

- Breast cancer and mammography
- Cervical cancer and pap smears
- HIV/AIDS
- Asthma
- Diabetes
- Hypertension
- Sexually transmitted diseases
- Cholesterol screening
- Prevention of influenza
- Smoking prevention and cessation
- Immunizations

- Domestic violence

These standards are developed by the OMPP's Quality Improvement Committee (QIC) based on consultation with and recommendations from the following:

- IHCP physician providers
- Indiana medical community at large
- External Quality Review Organization (EQRO) and the Health Plan Employer Data and Information Set (HEDIS)
- Federal Agency of Health Care Policy and Research (AHCPR)
- Centers for Disease Control and Prevention (CDC)
- IHCP Coordinated Care Technical Assistance Group (TAG)
- Other Department of Health and Human Services (DHHS) collaborative TAG committees.

A medical director and one other person knowledgeable about care management, quality improvement, and data analysis processes represents CMOs on the QIC committee. CMOs must have practice standards in place for any of the previously listed or other conditions and must make these standards available to *Care Select* enrollees after review and approval by the OMPP.

Reimbursement Overview

The reimbursement methodology and process for the *Care Select* Program includes the following:

- The *Care Select* Program continues to reimburse providers directly based on the standard IHCP fee-for-service schedule. The CMO should reference the *IHCP Provider Manual* for all requirements for *Care Select* claims processing.
- PMPs receive a monthly $15 case management fee for each *Care Select* member enrolled with the PMP, in addition to the fee-for-service reimbursement.
- The PMPs are eligible to be reimbursed for the CMO care coordination conferences. The CMOs coordinate with the *Care Select* PMPs to perform care coordination conferences to review a member's progress and care management plan.

Reimbursement for PMPs

Indiana Health Coverage Providers and PMPs providing services to *Care Select* members should continue to bill the *Care Select* Program via EDS. Reimbursement for these services is based on the standard IHCP fee-for-service schedule.

Reimbursement for the *Care Select* Care Coordination Conference service requires the service be performed by the PMP assigned to the member or a nurse practitioner in the same group as the *Care Select* PMP. If a provider other than the member's *Care Select* PMP or nurse practitioner in the same group as the *Care Select* PMP bills for the service, the claim will be denied for Explanation of Benefit code, 1050 – *The recipient is enrolled in the Care Select Program. Care Management service must be billed by the member's assigned Care Select PMP or nurse practitioner in the same group as the Care Select PMP.*

Each *Care Select* PMP is limited to two one-hour care coordination conferences per 12 rolling month period, for each *Care Select* member.

Services must be billed using HCPCS 99211 SC – Office or other outpatient visit for the evaluation and management of an established patient. *Care Select* PMPs are reimbursed $40 for each encounter.

The *Care Select* PMP may allow a Nurse Practitioner in the same group to perform the *Care Select* Care Coordination Conference service. When billing, the Nurse Practitioner must use their unique rendering provider number that is associated with the *Care Select* PMP's group number. If the Nurse Practitioner is not enrolled in the IHCP with their provider number, then the service is billed using the PMP's provider number and the SA modifier must be appended to the service.

For example, the Nurse Practitioner in the same group as the *Care Select* PMP performs the *Care Select* Care Coordination Conference service. The Nurse practitioner is not enrolled in the IHCP with their provider number. The claim is billed with the *Care Select* PMP's provider number as the rendering provider and the service is billed as 99211 SC SA.

Claims billed by a Nurse Practitioner that is enrolled with their own IHCP Provider number, but the provider number is not associated with the *Care Select* PMP's group billing number will be denied for edit 1050 – *Care Select Care Coordination Service must be billed by a Care Select PMP or a Nurse Practitioner in the same group as the Care Select PMP*.

Claims for *Care Select* Care Coordination Conference services that exceed the program limitation will be denied with Explanation of Benefit code, 6925 – *Care Select Care Coordination service is limited to 2 units of service per member, per rolling 12 months*.

Claims Processing

EDS will process claims for *Care Select* members. However, the CMO to which the member is assigned is responsible for reviewing claims that suspend for medical policy audits directly related to the *Care Select* programs. ADVANTAGE Health Systems - FFS is responsible for reviewing claims that suspend for medical policy related audits for services rendered to members in FFS. *Care Select* claims submitted with missing or invalid certification codes that require PMP referral will be subject to the following *Care Select* Edits and will systematically deny:

1047 - The Certification Code is Missing-*Care Select*. Please verify and resubmit.

1048 - The Certification Code is Invalid-*Care Select*. Please verify and resubmit.

1049 - The recipient is enrolled in the *Care Select* Program. Claim must have recipient's primary medical provider information. Please provide information and resubmit.

Care Management Fee

PMPs enrolled in the *Care Select* network, not receiving cost-based reimbursement (that is, not in a Federally Qualified Health Center), will receive a $15 per member monthly case management fee. Reimbursement is sent automatically on or about the fifteenth of each month. The case management fee is not a separate payment. The case management fee will be included on the physician's Remittance Advice for all members assigned to the PMP's member panel when the Administration fee job runs for the month. Administrative management fees are not pro-rated for members who are effective with the PMP for only half of the month. Federally Qualified Health Centers (FQHCs) and other providers receiving cost reimbursement do not receive the $15 case management fee.

The fiscal agent will create an administrative fee listing report for each PMP that will be mailed to the either the PMP or group provider's mailing address. *Appendix G : Administration Fee Listing Layout* provides a sample administration fee report layout.

Stop Payment Administration Fee

The CMOs have the mechanism through Indiana*AIM* to place a stop payment on the Administration fee to be paid to a PMP for a specific member due to noncompliance of the care management of a

member. The OMPP with the coordination of the CMOs will be creating business rules that will outline the creation and approval of the Stop payment administration fee process.

The CMOs can access the Indiana*AIM* Stop Payment window through the member's PMP assignment history window. (See sample screens below.) The CMOs will only be able to view, create or modify the current and historical information of their assigned members. The CMOs will need to assign users access to the Admin Fee Stop Payment Maintenance window so that they can perform the data entry. To assign users to the window, complete the Indiana*AIM* Access Security form found on the CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa. All users accessing Indiana*AIM* must complete the State's HIPAA training requirements.

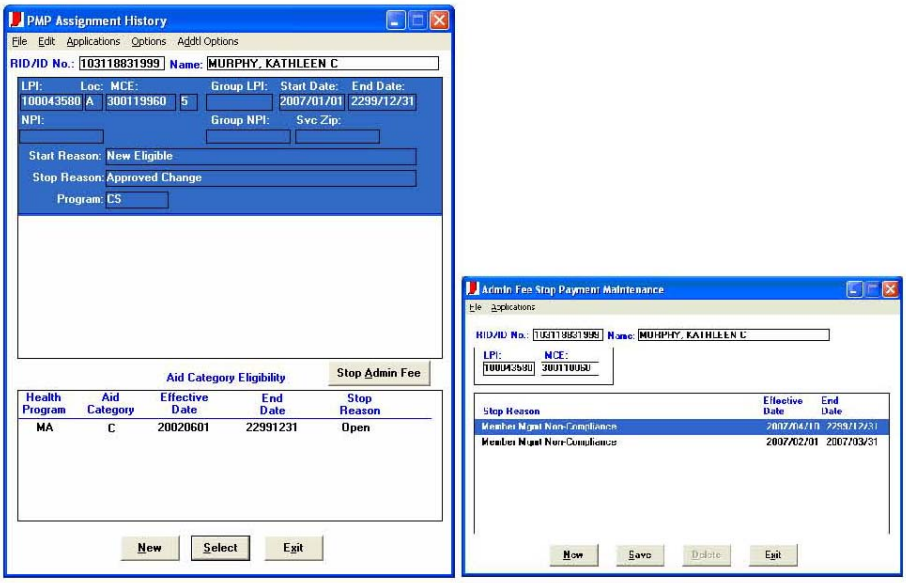

Figure 8.1 Stop Administration Fee Payment Windows

Upon entry of a stop payment record for a member, the administration fee will be discontinued for the PMP until the stop payment record has expired. The Administration fee listing will record the member with a zero in the amount paid and include the effective date of the Stop payment until the stop payment record is no longer effective.

Appropriate Claim Forms

Consistent with *Care Select* policy, all *Care Select* providers are required to submit claims to the OMPP's fiscal agent (EDS) using the appropriate claim filing methodology when requesting reimbursement for medical services rendered to *Care Select* members. For specific detail, please refer to the *IHCP Provider Manual*.

Non-PMP Billing

All medical providers, other than the member's PMP, who are rendering services to *Care Select* members, must contact the member's PMP prior to providing any services, unless the member is accessing a self-referral provider. Medical providers other than the PMP must obtain authorization from the member's PMP in order to submit claims to the *Care Select* program.

If the provider rendering care to a *Care Select* member is not the member's PMP, all submitted claims must indicate the referring PMP's IHCP provider number, and two-digit certification code. (UB- 92

claims use the PMP's license number and certification code to indicate PMP authorization.) Without this information, the claim will not be paid. This requirement does not apply to PMP-enrolled physicians within a group practice or clinic enrolled under the same billing number.

Reimbursement for care provided to a *Care Select* member follows the same procedures whether the rendering provider is a resident, a mid-level practitioner or another physician who is not the member's PMP. Providers rendering services to *Care Select* members are reimbursed under the existing IHCP Fee Schedule. (See the current IHCP Fee Schedule on the web at www.indianamedicaid.com.)

Providers of ancillary type services should submit claims for reimbursement to IHCP. All providers must verify *Care Select* eligibility and care management enrollment through the various member eligibility verification systems, and submit claims for reimbursement accordingly.

For *Care Select* members, pharmacy, home health and transportation providers should submit claims directly to EDS. Providers of these types of service must continue to complete Prior Authorization requests to PA vendor for members in *Care Select* as directed in the Indiana Health Coverage Programs Manual.

Billing and Balance Billing IHCP Enrollees

The IHCP and federal regulations specifically prohibit providers from charging IHCP enrollees for covered services except in specific, limited circumstances. IHCP-enrolled providers are required to accept the IHCP's determination of payment for covered services as payment in full, except for co-payments and any other patient liability payment as authorized by law. The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that it is not covered by the program.

The *IHCP Provider Manual* contains detailed information about billing IHCP members. Generally, IHCP-enrolled providers can bill members only under the following conditions:

- The service is not covered under the IHCP (for example, cosmetic procedures)
- The member has exceeded the program limitation for a particular service
- The member understands that IHCP does not cover the service and accepts financial responsibility prior to receiving a service that is not covered by the program
- The services provided are covered or non-covered embellishments or enhancements to covered services. These services can be considered and billed separately from the basic service only if a separate procedure, revenue, or National Drug Code (NDC) exists for the enhancement. Otherwise, a service in its entirety is considered covered or non-covered
- The provider has taken appropriate action to identify a responsible payer, and the enrollee has failed to inform the provider of IHCP eligibility before the one-year claim filing limitation

CMO contracted providers, as IHCP-enrolled, are subject to the same policy outlined above. While the OMPP and Centers for Medicare & Medicaid Services (CMS) recognize that there may be circumstances unique to the care management environment in which billing a member may be appropriate, the OMPP discourages this practice. If a CMO elects to permit its contracted providers to bill members under any circumstance, the CMO must do all of the following:

- Develop sufficient safeguards to ensure that members are able to access medically necessary services
- Ensure that members are not subject to any coercive practices
- Ensure that members are informed of their right to file a grievance

The CMO can permit a provider to bill a member for services that require authorization, but for which authorization is denied, if certain safeguards are in place and followed by the provider. CMOs must establish, communicate, and monitor compliance with procedures that must include at least the following:

1. The provider must establish that authorization has been requested and denied prior to rendering the service.
2. The provider can request CMO review of the authorization decision. The CMO must inform providers of the contact person, the means for contact, the information required to complete the review, and procedures for expedited review if necessary.
3. If the CMO maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that the authorization has been denied. Covered services may be available without cost in the CMO network if authorization is provided.
4. The member must be informed of the right to contact the CMO to file an appeal if the member disagrees with the decision to deny authorization.
5. The providers must inform the members of member responsibility for payment if the member chooses to or insists on receiving the service without authorization.
6. If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver must meet the following requirements:
   - The waiver is signed only after the member receives the appropriate notification stated in requirements 3 and 4.
   - The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.
   - Providers must not use non-specific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services.
   - The waiver must specify the date the services are provided and the services that fall under the waiver's application.
7. The provider must have the right to appeal any denial of payment by the CMO for denial of authorization.

Physician Pay for Performance

The CMO will develop a pay for performance program that focuses on rewarding physicians' efforts to improve health outcomes for Indiana *Care Select* Program members.

Pay for performance programs are performance-based payment systems that offer financial and non-financial incentives to health plans, providers and members for meeting quality performance targets. The CMO must establish a performance-based incentive system, at a minimum, for high volume providers and for members. The OMPP will define high-volume providers, and will identify the priority areas to be addressed by the provider and member incentive system. These priority areas may change from time to time and the OMPP will determine these priority areas based on State and Federal priorities, and with input from the CMO.

With State approval, the CMO will determine its own methodology for incenting providers and members. Incentives may be financial or non-financial. However, if the CMO offers financial incentives to providers, these payments must be above and beyond the standard Medicaid fee-for-service fee schedule. At least 75 percent of any performance-related delayed payments the CMO receives from the State must be passed on to providers and/or members.

Disclosure of Physician Incentive Plan

The CMO may implement a physician incentive plan (PIP) only if:

- The CMO makes no 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 enrollee; and
- The CMO meets requirements for stop-loss protection, member survey, and disclosure requirements under 4*2 CFR 438.6*.

Federal Regulations *42 CFR 438.6*, *42 CFR 422.208,* and 42 *CFR 422.210* provide information about physician incentive plans, and the CMS provides guidance on its Web site. The CMO must comply with all federal regulations regarding PIP and supply to the OMPP information on its PIP as required in the regulations and with sufficient detail to permit the State to determine whether the incentive plan complies with the federal requirements. The CMO must provide information about its PIP, 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.

The disclosure to the State shall include the following:

- The CMO must report whether services not furnished by physician/group are covered by incentive plan. No further disclosure required if the PIP does not cover services not furnished by physician/group.
- The CMO must report type of incentive arrangement, for example withhold or bonus
- The CMO must report percent of withhold or bonus (if applicable)
- The CMO must report panel size, and if patients are pooled, the approved method used
- If the physician/group is at substantial financial risk, the CMO must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

Section 9: Member Eligibility and Enrollment

General Eligibility Information

The Division of Family Resources (DFR) is responsible for IHCP eligibility determination. DFR is also responsible for updating member eligibility and personal data for continuing enrollees (such as changes in household, including births, deaths, and so forth) at periodic eligibility redeterminations. This data is entered into the Indiana Client Eligibility System (ICES). Potential *Care Select* care management members can apply at various enrollment centers located in hospitals, clinics, schools, and other outreach locations throughout the state. Enrollment center personnel help potential members complete applications and forward them to the DFR for processing. Potential members may also call the *Care Select* helpline at 1-877-963-7383 or visit the Indiana Family and Social Services Administration (IFSSA) Web site at www.ifcem.com to apply online or request a mail-in application. The enrollment broker's Web site at http://www.indianacareselect.com/ allows users to search for DFR offices and enrollment centers.

EDS, as the OMPP fiscal agent, receives ICES enrollee eligibility updates that interface daily with Indiana*AIM*. Enrollee data retained in Indiana*AIM* is used to confirm eligibility for various IHCP programs, including *Care Select*, during claims processing. Providers may view enrollee eligibility data through Indiana*AIM* using the Eligibility Verification Systems (EVS). Caseworkers enter changes into ICES and Indiana*AIM* is updated by receipt of the daily ICES tapes. A member does not appear as *eligible* for the IHCP in Indiana*AIM* until EDS receives the member's ICES record.

The enrollment broker enrolls potential members in *Care Select* care management by establishing a link between the enrollee and their selected *Care Select* primary medical provider (PMP) and health plan in Indiana*AIM*. The State retains sole responsibility for the maintenance of general IHCP eligibility and assignment of the member's aid category.

The following IHCP members will be covered by the *Care Select* Program:

- Aged
- Blind
- Physically and mentally disabled
- Members receiving adoption assistance
- Members in the Waiver Program
- M. E. D. Works participants

Members who are enrolled in aid categories *MA3* and *MA4* or otherwise designated as *foster children* or *wards of the court* **are eligible for Hoosier Healthwise but should not be excluded from *Care Select* if another factor makes these children ineligible for Hoosier Healthwise.**

The State requires the CMO to accept as enrolled all individuals appearing on the enrollment rosters. The CMO and rendering provider are responsible for verifying the member's eligibility. In accordance with *42 CFR 438.56, Sections (c), (d) and (e)*, the CMO must have policies and procedures that allow members to change their PMPs.

IHCP Enrollees Not Eligible for Care Select

There are some categories of IHCP enrollees not eligible for the *Care Select* care management program even though the enrollees are in an otherwise eligible aid category. Some examples of these groups are the following:

- *Care Select* members who move out of Indiana, even though they may retain IHCP eligibility while residing outside the state
- Illegal aliens who are eligible for limited benefits in the IHCP (Package E)
- Members eligible for Medicare
- Members who have been State-approved for long-term care and the level of care has been entered into Indiana*AIM*
- Members who receive IHCP hospice care
- Members who receive services under the Home and Community Based Services Waiver (HCBS) program
- Members eligible for spend-down
- Other members and potential members as determined by the OMPP

Members in these sub-groups are disenrolled from the care management program when they are identified. *Member Disenrollment*, covered later in this section, provides additional information.

The State has sole authority to determine if families or individuals meet the eligibility criteria and are eligible to enroll in the care management programs.

Hoosier Health Identification Cards

Each newly enrolled member in any IHCP benefit package receives a Hoosier Health identification card. This card identifies IHCP members and provides current benefit information to their providers. New members are assigned a member identification number (RID) on initial entry in ICES. The RID is unique to each member and is a randomly generated, sequential identification number assigned for life. The fiscal agent, EDS, produces and mails identification cards to new members within three days of eligibility determination after the information transfers from ICES to Indiana*AIM*. Eligibility information on the plastic ID card is contained in a magnetic strip and is updated, as necessary, to reflect changes in eligibility status. The identification card is meant to be a permanent card, and is not reissued for members who become eligible after a period of ineligibility, unless the card has been lost or stolen. Members who require replacement Hoosier Health Cards must contact their assigned caseworker in the local county office of the DFR or call the *Care Select* Helpline at 1-877-963-7383.

The front of the Hoosier Health Card, shown in Figure 9.1, contains the following information:

- Member's name and gender
- A 12-digit member identification (RID) number identifying the member
- Birth date

Figure 9.1 – Hoosier Health Card

The member, or the member's parent or guardian, if the member is a child, must sign the identification card.

Even when a member presents a Hoosier Health Card, the provider is responsible for verifying eligibility prior to rendering services. Additional information about eligibility verification can be found later in this section. The *IHCP Provider Manual* provides detailed information about the Hoosier Health Card. Possession of a Hoosier Health Card does not guarantee current eligibility. Providers must verify eligibility each time they see an IHCP member, prior to rendering services.

Occasionally, ICES or a CMO identifies a member who has been issued more than one RID in error. CMO personnel who identify a member with a multiple active RIDs must contact EDS Managed Care with the information.

CMOs may present and distribute their own health plan ID cards for *Care Select* members enrolled in their networks. However, CMOs may **not** require *Care Select* members to produce a health plan card to receive services within the network. CMO ID cards do not replace the IHCP Hoosier Health card.

Retroactive Eligibility

Retroactive Eligibility is not applicable in *Care Select*. The newborn whose mother is enrolled in a CMO will be Hoosier Healthwise eligible, and therefore automatically assigned to an MCO in RBMC. The newborn's effective date with the MCO is prospective, since the mom belonged to a CMO versus an MCO at the time of birth.

Care Select Enrollment

After the IHCP eligibility has been determined or redetermined, members in eligible aid categories must enroll in *Care Select*. Potential *Care Select* members receive program information and education from the enrollment center or, another authorized site. In addition, a potential member can seek enrollment assistance or program information from a benefit advocate (BA) by calling the *Care Select* Helpline at 1-877-963-7383.

The enrollment broker helpline representative asks the caller to confirm that the education process has been completed prior to entering the PMP and CMO selection in Indiana*AIM*. If the potential member has not received education about the *Care Select* program, the representative provides the necessary education before taking the selection information.

Care Select-eligible members are given 30 days from initial eligibility to complete the education process and make a voluntary PMP and CMO selection. Eligible members whose PMP and CMO selection is not entered into Indiana*AIM* within the first 30 days of eligibility are enrolled by the system's auto-assignment process described later in this section. During this 30-day enrollment period, *Care Select* enrollees can access medical care in the IHCP fee-for-service (FFS) program. The

exception to the 30-day FFS period is for newborn children whose mothers were enrolled in a CMO network on the date of delivery. Additional information about newborn enrollment is included later in this section.

Enrollment becomes effective after a potential enrollee is linked to a PMP and CMO in Indiana*AIM*. Enrollments entered in Indiana*AIM* between the 11th and 25th days of the month are effective on the first day of the following month. Enrollments entered between the 26th day of a month and the 10th day of the following month are effective on the 15th day of the following month. The member's PMP and CMO selection is verified by the *Care Select Welcome Letter* that contains the PMP name, address, telephone number, and CMO health plan, name, and telephone number which is generated by Indiana*AIM* and sent to the member.

A pregnant woman can select a PMP for her unborn child. The CMO must encourage preselection and have procedures to facilitate that selection. The procedure for preselection of a PMP to care for the newborn child from the date of birth is included later in this section.

Members with Special Healthcare Needs

The CMO must have plans for provision of care for the special needs populations and for provision of medically necessary, specialty care through direct access to specialists. The *Care Select* care management program uses the definition and reference for children with special healthcare needs as adopted by the Maternal and Child Health Bureau (MCHB) and published by the American Academy of Pediatrics (AAP):

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

In accordance with *42 CFR 438.208(c)*, the State's enrollment broker conducts a Health Needs screening to identify members with potential special healthcare needs. The screening tool assigns children to one of the living with illness measures (LWIM) screener health domains based on the National Committee on Quality Assurance (NCQA) study design. The scoring for the LWIM screener identifies a child as potentially having a special healthcare need in one of seven different health domains:

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

The CMO receives the screening results for subsequent assessment by a CMO healthcare professional and facilitates care coordination. However, not all *Care Select* members complete the screening tool and individuals can complete the screening tool with or without the assistance of the enrollment broker. The State requires the CMO to conduct a health needs screening for its members who have not received the screening at the time of enrollment.

In accordance with *42 CFR 438.208(c)(2)*, the CMO must have a healthcare professional assess the member when the health needs screening identifies the member as potentially having a special healthcare need. When the assessment confirms the special healthcare need, the CMO must coordinate

the member's healthcare services with the member's PMP's plan of care. The CMO must offer continued coordinated care services to any special healthcare needs members transferring into the CMO's membership from another plan. For example, CMO activities supporting special healthcare needs populations must include, but are not limited to:

- Conducting the initial health needs screening to identify members who may have special needs
- Scoring the screening tool results
- Distributing findings from health needs screening to the State's enrollment broker, PMPs and other appropriate parties in accordance with State and Federal confidentiality regulations
- Coordinating care services in accordance with the member's PMP care plan
- Analyzing, tracking, and reporting to the OMPP the issues related to children with special healthcare needs, including grievance and appeals data
- Participating in clinical studies of special healthcare needs as directed by the *Care Select* Clinical Studies Committee

On the 11th and 26th days of each month the fiscal agent runs program that contains Additional Function Identifier (AFI) information which is used to identify persons with special healthcare needs. The files are made available on File Exchange on the 12th and 27th days of each month. The AFI file format can be found in the CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa/..

Auto-Assignment

Occasionally, an IHCP member eligible for *Care Select* does not receive the initial program education or for some other reason fails to self-select a PMP and CMO within the first 30 days of eligibility. Because enrollment in the program is mandatory for most people who are eligible, after the first 30 days of program eligibility enrollment is accomplished in the auto-assignment process logic contained in Indiana*AIM*. Auto-assignments are subject to the following geographical and region requirements:

- Auto-assignments do not occur when a PMP's service location is greater than 45 miles from the member's address. Only self selections are allowed to override the 45 mile geographic limits.
- Auto-assignments do not occur outside the member's region, even if within the 45 mile geographic limit. Members may self-select outside their region.
- Out-of-state providers are allowed to be PMPs, however, auto-assignments occur only to those with the IFSSA out-of-state designations. Other out-of-state PMPs only receive self selections. IFSSA out-of-state designations are defined in *405 IAC 5-5-2* and delineated as cities that reside outside the state of Indiana, excluded from out-of-state prior authorization (PA) requirements and required to follow in-state PA requirements. The cities defined as IFSSA out-of-state designations are as follows:
  - Danville, Illinois
  - Watseka, Illinois
  - Louisville, Kentucky
  - Owensboro, Kentucky
  - Sturgis, Michigan
  - Cincinnati, Ohio
  - Hamilton, Ohio
  - Oxford, Ohio
  - Chicago, Illinois

Auto-assignment is designed to consider several factors in linking a member to an appropriate PMP. *Figure 9.2: Auto Assignment Process* provides a high level flow of the logic used in the auto-

assignment process. The Auto Assignment Process diagram can also be found in the CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa/.

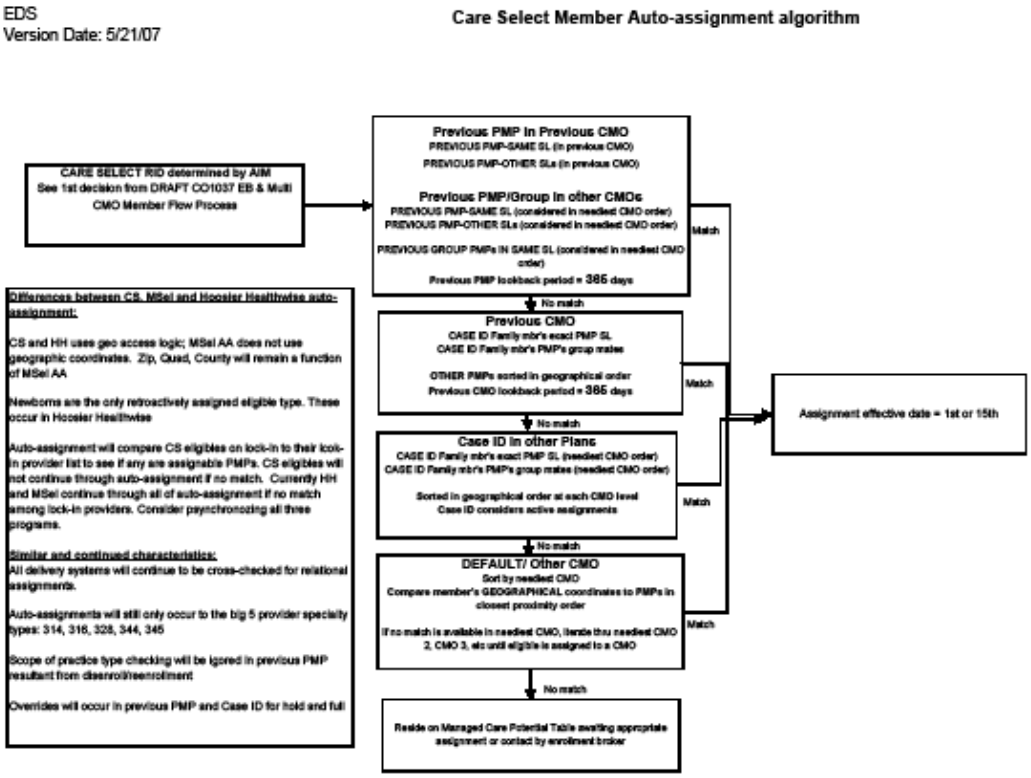

Figure 9.2 – Auto Assignment Process

General Auto Assignments is outlined below.

a. *Previous PMP in Previous CMO* – A *Care Select* member, who had previously been assigned to a PMP that is currently enrolled in the program, is reassigned to that PMP if the appropriate scope of practice and restrictions apply. Because continuity of care is one of the cornerstones of the *Care Select* program, the reassignment of members to their previous PMP takes precedence over other auto-assignment logic in Indiana*AIM*. The previous PMP auto-assignment logic considers the following when making an assignment determination:

1. *Previous PMP with Same Service Location* – If the member's previous PMP is found at the same service location where the member was previously assigned then the assignment is made.
2. *Previous PMP with Other Service Locations* – If the member's previous PMP is found at a different service location then the assignment is made.

b. *Previous PMP/Group in other Plans* – A *Care Select* member, who had been assigned to a PMP that is currently enrolled in other plans, is reassigned to that PMP if the appropriate scope of practice and restrictions apply. The auto assignment process will look for the neediest CMO and if not found look to the next neediest CMO. The previous PMP lookback period is 365 days. The previous PMP auto-assignment logic considers the following when making an assignment determination:

1. *Previous PMP with Same Service Location* – If the member's previous PMP is found at the same service location where the member was previously assigned then the assignment is made.
2. *Previous PMP with Other Service Locations* – If the member's previous PMP is found at a different service location then the assignment is made.
3. *Previous Group PMP with Same Service Location* – If there is an appropriate PMP in the member's previous group at the member's previous PMP's service location, then the assignment is made.

c. *Previous CMO/Previous Network* –If there is not a previous PMP relationship, the auto-assignment logic looks for a previous relationship with an CMO. The system then attempts to assign the member to an appropriate PMP in the network by geographical order at each hierarchical level for a lookback period of 365 days.

1. *Case ID – Family member's exact PMP Service Location* – If the family member's active assignment PMP is found at the same service location then the assignment is made
2. *Case ID – Family member's PMP Group Mates* – If the family member's active PMP Group Mates are found sorted in geographical order at each hierarchical level then the assignment is made
3. *Previous Network* – If a PMP is found based on geographical order in the previous network then the assignment is made.
4. *Other PMP* – If other PMPs are found based on geographical order then the assignment is made.

d. *Case ID in other Plans* – If there is not a previous CMO relationship, the auto assignment logic looks in the neediest CMO for the Case ID - *(Family Relationship)* - PMPs for family member with the same case ID. The previous PMP auto-assignment logic considers the following when making an assignment determination:

1. *Case ID – Family member's exact PMP Service Location* – If the family member's PMP is found at the same service location then the assignment is made
2. *Case ID – Family member's PMP Group Mates* – If the family member's PMP Group Mates are found sorted in geographical order at each hierarchical level then the assignment is made

e. *Default* – In the event the search for a previous PMP, CMO, and Case ID fails to make an appropriate PMP assignment, the default level of the auto-assignment logic looks for the neediest CMO and compares the member's geographical coordinates to PMPs in the neediest CMO in order of proximity. If no match is available in the neediest CMO, the logic continues to the next neediest CMO. When the auto-assignment logic has searched all available CMOs and has not found an appropriate PMP match, the member's name appears on a *BA Assistance Required* report to the enrollment broker. Members who cannot be matched to an appropriate PMP in the auto-assignment process must be manually assigned to an appropriate PMP. Members who are not manually assigned to a PMP remain enrolled in Traditional Medicaid (FFS). The members also remain on the potential assignment table in Indiana*AIM* and are auto-assigned when an appropriate PMP becomes available in any plan.

Special Characteristics of Auto-Assignment

The rule for determining the auto assignment start date is as follows: If the day that the auto assignment is processed falls between the first and the 10th of the month then the PMP assignment start

date is the 15th of the current month. If the day that auto assignment is processed falls between the 11th and the 25th then the PMP assignment start date is the first of the next month. If the day that the auto assignment is processed falls on or between the 26th and the end of the month then the PMP assignment start date is the 15th of next month.

Auto assignment nuances are listed below:

1. *Previous PMP*
   - A PMP will have its *panel full* status overridden.
   - A PMP will have its *panel hold* status overridden.
   - A female member previously linked to an obstetrician/gynecologist (OB/GYN) physician is relinked to the same physician if the all-women-indicator is on and she is not in a pregnancy aid category.
   - A member must remain within the PMP's scope of practice.
   - A member who lost *Care Select* eligibility and is re-entering the program after a gap in coverage is auto-assigned to the previous PMP if the assignment is still appropriate within the PMP's scope of practice (for example, the member has not reached an age outside the scope of practice during the gap in coverage). If the gap in coverage is less than four months in duration, the member will be immediately subjected to auto-assignment
   - If the assignment remains appropriate for the PMP's scope of practice, a member who is auto-assigned to the previous PMP at the time of redetermination (with no lapse in coverage) remains in the same CMO, unless the PMP has disenrolled from the CMO.
   - The auto-assignment previous PMP logic does not consider a member and physician relationship that may have existed outside the member and PMP assignment in the *Care Select* care management program.
   - If a PMP disenrolls from an CMO or service location and has an active service location in the same or different CMO, the members who were linked to the PMP are auto-assigned to the same PMP in the new CMO or service location if the assignment is appropriate for the PMP's scope of practice criteria at the new service location
2. *Previous CMO*
   - All date logic looks at the current date instead of the auto assignment start date.
   - The panel size limit must be greater than actual panel size for a provider to be considered.
   - The panel hold indicator must not be active for a provider to be considered.
3. *Newborns*
   - If the mother does not have an assignment, then preselection is allowed.
   - Newborns are assigned retroactive to the date of birth (DOB) only in the instance where the mother was enrolled in an CMO at the time of the newborn's birth and there is an appropriate PMP available in the health plan.
   - The newborn is assigned to the same CMO in which the mother was enrolled at the time of birth if possible.
4. *Case Logic*
   - Uses same program to check PMPs as previous PMP logic; therefore, the rules are the same.
   - Overrides full and hold panels but checks for active assignment, not previous.
5. *Default*
   - CMOs targeted for auto assignment are viewed in target percent order, neediest being furthest from target.
   - The Panel size limit must be greater than actual panel size for a provider to be considered.
   - A panel hold must not be active for a provider to be considered.

Members who are in designated wards or fosters aid categories (*MA3, MA4*) or are identified as a ward or foster by a caseworker via ward code indicator are not auto-assigned. Instead, they are in a voluntary care management designation. These members may choose PMPs, but are not auto assigned

to PMPs. When a PMP disenrolls (this includes service location changes) these members must request relinkage (assignment) to their PMP if the PMP re-enrolls.

Eligibility Redetermination

Eligibility redetermination occurs at intervals determined by the DFR. Members whose IHCP eligibility is continuous and who do not change from a care management aid category to a non-care management aid category, maintain the PMP relationship.

Members who have had a gap in IHCP eligibility or care management eligibility are processed as new members for auto-assignment purposes. That is, they are given 30 days to choose a PMP. If a PMP selection is not made at that time, the member is auto-assigned according to the criteria outlined. A previously enrolled *Care Select* member who does not make a PMP change is auto-assigned to the previous PMP, if appropriate, to maintain that relationship.

Member Request to Change PMP

Members may request a PMP change at any time. The enrollment broker tracks reasons for requesting a PMP change, and examples are:

- Access to care
  - Member moved out of area
  - PMP's office not accessible on public transportation or an IHCP-reimbursable transportation provider is not available in the service area
  - Member waits in the office for one hour or more for a scheduled appointment on two occasions
  - Member experiences excessive delay between request for appointment and scheduled appointment
  - Member experiences difficulty contacting the PMP for care after normal business hours
- Continuity of care
  - Member has an ongoing relationship with a PMP other than the PMP to whom the member is currently assigned
  - The member's current PMP disenrolls from the *Care Select* program
  - The member is in late stages of pregnancy and wishes to continue care with the current doctor through the pregnancy
- Quality of care or service
  - Member expresses dissatisfaction with treatment by doctor or staff
  - Member requires specialty services due to language, cultural, or other communication barriers with current PMP
  - Ongoing, unresolved provider or member conflict exists
  - Member no longer fits into provider's scope of practice
- Member was auto-assigned to a PMP
- Other

The enrollment broker maintains responsibility for approving and processing PMP change requests through the *Care Select* Helpline at 1-866-963-7383. The enrollment broker monitors and addresses participants who have frequent PMP changes or who alternate frequently between CMO providers.

CMOs are responsible for approving PMP changes within their own health plan. The CMOs must forward these changes to the enrollment broker using the CMO customized PMP form that was developed from the base enrollment broker PMP form template. The enrollment broker enters the change into Indiana*AIM*. PMP changes within the CMO may be effective any day of the month.

To ensure the accuracy of the PMP enrollment rosters and CMO administration fee payments, PMP changes between plans are effective only on the first day of a month. PMP changes entered into Indiana*AIM* by the 25th day of the previous month are effective the first day of the next month. Changes entered into the system after the 25th day of the month are not effective until the first day of the second month.

Provider-Initiated Requests for Member Reassignment

The goal of the *Care Select* program is to encourage a positive and continuous relationship between members and PMP. In rare instances, a PMP may request reassignment of a member to another PMP within the CMO's network. The CMO must approve and document these situations. The documentation must be sent to the enrollment broker for processing into Indiana*AIM*. The reasons for these situations include:

- Missed appointments (with appropriate documentation and criteria)
- Member fraud (upper-level review required)
- Uncooperative or disruptive behavior resulting from the member or member's family (upper-level review required)
- Medical needs could be better met by a different PMP (upper-level review required)
- Breakdown in physician and patient relationship (upper-level review required)
- Member accesses care from providers other than the selected or assigned PMP (upper-level review required)
- Previously approved termination
- Member insists on medically unnecessary medication

The CMO's medical director or a committee appointed by the medical director performs an *upper-level review*. It is a thorough review of the individual case to determine whether the cause and documentation are sufficient to approve a reassignment request. The upper level review includes monitoring to ensure consistency in the CMO's guidelines and policies with the *Care Select* program and to improve the overall program quality.

The following, developed and finalized by the *Care Select* QIC, provides guidelines for the situations outlined previously:

- *Missed appointments* – A member may miss at least three scheduled appointments without defensible reasons prior to a PMP request for member reassignment. The PMP or staff is responsible for educating the member about the problems and consequences associated with missed appointments on the first occurrence. *Care Select* members are not penalized for inability to leave work, lack of transportation, or other defensible reasons. Missed appointments must be documented in the member's chart accessible to the PMP and staff. On documentation of the third missed appointment for non-defensible reasons, the CMO may approve the PMP's request for the member's reassignment within the CMO network.

  CMOs are encouraged to have procedures in place to assist members and PMPs with missed appointment problems and are expected to intervene as required to resolve issues while supporting the overall goals of the *Care Select* program.
- *Member fraud* – This reason for member reassignment must be restricted to those cases referred to the Indiana Bureau of Investigation or the Office of the Inspector General (OIG).
- *Threatening, abusive, or hostile actions by members* – The PMP can request a member's reassignment when the member or the member's family becomes threatening, abusive, or hostile to

the PMP or to the office staff after attempts at conflict resolution have failed. The request must be consistent with the PMP's office policies and criteria used to request reassignment of commercial patients. The CMO must have conflict resolution procedures designed to address these concerns.

- *Member's medical needs may be better met by another PMP* – A PMP request for member reassignment because the PMP believes a member's medical needs are better met by a different PMP must be documented as to the severity of the condition and reviewed by the CMO's medical director. The CMO medical director must review the request based on the specific condition or severity of the condition as a PMP scope of practice matter not based on a bias against an individual member.
- *Breakdown of physician and patient relationship* – The CMO must conduct an upper-level review, as defined previously, to ensure the breakdown in the relationship is mutual between the PMP and the member.
- *Member accessing care from other than the selected or assigned PMP* – The CMO must conduct member education about the network and the PMP selection process. If the member does not initiate a PMP change and continues to access primary care services from a provider other than the PMP, the PMP may request the member's reassignment. Misuse of the emergency room is not a valid reason for requesting a member's reassignment.
- *Previously approved termination* – The PMP may request a member's reassignment if the member was previously reassigned for an approved reason and became re-linked through the auto-assignment process.

Most of these situations can be resolved by facilitating the member's selection of another PMP within the health plan. Members who require services of a provider not available within the health plan generally are not disenrolled, but remain in the CMO, with the CMO managing and reimbursing for out-of-network services.

> *Note: The enrollment broker must review provider or CMO-initiated PMP change requests that would result in a member's disenrollment from the network for compliance with program policy before processing is allowed.*

CMOs must use PMP-initiated requests for member reassignments to identify issues and concerns documented in quality improvement processes. Each CMO must develop an internal policy for approval of PMP-initiated member reassignments based on the criteria outlined previously. Unacceptable reasons for PMP-initiated member reassignment requests:

- *For good cause* – This term is used for member-initiated PMP change requests.
- *Noncompliance with mutually agreed to treatment* – Members are not reassigned for being noncompliant or refusing treatment. A patient has the right to refuse treatment.
- *Demand for unnecessary care* – A PMP-initiated request for member reassignment is not approved for this reason unless there is documentation of threatening, abusive, or hostile behavior as described above.
- *Language and cultural barriers* – PMPs who have difficulty with a member's language or other cultural barriers must request assistance from the CMO health plan resources to address the problem.
- *Unpaid bills incurred prior to Care Select enrollment* – PMPs may not initiate member transfer requests because of unpaid medical bills incurred prior to *Care Select* enrollment. PMPs can pursue charges outstanding prior to *Care Select* enrollment through the normal collection process.

Member Disenrollment from Care Select

The following are causes for which a *Care Select* member can be disenrolled from the IHCP and *Care Select* programs:

- Member was enrolled in error or due to data entry error.
- Member loses eligibility in IHCP.

A CMO enrollee may disenroll from a CMO while retaining eligibility in the *Care Select* program. Member disenrollment from a CMO with enrollment into another CMO occurs under any of the following circumstances:

- The member selects a PMP in another CMO.
- The member's PMP disenrolls from the CMO and is available to *Care Select* members in another CMO.
- The disenrollment is approved by the OMPP due to circumstances which, in the judgment of the OMPP, are documented and justified.

Some instances may warrant a member's disenrollment from the *Care Select* care management program while eligibility is maintained in another IHCP component. It is important to program integrity that criteria used to make this determination are valid reasons for disenrollment and are applied consistently for all program enrollees. The enrollment broker monitors, tracks, and approves all member disenrollment activity based on program policy for quality improvement purposes. The OMPP has ultimate authority for allowing eligible members to disenroll from the program.

Examples of acceptable reasons for member disenrollment from the *Care Select* care management program to participate in another IHCP program include but are not limited to the following:

- Member is determined to be ineligible for care management under the terms of the state of Indiana 1915(b) waiver.
- Change in aid category causes enrolled member to become ineligible for care management.
- Residency change causes enrolled member to become ineligible for care management. *Care Select* members who have out-of-state addresses are systematically identified and disenrolled by EDS. The former *Care Select* members can retain IHCP eligibility during a defined notification period as required in the Indiana Administrative Code (IAC). Disenrollment from *Care Select* prevents further payment of capitation during this notification period.
- Enrolled member meets long-term care criteria as determined by the Indiana Pre-Admission Screening and the Federal Pre-Admission Screening (IPAS/PASRR) processes. *Care Select* members who are in an LTC facility for more than 60 days can be disenrolled from the program because CMOs are not financially responsible for long-term facility care. After a member has met IPAS/PASRR, the appropriate level of care is entered into Indiana*AIM*, and the member is disenrolled from *Care Select*. LTC facilities must notify the CMO immediately after becoming aware of a CMO enrollee who is undergoing the screening process for long-term admission. The IHCP FFS is financially responsible for all long-term care charges, excluding ancillary services, if the member meets the criteria for long-term level-of-care (LOC). CMOs must monitor the care of members who are potential candidates for long-term care so they can help facilitate disenrollment from care management. The CMO must work with the facility to ensure that the level of care process is completed (for example, submit the *Form 450B*). Otherwise the member may be re-enrolled into care management due to incomplete documentation for LOC. Once the LOC is entered into Indiana*AIM*, the member is automatically disenrolled. The LOC also prevents enrollment into care management.

- Enrolled member is a ward or foster child whose legal guardian requests disenrollment from the program. Wards and foster children in aid categories *MA3* and *MA4* or as identified by a ward indicator may select a PMP and participate in the *Care Select* program on a voluntary basis or mandatory for wards or foster children located in Lake county. Members who are placed in group homes within Indiana or out-of-state must be disenrolled from *Care Select* upon request to facilitate access to care in the current setting.
- Enrolled member becomes eligible for and enrolls in a home- and community-based services (HCBS) waiver program. *Care Select* members can become eligible for HCBS waiver services. Because IHCP enrollees can participate in only one waiver program at a time, *Care Select* members who participate in another waiver program must be disenrolled from *Care Select*. CMOs that become aware of this circumstance must contact the *Care Select* Helpline at 1-800-889-9949 to begin the disenrollment process.
- Enrolled member becomes eligible for and enrolls in the IHCP Hospice Program. To receive hospice benefits, a member must elect hospice services, the attending physician must make a certification of terminal illness, and a plan of care must be in place. At the time a *Care Select* member elects to enroll in the IHCP Hospice Program the member must be disenrolled from *Care Select* so the appropriate level of care can be entered in Indiana*AIM*. The hospice analyst at ADVANTAGE Health Solutions, Inc.[SM] requests that the enrollment broker immediately disenroll the *Care Select* member. The member becomes eligible for hospice care on the care management disenrollment effective date. This process ensures that both the CMO and the hospice providers have an accurate effective date on which to end or begin services. Hospice benefit begins the day after care management disenrollment.
- Enrolled member who becomes eligible for Medicare is no longer eligible to participate in the *Care Select* program.
- Member who has other medical coverage in a care management plan may be required to select a PMP in that plan. If the PMP in the commercial network is not in a *Care Select* health plan and coordination of benefits is not appropriate due to a documented reason or circumstance, the member can be disenrolled from *Care Select* and placed in the IHCP FFS program.
- Enrolled member who is determined to be an undocumented person is limited to emergency services under IHCP Package E.
- Other enrolled members as determined by the OMPP.

Restricting Disenrollment

Federal regulation *42 CFR 438.56* allows Medicaid programs the option of CMO lock-in periods up to 12 months. At the current time, *Care Select* does not have a plan lock-in requirement. Members are encouraged to stay with the PMP to establish a relationship, but they may change PMP or health plan at any time without cause.

However, if a state elects to implement a 12-month lock-in, certain other requirements apply as follows: Members must be allowed to change CMOs without cause at any time within the first 90 days of enrollment and the members must be notified, at least 60 days prior to the end of the enrollment year, of their opportunity to change at 12 months.

Member Enrollment Rosters

On behalf of the OMPP, EDS notifies each PMP and CMO of all members enrolled in its plan by region. Using information obtained from the State's ICES transmissions and PMP assignments entered in Indiana*AIM* by self selections and the auto-assignment process, EDS generates HIPAA 834 CMO

benefit enrollment and maintenance transactions, also known as the enrollment roster three times a month. Refer to *Companion Guide - 834 MCE Benefit Enrollment and Maintenance Transaction* for more information about this transaction.

The CMO member enrollment roster provides the CMO with a detailed list of members for whom the CMO is responsible. Change files are created twice a month, indicating new, terminated or deleted members, or changes to continuing member records that have occurred since the previous change file was created. Audit files are created toward the end of each month listing all the members effective with the CMO and region as of the first of the following month. An additional change file runs on the last day of each month to capture and report last minute eligibility changes affecting the following reporting period. The member enrollment roster's segments are categorized as follows in the Companion Guide 834 change files:

- Continuing enrollees
- New enrollees
- Terminated enrollees
- Deleted enrollees who appeared as eligible members on the previous roster, but whose eligibility terminated prior to the actual effective date with the CMO
- Unpassed eligibility due to timing of the PMP change
- Worksheet summarizing the categories listed above

In addition to the eligibility status and demographic information, the CMO member enrollment roster includes an auto-assignment indicator, level of care indicator, and the First Steps eligibility indicator. The auto assign indicator is used to identify members who were auto-assigned regardless of the auto-assignment reason (previous PMP, case ID, default) described previously in this section. This indicator assists the CMO in identifying members who were auto-assigned and who may not have participated in the enrollment broker's education program provided to new *Care Select* members. CMOs can use this indicator to identify a target population for new member orientation or additional program education. The First Steps eligibility indicator is used to identify members who are active with the First Steps program. If a member is identified as active with the First Steps program the CMO member roster also includes the date they were effective and terminated from the First Steps program. The level of care indicator provides the mechanism of identifying the type member's waiver type.

Member's benefit package is also included on the *834 MCE Benefit Enrollment and Maintenance Transaction Companion Guide.*

Monthly member enrollments are provided to the CMO in the following two segments:

- Care management enrollments entered into Indiana*AIM* from the 11th through the 25th days of the month are processed on the 26th and available to the CMO in the early morning hours on the 27th of the month, listing members with effective dates on the first day of the following month.
- Care management enrollments entered in IndianaAIM from the 26th day of the month through the 10th day of the following month are processed on the 11th and available to the CMO in the early morning hours on the 12th day of the month for members with effective dates on the 15th day of the current month.

Discrepancies in Eligibility Reporting

Deleted Eligibility

Member data on enrollment rosters is current as of the day the rosters are produced. Because the enrollment rosters are produced three times a month, while Indiana*AIM* is updated with daily ICES transmissions, changes in enrollment may occur during the period between the production of the roster and the effective date. The end of the month change files will help providers with more timely updates. Some scenarios that cause eligibility reporting discrepancies follow.

Member Information Changes

A member may become ineligible before the effective date of enrollment with a CMO. For example, a member auto-assigned to the CMO on the 20th day of the month with an effective date on the first day of the following month appears on the 834 CMO change file produced on the 26th of the month. If the member lost eligibility prior to the effective date in the CMO health plan the member is reported as a deleted member on the next 834 change file. CMOs must have a procedure to remove deleted members from their records.

When a CMO receives member information regarding a change in address or telephone number, the CMO may complete *State Form 44151, Report of Change*, and complete the CMO's internal procedure for updating the CMO's database. CMO's must use the blue form (*State Form 44151*) to report changes to the county DFR. The CMO must only complete the name of case, case number, change of address information, and telephone number. Under the state seal, the CMO representative must write **Per client call to (Name of CMO) on (date)**, and the CMO representative must sign the form. After matching the member with the appropriate county, the CMO representative can use a prefabricated reference file or the Internet listing of the Division of Family Resources (DFR) offices to submit changes directly to the county Office of Family Resources (OFR). As the result of the State's eligibility modernization project, the CMOs will direct member changes and inquiries to the FSSA Document Center and call center as delineated in the project phase-in time line. Information regarding the eligibility modernization project can be found at http://www.in.gov/fssa, click on Eligibility modernization.

The contact information for the FSSA Document Center and Call Center is as follows:

FSSA Document Center
P.O. Box 1810
Marion, IN 46952

Call Center Telephone Number: 1-800-403-0864

The CMO also notifies the DFR within 30 days of the date the CMO becomes aware of the death of one of its *Care Select* enrollees and provides the following:

- Member's full name
- Member's address
- Member's Social Security Number (SSN)
- Member's RID number
- Date of death

The CMO has no authority to pursue recovery against the estate of a deceased IHCP enrollee.

The change form for *Care Select* members whose coding identifies them with a Marion County Office, DFR must be submitted to the administrative office at the following address:

Marion County Office of Family Resources/Department of Child Services
129 E. Market St., Suite 1200
Indianapolis, IN 46204

This office uses courier service to the other Marion County Office, DFR locations daily.

The change form for *Care Select* members whose coding identifies them as Lake county residents, must be submitted to the administrative office at the following address:

Lake County Office of Family Resources/Department of Child Services
661 Broadway
Gary, IN 46402

CMOs can obtain *State Form 44151, Report of Change*, by faxing a request on an official CMO letterhead to the State Forms Distribution Center at (317) 591-5333. There is no charge for the forms, which are issued in packages of 100.

Hard copy requests *instead* of faxed orders may be mailed to:

Forms Distribution
6400 E. 30th Street
Indianapolis, IN 46219

Note: Do not send both a fax and mailed request for forms.

Electronic Transmission of CMO Member Eligibility Rosters

The CMO 834 benefit enrollment and maintenance transactions are available three times a month to CMOs on File Exchange. To exchange data with the IHCP using File Exchange, trading partners are required to have an Internet service provider and secure file transfer protocol (SFTP) client software. Users may access File Exchange 24 hours a day, seven days a week.

The jobs that create the enrollment rosters always run on the evening of the 11th (Change File), 26th (Change and Audit Files), and the last day month (Change File) for every month. Files and summary reports are available for download from the File Exchange during the early morning hours of the 12th, 27th, and the first day of the following month.

Eligibility Verification

Enrollment transactions reflect members' status in Indiana*AIM* as of the day the roster was produced. As explained earlier this section, ICES eligibility is updated in Indiana*AIM* daily. The eligibility verification options described in the following subsection are updated with the daily ICES information; therefore, they contain the most current eligibility status. CMOs must advise providers to *verify member eligibility each time a service is rendered*. Failure to verify eligibility may result in a provider rendering services to an ineligible member. All of the eligibility verification systems provide an inquiry verification number that must be recorded in the event it is required for subsequent transactions. CMOs must assume all telecommunication and hardware costs associated with these systems.

Options for Eligibility Verification

The eligibility verification system (EVS) consists of three options: the Automated Voice Response (AVR) System, Point-of-Service (POS) Terminal Device also called Omni, and Web interChange. Using any of these options, eligibility verification is accomplished in a real-time, interactive mode.

After the user enters the provider number, the member ID number, and the from and through dates of service, eligibility information is transmitted online. The eligibility information includes the member's PMP name and telephone number along with the CMO name, CMO telephone number, CMO network (if applicable), and CMO network telephone number (if applicable).

Section 10: Network Development, Services, and Data

Provider Network

Because people with disabilities and chronic conditions often spend years finding providers with the appropriate clinical knowledge and disability competency, the composition and adequacy of the CMO's provider network is critical.

The CMO must ensure that its provider network is available and geographically accessible and provides adequate numbers of facilities, physicians, ancillary providers, service locations and personnel for the provision of high-quality covered services for its members in accordance with *42 CFR 438.206*. The CMO must also ensure that all of its contracted providers are IHCP providers and can respond to the cultural, racial and linguistic needs of the Indiana *Care Select* Program population. The network must be able to handle the unique needs of Indiana *Care Select* Program members particularly those with special health care needs.

The OMPP will regularly and routinely monitor network access, availability and adequacy. Failure to demonstrate a complete and comprehensive network prior to the contract effective date may result in a delay of initial member enrollment. Failure to meet the PMP provider network standards may result in corrective action plans and liquidated damages, as determined by the OMPP. The OMPP will monitor the CMO's PMP provider network to confirm the CMO is maintaining the required level of access to care. The OMPP reserves the right to increase the number or types of required specialty providers at any time.

Physicians with these specialties can apply for enrollment as a primary medical provider (PMP):

- Family practitioner
- General practitioner
- Obstetrics and gynecology (OB/GYN)
- General pediatrician
- General internist
- All other physician specialties (provider type 31) may enroll as PMPs. However, specialist PMPs will not receive members through the auto-assignments process. Specialist PMPs will receive members only if the member actively chooses that physician as a PMP. Other PMP information about *Care Select* is as follows:

> *Note: Physicians must be enrolled in the IHCP at the service location where they wish to practice as a PMP before contracting with an CMO to be a PMP.*

The network consists of providers directly contracted or subcontracted with the CMO. The CMO must provide members with a network directory upon enrollment and upon request. The directory must include PMPs and self-referral services. The directory must also include the names, addresses or geographic locations, telephone numbers, office hours, description of office accessibility, spoken languages, and types of physicians, including certification and scope of practice. The network directory must be updated monthly, or as needed, using addenda or reprints.

Physician Extenders

According to *IAC 25-27.5*, the following physician extenders are licensed to provide care in Indiana:

- Advanced practice nurses, including nurse practitioners, nurse midwives and clinical nurse specialists
- Physician assistants
- Certified registered nurse anesthetists

The CMO must implement initiatives to encourage providers to use physician extenders.

Examples of these types of initiatives include:

- Educate providers about the benefits of physician extenders
- Educate providers about reimbursement policies for physician extenders
- Offer financial or non-financial incentives to providers who increase their use of physician extenders to increase access

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Since Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are essential safety net providers, the OMPP strongly encourages the CMO to contract or enter into business agreements with FQHCs and RHCs that are willing to contract with the CMO and meet all of the CMO's requirements regarding the ability of these providers to provide quality services.

Health Departments

The OMPP strongly encourages the CMO to contract or enter into business agreements with any health departments that are willing to coordinate with the CMO and are able to meet the CMO's credentialing and service delivery requirements.

Community Mental Health Centers (CMHCs)

The CMO will contract or enter into business agreements with CMHCs to provide behavioral health care services to its members. The CMO will conduct prior authorization for services provided to its members at CMHCs, with the initial exception of MRO services. CMHCs must enter into agreements with the CMO in order to be reimbursed by the State for non-MRO services rendered to the Indiana *Care Select* Program membership.

The CMO will authorize MRO services based on the implementation timeline established with and approved by the OMPP.

The CMO will help coordinate physical and behavioral health care services between the CMHC and its membership's physical health care providers.

The CMO will contractually require the CMHCs and its physical health provider network to share member medical data and coordinate care for all members receiving both physical and behavioral health services, to the extent possible, based on the member's willingness to sign a consent to release this physical and behavioral health information, if such consent is required.

Other Providers

In addition to the provider types discussed above, the OMPP strongly encourages the CMO to affiliate but not necessarily contract with other safety net providers. The CMO should affiliate with urgent care clinics (may also be a contracted provider).

Regional Network Development

Upon a date determined by the State, the CMO must have a regional provider network comprising PMPs. This network may consist of providers contracted or subcontracted with the CMO. The OMPP, or its contractor, conducts a readiness review of the provider network prior to the effective date of the CMO contract.

The CMO must consider the following in developing a regional network that renders services to members in *Care Select*:

- Anticipated enrollment
- Access to care within the network location of PMP service sites, travel time, availability of public transportation services, or other factors affecting accessibility to care in a given service area
- Response to the cultural, racial, and linguistic needs of the population
- Assessment of the number and type of primary medical providers accepting newly enrolled members.
- Detailed process for credentialing and recredentialing providers to ensure that provision of quality care is maintained
- Access to a specialty and hospital network, and plans for provision of medically necessary non-contracted specialty care out of the network
- Provision of ancillary services, including dental care, transportation, durable medical equipment, pharmacy services, and home healthcare

Regional Network Development Plan

Additional service areas in provider network development can be required in the *Care Select* CMO. The CMO must provide a comprehensive plan for network development throughout each contracted region. The plan must detail targeted areas for development and prioritization of those targeted areas, explain how development is accomplished, and establish time lines for implementation, including provider education, outreach, and staff training. The plan must be updated quarterly and made available to the OMPP for review and comment.

The CMO must describe the number of PMPs accepting patients newly enrolled in *Care Select*, their locations and numbers, and the type of primary care physicians (such as, family practice, general practitioner, internist, pediatrician, and OB/GYN). This description of PMPs accepting new patients provides information to track providers who have not met the minimum. This description assists the CMO in targeting geographical areas for network development.

The CMO must have established provider networks of geographically accessible locations for the *Care Select* CMO population to be served. Accessibility to hospitals, physicians, pharmacies, transportation services, and so forth, must be demonstrated by the CMO.

The CMO must document a complete description of the provider network available to enrollees. There must be a plan that ensures selected PMPs are accessible, taking into account travel time and the availability of mass transit for enrollees.

The CMO must present a detailed plan for provision of ancillary services. The plan must include assurance of adequate access to ancillary services such as transportation services, durable medical equipment services, pharmacy services, and home health services.

The network development plan must also include, but is not limited to, the following:

- Goals and objectives
- Gantt chart, including a list of network development tasks, associated time frames, and responsible positions
- Description of how the network development plan interacts with education and outreach, quality improvement, and financial stability
- Description of the corrective action process
- Description of strategies and methods used for recruiting providers, including staff positions and time frames
- Description of target areas for network development
- Reports that include number and type of providers enrolled and current provider-to-member ratios
- Evaluation plan of network development activities
- Physician incentive arrangements

The plan must establish numeric, geographic, and linguistic targets for all provider types (such as PMPs, specialists, and facilities) based on IHCP-eligible members and expected enrollments. The plan must detail targeted areas for development, prioritization of those targeted areas, explanation of how development is accomplished, and established time lines for implementation. The plan must include functions for evaluation of plan success or failure in achieving targets, resolution of problems in plan implementation, and plan modification based on updated projections.

CMO Responsibilities for PMP Requirements

When the physician elects to participate in *Care Select*, he or she may contract as a PMP with one or more CMOs. PMPs may also participate as a specialist in any other *Care Select* health plan.

The CMO 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 care and make any referrals necessary. The OMPP requires CMOs to provide access to PMPs within at least 30 miles of the member's residence.

The CMO's PMP contract must state the PMP panel size limits, and the CMO must assess the PMP's non-*Care Select* practice when assessing the PMP's capacity to serve the CMO's members. The OMPP monitors the CMO's PMP network to evaluate its member-to-PMP ratio on a quarterly basis

The CMO must have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services 24-hours-a day, seven-days-a-week and that PMPs have a mechanism in place to ensure members are able to make direct contact with their PMP, or the PMP's qualified clinical staff person, through a toll-free member services telephone number 24 hours a day, seven days a week. The CMO must also ensure that PMPs are available to see members a minimum of 20 hours over a three-day period at any combination of sites. The CMO must also assess the PMP's non-*Care Select* practice

to ensure that the PMP's *Care Select* population is receiving accessible services on an equal basis with the PMP's non-*Care Select* population.

The CMO must ensure that the PMP provide *live voice* coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The CMO must ensure that members have telephone access to their PMP in English and Spanish 24 hours a day, seven days a week.

The CMO must ensure that PMPs are maintaining the PMP medical care standards and practice guidelines detailed in the *IHCP Provider Manual*. The OMPP monitors medical care standards to evaluate access to care and quality of services provided to enrollees and to evaluate providers regarding their practice patterns.

Provider Directory

The CMO must provide its members, the OMPP, and the enrollment broker with the following information about its network providers as required by the *Code of Federal Regulations (CFR)* at *42 CFR 438.10(e)*:

- Lists of PMPs, the PMPs' service locations (including county), telephone numbers, office hours (including evening and weekend hours of operation), type of PMP (for example, family practice, general practitioners, general internists, general pediatricians, obstetricians and gynecologists), languages spoken by the provider or provider's office personnel, and whether the PMPs are accepting new members

The fiscal agent provides a daily electronic data file of the PMPs to the enrollment broker that includes the provider name, specialty, 24-hour telephone number, service location code, service location information, CMO ID, region codes, effective date, end date, PMP actual panel size, panel size, panel size effective date, panel size end date, and panel size hold indicator.

The CMO must maintain an update process with the OMPP or its agent to transmit changes in provider status including, but not limited to provider additions, deletions, and opening or closing of practices.

The CMO must include provider network information in an OMPP-approved format (currently Bobby™ format) on its member Web site. Provider network information on the CMO's Web site must be updated monthly and be available for users to print from a remote location.

Section 11: Referral Authorization Process

Referral/Authorization Process

This section describes the OMPP's policies for the PMP referral process in the *Care Select* program. In order to act effectively as a member's medical case manager, the PMP is responsible for determining whether to authorize, via the referral process, most services provided to members enrolled in the *Care Select* program, if the PMP is not providing the service. The PMP is responsible for all PMP related services rendered to patients on his/her panel. The PMP must document all referrals of *Care Select* members.

Automatic Referrals

If, at the time of PMP assignment, a member has an established relationship with another provider from whom the member requires immediate medical attention, the newly assigned PMP is required to make an automatic referral to that provider in order to maintain continuity of care. Examples of this situation include:

- Members who enroll in *Care Select* during late stages of pregnancy (third-trimester)
- Members who have previously scheduled surgery with a physician other than the PMP

PMP Certification or "Cert" Code

Upon enrollment in *Care Select*, each PMP will receive his/her own certification or "cert" code, which is required for the Program referral process. During the Web PMP enrollment, the certification codes are automatically assigned and recorded in Indiana*AIM* for new PMPs. A certification code letter is mailed to the PMP notifying the certification code. A copy of the certification letter can be found in the CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa/.. Subsequent certification codes are system-generated.

PMPs are mailed a new, randomly generated two character alpha numeric certification code from EDS, approximately three weeks prior to the beginning of each calendar quarter. It is possible for more than one PMP to have the same certification code. However, the combination of the PMP's provider number with the certification code creates the unique PMP authorization code required for referrals.

Certification codes are valid only for one calendar quarter. This procedure discourages referred providers from using a PMP's authorization inappropriately. Because a PMP is responsible for all PMP related services rendered to patients on his/her panel, inappropriate distribution of a PMP's certification code is strongly discouraged.

If the dates of service for a course of treatment extend over more than one calendar quarter, providers must obtain the certification code for each quarter during which the services were rendered.

Billing for services over multiple calendar quarters must be submitted on separate claim forms. Billing for services for overlapping PMP/member assignment dates must be submitted on separate claim forms.

PMP referrals through the use of the PMP's certification code should not be confused with the prior authorization process that is necessary for some specific IHCP or *Care Select* covered services.

CMOs have access to their applicable Certification Code OnDemand reports to facilitate questions regarding certification codes and letters. The Certification code reports are as follows:

- MGD-0017-D: Daily Care management - Cert Code Summary Report Advantage Health Solutions
- MGD-0017-Q: Quarterly Care management – Cert Code Summary Report Advantage Health Solutions
- MGD-0018-D: Daily Care management - Cert Code Summary Report MDwise
- MGD-0018-Q: Quarterly Care management - Cert Code Summary Report MDwise

CMOs should also facilitate issues related to certification code usage, for example, PMP will not furnish to provider.

PMP Referral Process

All PMP services that are not provided by the member's PMP must be referred by the PMP in the following manner:

Referrals may be given in writing or by telephone. (A sample referral form is provided in *Appendix A: Sample Written Referral Form* for your convenience. This form may be used if the PMP elects to make written referrals, but this is not required).

Referrals must include the PMP's provider identification number and certification code.

The referral must be documented in the medical record by the PMP.

The PMP must specify which services are covered by the referral. The PMP referral may cover one or multiple visits to complete a plan of care, but the referral must be renewed at the beginning of each calendar quarter to ensure reimbursement of claims.

The provider receiving the referral must document the referral in the member's chart.

Group Practices and Clinics

Services provided by *Care Select* PMPs and nurse practitioners enrolled under a common billing number, within the same group practice/clinic as the patient's PMP, do not require a formal referral from the member's PMP, if services are billed under the same group provider number. In instances where a physician is enrolled in the same group/clinic as the member's PMP and renders care to the member, the services/care provided must be documented in the member's chart.

If the rendering physician within the same group is also a PMP enrolled in the *Care Select* program, the certification code is not necessary on the claim form. If a non-PMP enrolled physician within the same group/clinic practice renders services to a *Care Select* member, the certification code is required on the claim form.

Section 12: Prior Authorization

PA Overview

Prior authorization (PA) is a mechanism to determine the medical necessity of selected nonemergency, Medicaid-covered, medical services prior to delivery (and retroactively in special cases). Providers submit requests for PA to perform specified services.

Each CMO is responsible for processing medical service PA requests and updates for members assigned to their organization at the time of the request. Additionally, ADVANTAGE Health Solutions is responsible for processing PA requests and updates for all Traditional Medicaid FFS members. ACS will continue to serve as the pharmacy PA contractor. For pharmacy PA information, contact ACS Clinical Call Center at 1-866-879-0106.

Coverage may not be arbitrarily denied or reduced and is subject to certain limitations in accordance with 42 CFR 438.210(a)(3)(iii) regarding:

- Medical necessity determinations
- Utilization control, provided the services furnished are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished

Covered services are medically necessary if, in accordance with IC 27-8-10-1(u) they:

- Are recommended by a legally qualified physician
- Are commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed illness
- Are not primarily for the scholastic education or vocational training of the provider or patient

To obtain a PA, providers may submit a Prior Review and Authorization Request via telephone (depending on the service), Web interChange, fax, or in writing.

The following provider types can submit PA requests via Web interChange:

- Chiropractor
- Dentist
- Doctor of Medicine
- Doctor of Osteopathy
- Home Health Agency (authorized agent)
- Hospice
- Hospitals (authorized agent)
- Optometrist
- Podiatrist
- Psychologist endorsed as Health Service Provider in Psychology (HSPP)
- Transportation Providers (authorized agent)

Additional information regarding submission of PA requests via Web interChange can be found on the IHCP Web site at www.indianamedicaid.com.

Telephone PA requests do not require a request form but may require follow-up documentation. In most cases, the provider receives an immediate response. All PA requests are reviewed using the same criteria regardless of the method which the request was received. Once reviewed, the Contractor staff updates IndianaAIM, which produces a Notification of Approval, Modification, or Denial (the provider will receive this information verbally if the request is made by phone). The requesting provider will receive a system-generated Indiana Prior Review and Authorization Request Decision Form indicating the approval status of their request. If the approval is "other than approved," it will be accompanied by an explanation of the decision and a description of the provider's administrative review/appeal rights. Recipients also receive notice and appeal rights.

For ongoing conditions, a provider may request an update (for example, extension of service, change of recipient condition) of the existing PA rather than submitting a new PA request. Updates can be requested by telephone, fax, or in writing. Once a decision is made, Indiana*AIM* produces a System Update Form showing the information that was changed.

Prior Authorization Form

In an effort to provide the level of service to which providers are accustomed, each CMO will continue to use the same PA and Medical Necessity forms that are currently used. Due to the multiple PA entities, the PA form has been modified to not include the submission address for PAs. However, the form includes a link to access the organizations performing PA to ensure that the PA request or update is mailed to the correct address.

Additionally, some fields have been modified and new fields added to the *Prior Review and Authorization Request* form, *Prior Review and Authorization Dental Request* form, and the *Prior Authorization-System Update Request* form. These forms can be located on the IHCP Web site at www.indianamedicaid.com/ihcp/Publications/forms.asp. The modifications to the forms include a change to the member information section allowing a provider to select the program to which the member is assigned, based on the information provided in the eligibility verification of the member. A new field has been added to the forms, in the requesting provider field, to indicate the MAIL TO provider ID and service location. If you are the requesting provider, but do not have a service location associated with your requesting provider ID, complete these fields in conjunction with the requesting provider information to ensure that the system generates a provider mailing address for the PA decision letter. Failure to complete this field when a requesting provider does not have a service location will prevent the production of a PA decision letter to the provider. By indicating a provider ID and service location in the requesting and mailing provider ID and service location fields, the mailing provider ID information will be selected as the mailing address for the PA decision letter.

EDS has established a new link in the contents Web site of www.indianamedicaid.com for providers to easily access the organizations that are performing PA and their contact information such as contact phone numbers, mailing address, and so forth. It is important for providers to know that this information will always be retrieved from real-time data available in the Indiana*AIM* claims processing system. Therefore, this information may be more current than information available in the IHCP Quick Reference Guide.

PA Number Format

The PA number includes an alpha-numeric to identify the organization that processed the PA request. Modifications have been made to all Eligibility Verification Systems (EVS) to accommodate the alpha-numeric PA number, as well as Web interChange.

PA Process

The review of PAs will remain consistent across the CMO and FFS organizations performing PA determinations to serve as a utilization management measure allowing payment only for those treatments and/or services that are medically necessary, appropriate, and cost-effective. The *Care Select* Program will emulate the PA requirements that have been established for the Traditional Medicaid FFS population.

Because there will be multiple vendors performing PA, providers must verify member eligibility to determine to which organization to send the request. The EVS available to the provider community will provide specific information regarding the member's assignment to a PMP and the CMO to which they are assigned. PA requests must be submitted to the CMO to which the member is assigned on the date of the request. PA updates that are submitted for review must also be submitted to the appropriate CMO. For example, if the member is assigned to MDwise at the time the PA was originally submitted, but has since moved from *Care Select* to Traditional Medicaid, fee-for-service, then the PA update should be submitted to ADVANTAGE Health Plan-FFS for review. This protocol should be followed regardless of which program the member belongs.

Rejected PA Requests

In the event that a provider submits a paper or faxed PA request to the incorrect organization, the provider will receive a PA decision letter informing them of the rejected status of the PA request. However, for PA requests that are submitted via Web interChange, the request will systematically determine which CMO/FFS vendor needs to receive the information for the PA to be processed appropriately. For PA requests submitted via the 278 transaction PA Request and Response submitted to the incorrect CMO, the PA request will be rejected regardless of the certification type with reason code 78, Subscriber/Insured not in Group/Plan identified and a PA decision form will not be generated. When providers receive notification that the submitted PA request has been rejected, a new PA or PA update request must be submitted to the member's correct CMO or FFS organization.

Suspension for PA Requests of Additional Information

For the PA reviewer to determine if a service or procedure is medically reasonable and necessary, the PA vendor may request more information from the member and/or provider. The IHCP must receive this information within 30 days or it must deny the PA. If the PA vendor determines medical necessity, the dates authorized are those on the originally suspended PA request. In the event that a PA is in suspense and the member is re-assigned between the *Care Select* Program and/or the Traditional Medicaid FFS program, the supplemental documentation that has been submitted for review will be forwarded to the appropriate PA vendor for review and approval.

Outstanding Prior Authorizations

If a member changes programs between Traditional Medicaid FFS, *Care Select*, and Hoosier Healthwise, or between Hoosier Healthwise or *Care Select* plans, all existing PAs are honored for 30 days. This requirement will only be applicable if the member is re-assigned programs between Hoosier Healthwise and *Care Select* or the Traditional Medicaid FFS program. PAs that are approved by either of the two *Care Select* vendors or the FFS vendor will be available in Indiana*AIM* for claims processing by EDS. The PAs may be for a specific procedure, such as surgery, or for ongoing procedures authorized for a specified duration, such as physical therapy or home healthcare. The IHCP honors the PA for 30 days or for the remainder of the PA dates of service, whichever comes first. Requiring a duplicate authorization from the new plan places an additional burden on the provider and can result in delayed or inappropriately denied treatments or services to the member.

Hearing and Appeal and Administrative Review

Hearing and Appeals, as well as Administrative Reviews, will be completed by the PA vendor who denied the request. (In the event that the Hearing and Appeal or Administrative Review is submitted to the incorrect CMO or FFS organization, the request will be returned to the provider for submission to the appropriate organization for review.) If the member has been assigned to a different program since the request for PA was denied, providers can either appeal to the PA vendor that denied the request or submit a new PA request for review to the current CMO/FFS PA vendor for review. The policies and procedures regarding Hearing and Appeal or the Administrative Review process will remain the same as they are currently published. This information is distributed to the provider and member upon the generation of the PA decision letter or PA update. Further information regarding the Hearing and Appeal and the Administrative Review process can be found in the *IHCP Provider Manual*, Chapter 6, Prior Authorization.

PA System Support

The CMO is responsible for providing hardware, software, and communications links for Contractor staff to meet the requirements set forth by the OMPP and utilize the capabilities and functionality present in Indiana*AIM.*

Indiana*AIM* performs the following functions to support the PA process:

- Maintains all PA requests on-line (the system stores all PA requests regardless of their current status, for example, under evaluation, approved, denied)
- Decrements PA units during claims processing
- Maintains an authorization history for all recipients with a PA on file
- Links PAs to relevant claims history against the approved PA
- Maintains all PA administrative review and appeal information on-line
- Produces a variety of daily, monthly, and quarterly reports for use by PA and State staff; reports provide information used to evaluate and improve the PA process and monitor the timeliness of PA processing
- Produces approval, denial, and other status notifications sent to providers
- Monitors approved home health services in coordination with HCBS plans of care
- Provides an audit trail of changes to the PA file
- System supports authorization of dollars, units, or period of time
- PA Contractor Responsibilities and Performance Standards

The following presents the performance standards for the Prior Authorization business function. The CMO shall be responsible for meeting these standards, and shall be subject to performance penalties as outlined elsewhere in the contract if they are not met.

1) Receive PA requests and approve or deny the requests as appropriate by implementing mechanisms to ensure consistent application of review criteria for authorization decisions; and consulting with the requesting provider when appropriate.

2) Accept and input PA determinations made by the Children With Special Health Care Needs program and other State programs.

3) Review and approve hospice authorization requests in accordance with State instructions and process the required paperwork, assuring the proper completion and that appropriate signatures are present when required.

4) Enter 95 percent of all PA requests into the Indiana*AIM* PA system online within two business days of receipt. Enter the remaining 5 percent within five business days of receipt. The CMO must develop and submit a report to the State to verify how this standard is being met.

5) Provide adequate professional medical staff and behavioral health professionals for staffing and managing the PA function, including medically knowledgeable PA analysts for processing requests and availability of licensed medical professionals to provide consultative services regarding all Medicaid-covered service types. The CMO shall submit to the State a list identifying the individuals responsible for performing PA activities and the types of services for which each individual is responsible. The CMO shall submit a quarterly report to the OMPP detailing how often and for what number and type of PA requests the licensed medical professionals were used in determining whether to approve or deny a request.

6) Research, analyze, and evaluate all PA requests to ensure all medical facts have been considered prior to rendering a decision to approve or deny the request. Ensure PA staff utilizes well-defined processes and procedures for research and analysis of PA requests.

7) Correctly disposition (i.e., approve, deny, or modify, not merely enter into Indiana*AIM* as pending) prior authorization requests within five (5) business days of receipt. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

8) Ensure that non-covered or per diem-reimbursed services are not prior authorized.

9) Ensure that authorized dollars and/or units are appropriately decremented from the PA file by paid claim.

10) Review, verify, and deliver to the State, within 15 calendar days of the following month, a report summarizing the CMO's PA activities performed for the preceding month. The report shall delineate the method of request, types of services, and the number of services being requested by the provider community, and whether each request was approved or denied. The report should include each request as a single line item, as well as summary information. The exact format and content of the report will need to be finalized in consultation with the OMPP.

11) Maintain a sufficient number of toll-free (for Indiana and contiguous states) phone lines and qualified personnel to staff the phone lines so that:

- At least 90 percent of incoming calls are answered on or before the fourth ring
- No more than 10 percent of incoming calls ring busy or remain on hold for more than one minute.
- No more than 5 percent of incoming calls remain on hold for more than two minutes
- Average hold time does not exceed thirty seconds
- Call length is sufficient to ensure adequate information is imparted to the caller

12) Staff PA phone lines from 7:30 a.m. to 6:00 p.m. in all of the State's time zones Monday through Friday (including State holidays). The CMOs should provide an explanation of what coverage is available for PA requests after hours to the OMPP.

13) Provide a minimum of three fax lines and fax machines dedicated to receipt of PA requests, with sufficient memory or buffers to handle multiple incoming transmissions.

14) Produce monthly reports of PA phone and fax line availability, incomplete calls, and disconnects. Furnish these reports to the State within five days of the end of the month.

15) Post the medical criteria and a list of services requiring PA for providers to access online, and make the list of services and criteria available in hard copy upon their request Hard copies of the criteria shall be provided within five business days of the provider's request. The CMO may charge providers for copies made of the criteria, but the cost shall not exceed the CMO's cost to produce the copies.

16) Interface with providers on a regular basis to refine procedures for submission of PA requests to ensure that internal policies agree with changing practices in the provider community. Provide necessary staff to attend meetings (provider association meetings, and so forth) on an as-needed basis.

17) Research and prepare appropriate, timely, accurate, and thorough responses to inquiries received from the State or providers. Inquiries from government officials require a written response within three business days of receipt. All other inquiries shall be responded to within 10 business days of receipt.

18) Design PA forms or attachments as needed or define revisions to existing forms if changes are needed. All forms are subject to the OMPP approval. Produce, print, and distribute to providers, free of charge, PA forms and procedure manuals.

19) Purge old PA records according to State-specified criteria.

20) Prepare an annual work plan for the PA unit, and update the work plan quarterly. The annual plan shall be delivered 60 calendar days before the end of the calendar year, and quarterly updates shall be delivered every 90 days thereafter. The work plan shall include projects that will be performed, anticipated schedules, and resources for the projects. The work plan shall also include a summary of the activities performed the previous quarter or year. Upon completing each quarterly review, the CMO shall provide the State with a report of progress made to date on the projects. The quarterly report shall be delivered to the OMPP for review, and the OMPP's input shall be incorporated.

21) On a semi-annual basis, covering the period from January through June and July through December, the CMO shall provide a trending analysis to the State to evaluate authorized services, the number of services rejected, the number of appeal requests by PA category, and the number of appeals that are successful. Upon completion of the qualitative and quantitative analysis, the CMO shall provide recommendations to the State for suggested policy changes. The report shall be delivered within 30 days of the end of the six-month period.

22) On a semi-annual basis, covering the period from January through June and July through December, initiate a review of administrative reviews, hearings, and appeals from the previous period to determine if providers are submitting sufficient information for making appropriate PA decisions. The analysis shall include evaluating administrative reviews to determine how many result in a reversal, denial, or modification. Upon review completion, findings will be provided to the State that include potential policy change recommendations to correct problems.

23) Implement a quality assurance process and establish procedures to periodically sample and review dispositioned PA requests to determine if PA policies and procedures are being followed.

24) Conduct quarterly quality assurance reviews to ensure appropriateness of Medicaid PA analyst decisions. Provide the results of these reviews to the State no more than thirty (30) days after the end of the quarter.

25) Provide staff to represent the State through written and personal testimony as well as research and documentation in PA appeal matters, grievances, and court cases.

26) Participate in periodic reviews of PA criteria against current practices to ensure appropriateness of PA decisions and to aid in the determination of whether or not changes to policy are required. Include representatives from the Medical Policy contractor and/or Hoosier Healthwise contractors in the review discussions as appropriate.

27) Refer instances of suspected fraud/abuse to the Surveillance and Utilization Review (SUR) Contractor.

28) Meet at least monthly with the SUR Contractor and Medical Policy Contractor t ensure coordination. Coordinate with the State's Fiscal Agent on PA issues at least monthly or as determined to be necessary.

State Functions

The State anticipates that the OMPP or its contractors (not the CMO) will perform the following functions:

1) Review and approve all PA error messages and the content of notification letters.

2) Approve the format of all PA request forms and related material.

3) Specify PA record purge criteria.

4) Work with the Contractor to confirm content, format, and expectations for reports prepared by the Contractor.

5) Specify and approve the types of services that may be requested by phone, fax, or other electronic inquiry.

6) Conduct monitoring to ensure that PA decisions are correct and appropriate.

7) Provide policy and procedure research, development, evaluation, and rule promulgation for new rules.

8) Approve prior authorization requests for services not otherwise covered under the State's Medicaid plan but determined to be medically necessary by an EPSDT provider for an EPSDT-eligible child.

9) Provide medical necessity review criteria to the CMO. The State reserves the right to update the criteria as members' needs change.

PA Coordination Activities

The CMO is responsible for the following PA coordination activities:

1) Develop and maintain coordination methods to provide PA information to the Medical Policy Contractor, SUR Contractor, the Fiscal Agent Contractor, Waiver Unit staff, and other contractors, including the Care management Organizations, as necessary to support the Medicaid program.

2) Coordinate and establish protocols for call transfers and forwarding of PA requests to necessary outside personnel.

3) Work with the Fiscal Agent Contractor to resolve claims issues regarding PA.

4) Coordinate activities with the Medical Policy and Review Services Contractor to develop standards regarding PA assignment. Include standards cited to document decision appropriateness.

5) Proactively provide feedback to the Fiscal Agent Contractor and other identified contractors as necessary regarding PA issues.

6) Prepare materials related to PA (for example, appropriate telephone numbers and information on how to obtain hard copies of PA criteria, etc.), subject to State approval, for inclusion in bulletins, newsletters, manuals, etc., prepared and issued by the Fiscal Agent Contractor.

Section 13: Utilization Review

Utilization Management

The CMO must maintain a utilization management program that integrates with other functional units as appropriate and supports the Quality Management and Improvement Program. The utilization management program must have policies and procedures to assist utilization management staff to:

- Identify instances of over- and under-utilization of emergency room services and other health services
- Identify aberrant provider practice patterns (especially related to emergency room, inpatient services, transportation, drug utilization, preventive care and screening exams)
- Ensure active participation of a utilization review committee
- Perform concurrent review of both inpatient and emergency room services at high volume facilities as defined by the CMO and approved by the OMPP
- Perform discharge planning at high volume inpatient facilities
- Evaluate efficiency and appropriateness of service delivery
- Incorporate subcontractor's performance data
- Facilitate program management and long-term quality
- Identify critical quality of care issues

The CMO's utilization management program policies and procedures must meet all stated NCQA and/or URAC standards and must include appropriate timeframes for, and must report on:

- 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 of the CMO's decisions on initial prior authorization requests and determinations of medical necessity
- Notifying provider and members of the CMO's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity

The CMO must operate and maintain its own utilization management program. With the OMPP's approval and in compliance with applicable laws and regulations, the CMO may place appropriate limits on coverage for physical and behavioral services on the basis of medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve their purpose. Note that while pharmacy UM will continue to be conducted through the State's current pharmacy benefit manager, the OMPP strongly encourages the CMO to provide input into pharmacy policy decisions and vice versa, and to regularly review and analyze pharmacy claims data and pharmacy utilization.

The CMO shall follow the State's medical policy decisions, and is prohibited from arbitrarily denying or reducing the number, duration or scope of required services solely because of diagnosis, type of illness or condition or because of overall program costs.

At a minimum, the CMO must provide the following utilization management services for physical and behavioral health services requiring prior authorization:

Determination of Medical Necessity and Prior Authorization. Once all relevant information is obtained, the request must be evaluated against nationally recognized and published clinical criteria or guidelines, such as Milliman, HCIA-Sachs, American Society of Addiction Medicine and Health Management Strategies, to ensure the request is appropriate. The criteria must differentiate between adults and children/adolescents.

Identification of Members Appropriate for Care Management or Disease Management Services. As part of the initial assessment, the CMO must determine if referral to services such as case management or disease management is appropriate.

Concurrent Review. The CMO must identify cases for concurrent review, evaluate the member's functioning and determine the next course of action.

Discharge Planning. As part of the discharge planning process, the CMO should identify potential member needs based on clinical characteristics and work with the member, the member's family and the facility discharge coordinator to ensure the member receives appropriate post-hospitalization care. The CMO's involvement in discharge planning will be particularly critical to avoid unnecessary nursing home placements. The State is planning to develop a program of transition teams for discharged aged patients. Once this program is operational, the CMO must coordinate with these transition teams as needed to provide care management. The CMO must also coordinate with the AAAs for IndianaOPTIONS counseling.

Retrospective Review. The CMO must provide both focused and random retrospective reviews, based on paid claims data, that examine high cost and problematic areas, including high payment claims, prior knowledge of inappropriate usage, readmission with 30 days, home health services and specific DRGs that are often upcoded.

Development and Review of Clinical Criteria. The CMO must review, update and/or revise clinical criteria annually under the direction of the CMO's Medical Director and Clinical Advisory Panel and obtain authorization from the OMPP's Medical Policy unit for any changes.

Member Education and Member Self-Management. The CMO is responsible for educating members regarding the importance of using preventive care services in accordance with preventive care standards. The CMO must encourage and provide opportunities for members to take a proactive role in their own self-management. The Policies and Procedures Manual provides information on access to preventive services.

Provider Education. The CMO must provide feedback to PMPs regarding their panel's utilization profile.

Identifying, Monitoring and Addressing Potential Over and Under-Utilization. The CMO must have a process in place to identify inappropriate utilization and must have a plan in place to identify opportunities to address over and under utilization.

The CMO must establish and maintain medical management criteria and practice guidelines in accordance with Federal and State regulations that are based on valid and reliable clinical evidence or consensus among clinical professionals and consider the needs of the CMO's members. The CMO's utilization management and case management staff must be licensed, experienced health care professionals 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 CMO's members. The CMO must periodically review and update the guidelines, distribute the guidelines to providers, make the guidelines available to providers via its Web site, and make the guidelines available to members upon request.

Utilization Management for Behavioral Health Services

The CMO must manage behavioral health care utilization through concurrent and retrospective reviews (with the initial exception of MRO services, for which the CMO will not be responsible for conducting authorizations until July 1, 2008.)

The CMO will be responsible for prior authorizing and monitoring utilization of MRO services provided through CMHCs and facilitating coordination of MRO services and other physical or behavioral health care services. The CMO will share member medical data and coordinate care for all members receiving both physical and behavioral health services, to the extent possible, based on the member's willingness to sign a consent form to release health information, if consent is required.

Emergency Care

Over the length of its contract with the State, the CMO will implement programs to reduce inappropriate utilization of the emergency room through some or all the following strategies, which may include:

- Having a Nurse Hotline available 24-hour-a-day, 7-days-a-week to help members appropriately use the emergency room, and to assist ER departments who are rendering care to members at the ER. If a nurse hotline is available, the CMO shall provide a quarterly report about the volume of calls it receives, whether members were advised to use the emergency room or not, and whether members subsequently used the ER
- Conducting follow up calls with members who go to the ER
- Profiling PMPs to identify panels with high ER utilization
- Educating members about appropriate use of the ER and the availability of a nurse hotline, if offered.
- A mechanism to track the emergency services notification to the CMO (by the emergency room provider, hospital, fiscal agent or member's PMP) of a member's presentation for emergency services
- A mechanism to document a member's PMP's referral to the emergency room
- A mechanism to alert a member's PMP to the member's presentation for emergency services within 48 hours

The CMO may not deny payment for treatment obtained when a representative of the entity instructs the enrollee to seek emergency services. When educating members about appropriate use of the emergency room, the CMO should provide guidelines corresponding to the "prudent layperson" standard of an emergency medical condition, as defined in 42 CFR 438.114 and IC 12-15-12.

The CMO must allow enrollees to obtain emergency services outside the CMO system regardless of whether the CMO referred the enrollee to the provider that furnished the services.

Utilization Management Committee

The CMO must have a utilization management committee directed by the CMO's Medical Director. The committee is responsible for:

- Monitoring providers' requests for rendering health care services to its members
- Monitoring the medical appropriateness and necessity of health care services provided to its members
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed
- Writing policies and procedures for utilization management that conform to industry standards including methods, timelines and individuals responsible for completing each task

Section 14: Quality Improvement Program and Performance Reporting

Quality Management and Improvement Program

The CMO must monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members by all providers in all types of settings, in accordance with the provisions set forth in the CMO's contract. In compliance with State and Federal regulations, the CMO must submit quality improvement data to the OMPP that includes the status and results of performance improvement projects. Additionally, the CMO must submit information requested by the OMPP to complete the State's Annual Quality Assessment and Improvement Strategies Report to the CMS.

The CMO's Medical Director must be responsible for the coordination and implementation of the Quality Management and Improvement Program. The program must have objectives that are measurable, realistic and supported by consensus among the CMO's medical and quality improvement staff. Through the Quality Management Program, the CMO must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of health care services to members. Over time, it may be possible to incorporate physician profiling into the QM/QI program. The CMO should include physician profiling to the extent feasible and should include documentation on its current physician profiling capabilities in the CMO's contract.

The CMO will use claims data as the primary data source to develop and assess the effectiveness of its QM/QI Program. In addition to claims data, the CMO will use other data to assess the effectiveness of its QM program:

- Member satisfaction survey (particularly surveys including issues specifically relevant to people with disabilities and chronic conditions, behavioral health conditions, and so forth)
- Provider satisfaction survey
- Access and availability audit information
- The reliability of the CMO's data and IT systems
- Other data

As a key component of its Quality Management Program, the CMO will develop incentive programs for both providers and members that are based on the OMPP-designated quality improvement targets, with the ultimate goal of improving health outcomes of Indiana *Care Select* Program members.

The CMO must meet the requirements of 42 CFR 438 subpart D and the National Committee for Quality Assurance (NCQA), including but not limited to the requirements listed below, in developing its quality management program. In doing so, it shall include an assessment of quality and appropriateness of care provided to members with special needs, complete performance improvement projects in a reasonable time so as to allow information about the success of performance improvement projects to be incorporated into subsequent quality improvement projects, and produce quality of care reports at least annually.

The CMO's Quality Management and Improvement Program must:

- Include developing and maintaining an annual quality improvement plan which sets goals, establishes specific objectives, identifies the strategies and activities to undertake, monitors results and assesses progress toward the goals.

- Have written policies and procedures for quality improvement. Policies and procedures must include methods, timelines and individuals responsible for completing each task.
- Incorporate an internal system for monitoring services, including data collection and management for clinical studies, internal quality improvement activities, assessment of special needs population and other quality improvement activities requested by the OMPP.
- Participate appropriately in clinical studies, and periodically and regularly (at least annually, or more frequently as directed by the OMPP) assess the quality and appropriateness of care provided to members in accordance with EPSDT/Health Watch requirements.
- Collect measurement indicator data related to areas of clinical priority and quality of care. The Quality Improvement Committee, in collaboration with the OMPP, will establish areas of clinical priority and indicators of care. These areas may vary from one year to the next and will reflect the needs of the Indiana *Care Select* Program population.

Examples of areas of clinical priority include:

- Behavioral health and physical health care coordination
- Emergency room utilization
- Access to care
- Special needs care coordination and utilization
- Hospital utilization
- Disease management
- Pharmacy utilization
- DME utilization (examine equipment repair rates for members with disabilities and identify members with faulty equipment and discuss potential resolutions)
- Hospitalization for ambulatory sensitive conditions (use AHRQ's Ambulatory Sensitive Conditions list as a starting point for identifying which preventable hospitalizations data to collect. For example, conditions like urinary tract infections, chronic obstructive pulmonary disease, and bacterial pneumonia are common in people with disabilities and chronic conditions and represent conditions that could be preventable with effective outpatient care.)
- Report any national performance measures developed by the CMS. The CMO must develop an approach for meeting the desired performance levels established by the CMS upon release of the national performance measures, in accordance with 42 CFR 438.240(a)(2).
- Have procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with protocols developed in the public or private sector. The CMS Web site contains an example of available protocols.
- Develop and maintain a physician pay-for-performance program based on clinical and service outcomes priorities as set by the OMPP.
- Develop a member incentive program to encourage members to be personally accountable for their own health care and health outcomes. Targeted areas of performance could include the appropriate use of emergency room services, keeping appointments, and scheduling appointments for routine and preventive services, disease screenings, compliance with behavioral health drug therapy and compliance with diabetes treatment.
- Participate in other quality improvement activities to be determined by the OMPP.

Quality Management and Improvement Committee

The CMO must establish an internal Quality Management and Improvement Committee to develop, approve, monitor and evaluate the Quality Management and Improvement Program and annual work plan. The CMO's Medical Director must be an active participant in the CMO's internal Quality Management and Improvement Committee. The committee must be representative of management staff, CMO departments and community partners, advocates, members and subcontractors, as appropriate. Subcontractors providing direct services to members must be represented on the committee. Additionally, the Medical Director must attend the Quality Improvement Committee (QIC) meetings at least quarterly to update the OMPP and report on the CMO's quality management and improvement activities and outcomes. The CMO must have other appropriate personnel attend the Medicaid QIC meeting monthly.

The CMO must have a structure in place (for example, other committees, sub-committees, work groups, task forces) that is incorporated into, and formally supports, the CMO's internal Quality Management and Improvement Committee and quality management and improvement plan. All functional units in the CMO's organizational structure must integrate their performance measures, operational activities and outcome assessments with the CMO's internal quality management and improvement committee to support the CMO's quality management and improvement goals and objectives.

Quality Management and Improvement Work Plan Requirements

The CMO's Quality Management and Improvement Committee, in collaboration with the CMO's Medical Director, must develop an annual Quality Management and Improvement Work Plan. The plan must identify the CMO's quality management goals and objectives and include a timeline of activities and assessments of progress towards meeting the goals. The CMO must submit its Quality Management and Improvement Work Plan to the OMPP during the readiness review and annually thereafter, and must be prepared to periodically report on its quality management activities to the Indiana *Care Select* Program Quality Improvement Committee.

Program Integrity Plan

The CMO must immediately report any suspicion or knowledge of fraud and abuse including, but not limited to the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent. The CMO must report provider fraud to the OMPP, the Indiana Medicaid Fraud Control Unit (IMFCU) and the Surveillance and Utilization Review Unit (SUR). The CMO must report member fraud to the OMPP, the SUR, the Indiana Bureau of Investigation and the Office of the Inspector General. **However, no Program Integrity Plan is necessary.** FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services.

State Monitoring of CMO

External Quality Review (EQR)

Per *CFR 438.350*, states contracting with CMOs must ensure that a qualified External Quality Review Organization, (EQRO) performs an annual EQR for each CMO, in accordance with requirements set forth in the regulations. Mandatory activities include validation of performance improvement projects and CMO performance measures. Optional activities include validation of administration or validation of consumer or provider surveys, calculation of additional performance measures, conduct additional

performance improvement projects or studies that focus on a particular aspect of services. The results of the independent external review must be made public.

Scope of CMO Monitoring Activities

The OMPP contracts with a consulting contractor to assist in evaluating the effectiveness and efficiency of the *Care Select* care management program, its participating CMOs. The monitoring contractor evaluates the readiness of newly contracted CMOs to participate in the *Care Select* program and assesses compliance of all CMOs with federal and state regulations and contract provisions. The monitoring contractor also compares CMO policies, procedures, and performance against nationally established standards such as a *Health Care Quality Improvement System for Medicaid Care management: A Guide for States* (CMS) and *Medicaid HEDIS National Committee for Quality Assurance (NCQA)* and Indiana's state-specific performance standards. The monitoring contractor works with the OMPP, other OMPP contractors, and the CMOs to provide the OMPP with analysis, findings, and recommendations for quality improvement.

Readiness Reviews

To assist the OMPP in monitoring quality of care, the contractor is responsible for conducting a readiness review of CMOs that contract with the OMPP to determine if the organization is prepared to operate and accept enrollment.

The monitoring contractor verifies that certain program components are present and that a plan is in place to implement the requirements, before the CMO is allowed to deliver services to the *Care Select* population. These program components include, but are not limited to, the following:

- Network development (access or availability of services)
- Administration and organizational structure
- Utilization and financial information
- Education and outreach for members and providers
- Member and provider services, including grievance and appeal processes
- Quality management and improvement, including internal quality assurance plans

Readiness reviews typically begin at least eight to 12 weeks before the date a new health plan intends to serve *Care Select* enrollees.

If the contractor reports that the CMO is not meeting the readiness review requirements, the OMPP requires the CMO to develop a corrective action plan that includes a schedule for activities for the corrective action. If the CMO does not implement the requirements within the time indicated in the corrective action plan, sanctions can be issued by the OMPP, or the contract can be terminated.

Performance Reporting

The State places great emphasis on the delivery of quality healthcare to *Care Select* members. Performance monitoring and data analysis are critical components in assessing how well the CMO is maintaining and improving the quality of care delivered in the *Care Select* program. The State uses various performance targets, industry standards, national benchmarks, and *Care Select*-specific standards in monitoring the CMO's performance and clinical outcomes. The CMO must submit performance data specific to the *Care Select* program unless otherwise specified by the OMPP. The

State publishes the *Care Select* program's performance and recognizes the CMO when it exceeds these performance indicators.

The CMO must comply with all reporting requirements and must submit the requested data completely and accurately within the requested time frames and in the formats identified by the OMPP. The CMO must have policies, procedures, and mechanisms in place to ensure its financial and non-financial performance data that is submitted to the OMPP and the monitoring contractor is accurate and a true reflection of the CMO's operational efficiency. The CMO must submit its performance data and reporting under the signatures of its financial officer and executive leadership (such as, President, Chief Executive Office, Executive Director) certifying the accuracy, truthfulness and completeness of the CMO's data. The *CMO Reporting Manual* details the reporting requirements that are outlined below.

The OMPP reserves the right to audit the CMO's self-reported data and change reporting requirements at any time with reasonable notice. The OMPP may require corrective actions or assess liquidated damages for CMO non-compliance with these and other subsequent reporting requirements and performance standards.

Contractor Reports and Time Frame for Processing

Contractor shall submit reports to the State, together with adequate supporting documentation, documenting to the satisfaction of the State the Contractor's progress toward the achievement of the performance targets set forth in contract. Such reports shall be submitted no later than 30 calendar days following the end of each calendar quarter, with the first such reports due no later than April 30, 2008.

The exact format and content of the report, including the requirements for any supporting documentation, shall be mutually agreed upon between the State and Contractor. Each report shall separately identify the Contractor's progress with respect to all of the following time periods:

(a) the most recent calendar quarter,

(b) calendar year-to-date and

(c) since the start of the Contract.

The State shall have 30 calendar days from the date of its receipt of any such report to review the report and any supporting documentation submitted by the Contractor. Within such 30 day time period, the State shall send a written notice to the Contractor indicating either that the report has been accepted or rejected. If the report has been accepted, the State's notice shall indicate the amount of payment, if any, recommended based upon the Contractor's performance relative to the metrics/measures addressed in the report. If the report has been rejected, the State's notice shall indicate that the report is incomplete or otherwise lacking adequate supporting documentation, and/or that the State desires to audit Contractor's records relative to its performance prior to accepting the report. If a report is rejected as incomplete or lacking adequate supporting documentation, Contractor shall have 21 calendar days from the date of its receipt of the rejection notice to furnish the State with the requested information. The State shall review any additional information timely submitted and notify Contractor whether the report has been accepted or rejected based upon the information submitted. In the event the State requests an audit, the State shall conduct its audit within a reasonable time period not to exceed 60 calendar days, provided the Contractor cooperates in such audit, and, within 30 calendar days of completing its audit, shall notify the Contractor whether the report giving rise to the audit has been accepted or rejected.

Reviews

Contractor agrees that the State may periodically review Contractor's books and records to verify the accuracy of Contractor's performance reports, and to otherwise determine Contractor's entitlement to performance based monies. Such reviews may be conducted at any time upon reasonable prior notice. Contractor shall cooperate with the State with respect to any such review. The State's review rights shall continue for a period of five years following the termination or expiration of the Contract, regardless of the reason for termination.

Performance Metrics and Health Outcomes Measures Reporting

Performance Metrics and Health Outcomes Measures Reports include the following:

- Member Assessments
- Members Stratified
- Members with Care Plan on Record
- Members with a Delivered Care Plan
- Timeliness of Prior Authorization Responses
- Call Management/Calls Answered
- Call Management/Calls Ringing "Busy" or On Hold for More Than One Minute
- Call Management/Calls on Hold for More Than Two Minutes
- Prevention Quality Indicator Measures
- Access to Medical Care
- Emergency Room Utilization Per Member Months.
- Emergency Room Utilization Per Outpatient Visit

Administrative and Financial Reports

This section includes all performance reporting required by the OMMP for the *Care Select* CMOs and any additional reporting requirements as requested by the division. Reports in this section include the following:

Vacancies of Key Staff

The CMO must report to the OMPP any vacancies of key staff and its plan for not only filling those positions but also the CMO's interim plan to cover the responsibilities created by the key staff member's vacancy. Likewise, the CMO must notify the OMPP's Care management Manager in writing within five business days after a candidate's acceptance to fill a key staff position or five business days prior to the candidate's start date, whichever occurs first. Whenever the information changes, the CMO must submit to the OMPP an updated organizational chart including e-mail addresses and phone numbers for key staff.

Financial Reporting

The reports in this section assist the OMPP in monitoring the CMO's financial trends to assess its stability and continued ability to offer health care services to its members. If the CMO does not meet the financial reporting requirements, the State will notify the CMO of the non-compliance and designate a period of time, not less than 10 calendar days, during which the CMO must provide a written response to the notification. The CMO must meet IDOI licensure and financial requirements.

- Audited financial statement

Member Service Reports

Member service reports identify the methods the CMO uses to communicate to members about preventive healthcare and program services and monitors member satisfaction. The following are examples of member service reports:

- Member Helpline Performance Report (Quarterly or as determined by the OMPP)
- Member Grievances Report (Quarterly)
- Member Appeal Report (Quarterly)
- Medicaid Hearing Appeals (As determined by the OMPP)
- Total Number of Members

Network Development Reports

Network development reports assist the OMPP in monitoring the CMO's network composition by specialty and county to assess member access and network capacity. The CMO must identify current enrollment, gaps in network services and the corrective actions that the CMO is taking to resolve any potential problems relating to network access and capacity. Examples of possible network development reports include, but are not limited to the following:

- Provider directory (annually)
- Network Geographic Access Report and Map (Annually)
- 24-hour availability audit (Annually)
- Subcontractor compliance summary report (Annually)
- Total Number of Providers

Provider Service Reports

Provider service reports assist the OMPP in monitoring the methods the CMO uses to communicate to providers about clinical, technical and quality management and improvement issues relating to the program. Examples of possible reports include the following:

- Provider Helpline Performance Report (Quarterly)
- Provider Grievance and Appeals

Quality Management Reports

Quality management reports review the ongoing or future methods and processes the CMO uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality, and utilization of program services by its members and providers. These reports assist the OMPP in monitoring the CMO's quality management and improvement activities. Examples of possible reports include the following:

- Quality Management and Improvement Program Plan – includes Program Integrity Workplan, Encounter Claim Workplan and Provider Network Development Activity Report (Annually)
- HEDIS Data Submission Tool (Annually)
- HEDIS Auditor Report (Annually)

Utilization and Financial Reports

Utilization assists the OMPP in monitoring the CMO's utilization trend. The CMO will monitor utilization b subpopulation, when appropriate.

- Service Utilization – Physical Health (Quarterly)
- Service Utilization – Behavioral Health (Quarterly)
- PA decisions, number of phone calls for A and the category for these calls, denials rates and other relevant and necessary information

The CMO must separately report behavioral health statistics for those members treated in a CMHC as compared to those members not treated in a CMHC. Additionally, the CMO must report utilization of substance abuse treatment services separate from utilization of mental health services. The CMO must particularly monitor use of services for its members with special needs and members with a diagnosis of severe mental illness or substance abuse.

Performance Monitoring and Incentives

On a quarterly basis, the CMO shall submit a report to the OMPP documenting the progress towards performance targets under the contract, at a granular level, for that quarter, that year, and the agreement to date. The exact format and content of the report will be finalized prior to the contract effective date.

Data submitted by the CMO as well as claims data will be the primary source of data the State uses in its monitoring efforts. The OMPP will establish the data submission requirements and timeframes. These data come to the State in various formats and at different times. The reporting templates provide information on performance reporting and targets.

Performance Targets, Standards, and Benchmarks

Listed below are the current performance indicators and the performance target for each measure. The OMPP may implement incentives, as described in Section 7.8.2, to reward any CMO whose performance is consistently above the targets for the majority of the measures listed below. The OMPP also will assess liquidated damages or apply other remedies listed in this section for failure to meet the minimum standards listed below.

Table 14.1 – Performance Indicators and Performance Targets

Service Area	Service Standard for Release of Withholding	Amount of Withholding Released if Service Standard Met
Financial performance/control fiscal growth/cost saving	To be determined	10% of administrative withhold
Other measures as defined by the OMPP and the CMOs	To be determined	10% of administrative withhold

The OMPP reserves the right to identify additional performance indicators and targets, modify the performance indicators and targets prior to contract award, and modify the performance indicators and targets in consultation with the CMO over the course of the contract.

Performance-Related Delayed Payments

The State shall pay 80 percent of each invoice the CMO provides with net 30 day payment terms. 20 percent of each invoice shall be held back, to be paid within 30 days of the end of each quarter, according to the CMO's demonstrated and documented performance against the targets and standards as defined by the OMPP.

Subject to the terms of the Contract, including Exhibit B, Contractor shall be eligible to receive the return of up to one-half of the CMO fee withheld by the Office pursuant to Exhibit B for the applicable period (i.e., Contractor shall be eligible to receive up to 10 percent of the CMO fee for the applicable period) based upon Contractor's satisfactory achievement relative to the performance metrics and health outcomes measures identified in this Attachment 2 to Exhibit B, as more fully described below.

The CMO will participate in a pay-for-performance program that focuses on rewarding the CMO's efforts to improve quality and outcomes for Indiana *Care Select* Program members. The CMO will design a program acceptable to the OMPP, in consultation with the OMPP, before the contract effective date. At least 75 percent of any performance-related delayed payments the CMO receives must be passed on to providers and/or members.

The OMPP's program is a three-tiered model:

- In the first tier, the OMPP will provide financial and/or non-financial performance incentives to the CMO based on performance targets in priority areas established by the State. The OMPP will finalize details during contract negotiations.
- In the second tier, the CMO will establish incentives for providers to improve quality and outcomes in areas consistent with the first tier.
- In the third tier, the CMO will establish incentives for members to actively participate in their health care and to improve compliance with health care in areas consistent with the first and second tier.

The OMPP expects to publish the specific measures for the first year of the contract. The OMPP reserves the right to revise measures on an annual basis and will notify the CMO of changes to incentive measures in the quarter preceding the beginning of the next contract year.

The CMO must establish a performance-based incentive system for, at minimum, high volume PMPs. The OMPP defines high volume PMPs as the top 10 percent of the CMO's contracted PMPs based on member enrollment. Incentives may be financial or non-financial, but the incentive system must address the priority areas identified by the OMPP. With State approval, the CMO will determine its own methodology for incenting providers. The State encourages creativity in designing pay for performance programs.

The CMO earning financial incentives must reinvest at least 75 percent of the incentive amount the CMO receives in member and provider incentives. The CMO must submit to the OMPP its proposal for reinvesting 75 percent of the incentive amount. Examples of financial incentives to providers include:

- Increased reimbursement rate based on performance
- Bonus payments based on performance or for providing selected services

The CMO may also provide non-financial incentives for meeting performance targets to providers, such as recognition dinners, a feature in the provider newsletter, or reduced reporting or prior authorization requirements.

The CMO will also be required to establish a program to encourage members' personal responsibility for health-promoting behavior in the priority areas defined by the OMPP. By rewarding personal

responsibility, the State's goals are to reinforce healthy behavior and lifestyle choices while increasing rates of preventive services.

Member incentives may be financial or non-financial. With State approval, the CMO will determine its own methodology for incenting members. The incentive program must address the OMPP's priority areas and must reward members' personal responsibility.

The value of member incentives may not exceed $50 per year per individual, and must be approved by the OMPP. The CMO is subject to penalties under the Social Security Act Section 1128A(a)(5) regarding inducements, remunerations and gifts to Medicaid recipients and Package C recipients. The CMO must comply with all marketing provisions in the 42 CFR 438.104, and Federal and State regulations regarding inducements. Examples of appropriate rewards include:

- Gift certificates for groceries
- Phone cards
- Gifts such as household products, etc.

Acceptance of Report

Each reporting period, the CMO shall submit all reports electronically, in a format acceptable to the OMPP, and shall receive written verification that the report was received. If the report was late, the OMPP shall note it in writing, and the CMO shall be subject to liquidated damages as described elsewhere in this section.

Upon receipt of each report, the OMPP shall have a period of 15 calendar days to review the report's format and content. Within the 15-day window, the OMPP may require the CMO to modify the format or content of the report by submitting a notice in writing. If no requests are made within 15 days of the OMPP's receipt of the report, the CMO may assume the report was accepted as-is.

Payment of Performance Withholding

After acceptance of each quarterly report, the OMPP shall determine whether the CMO's performance in the reporting period was sufficient to earn all or a portion of the 20% performance-related delayed payment. The OMPP's decision to release or continue to hold some or all of the withheld amount shall be final.

If the OMPP determines that payment of some or the entire withheld portion is due, the OMPP shall pay the CMO within 30 calendar days of the completion of its review of the relevant report(s).

Failure to Perform/Non-compliance Remedies

Areas of Non-Compliance

*Non-compliance with General Contract Provisio*ns

The objective of this requirement is to provide the State with an administrative procedure to address issues where the CMO is not compliant with the contract. Through routine monitoring, the State may identify contract non-compliance issues. If this occurs, the State will notify the CMO in writing of the nature of the non-performance issue. The State will establish a reasonable period of time, but not more than 10 business days, during which the CMO must provide a written response to the notification. If the CMO does not correct the non-performance issue within the specified time, the State may enforce any of the remedies listed in this section.

Non-compliance with Reporting Requirements

The CMO reporting manual will include sample reporting templates demonstrating the required formats and submission instructions for the reports. The OMPP may change the frequency of required reports, or may require additional reports, at the OMPP's discretion. The State will assess liquidated damages of $200 for each business day past the date due when reports are not delivered complete, on time, and in the correct reporting formats, or submitted incorrectly.

If the CMO's non-compliance with the reporting requirements impacts the State's ability to monitor the CMO's solvency, and the CMO's financial position requires the State to transfer members out of the Indiana *Care Select* Program, the CMO must pay any costs the State incurs to accomplish the transfer of members. Further, the OMPP will withhold all car management payments or require corrective action until the CMO provides satisfactory financial data.

Non-compliance with Readiness Review Requirements

If the CMO does not satisfactorily pass the readiness review prior to 30 calendar days before scheduled member enrollment, member enrollment may be delayed, the State may withhold payment, or the State may require other remedies, and the CMO will be responsible for any costs associated with the delay. In addition, the OMPP will assess liquidated damages in the amount of $200 for each business day that the CMO delays submitting the readiness review responses past the expected dates due.

Non-compliance Remedies

The CMO must ensure quality care for its members. To assess attainment of this goal, the State monitors certain quality and performance standards, an holds the CMO accountable for being in compliance with contract terms. The OMPP accomplishes this by working collaboratively with the CMO to maintain and improve programs, and not to impair CMO stability.

In the event that the CMO fails to meet performance requirements or reporting standards set forth in the CMO contract, the State will provide the CMO with a written notice of noncompliance and may require any of the corrective actions or remedies discussed in this section The State will provide written notice of non-compliance to the CMO within 60 calendar days of the State's discovery of such non-compliance.

If the OMPP elects not to exercise a corrective action clause contained in the CMO's contract in a particular instance, this decision must not be construed as a waiver of the State's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the contract, may be retroactively assessed.

Corrective Actions

In accordance with 42 CFR 438, Subpart I, the OMPP may require corrective action(s) when the CMO has failed to provide the requested services. The nature of the corrective action(s) will depend upon the nature, severity and duration of the deficiency and repeated nature of the non-compliance. The written notice of non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, any of the following:

- Written Warning: The OMPP may issue a written warning and solicit a response regarding the CMO's corrective action.
- Formal Corrective Action Plan: The OMPP may require the CMO to develop a formal corrective action plan to remedy the breach. The corrective action plan must be submitted under the signature of the CMO's chief executive and must be approved by the OMPP. If the corrective action plan is

not acceptable, the OMPP may provide suggestions and direction to bring the CMO into compliance.

- Withholding Care Management Payments: The OMPP may suspend care management payments for the following month or subsequent months when the State determines that the CMO is non-compliant. The OMPP must give the CMO written notice 10 business days prior to the suspension of care management payments and specific reasons for noncompliance that result in suspension of payments. The State may continue to suspend all care management payments until non-compliance issues are corrected.
- Suspending Enrollment: The OMPP may suspend enrollment of new members into the CMO. The State may suspend enrollment for the entire CMO or may selectively suspend enrollment for a county or a specific provider. The State will notify the CMO in writing of its intent to suspend new enrollment at least 10 business days prior to the first day of the suspension period. The suspension period may be for any length of time specified by the State. The State will base the duration of the suspension upon the nature and severity of the default and the CMO's ability to cure the default.
- Immediate Sanctions: If the CMO has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information, the State may impose immediate sanctions of up to $25,000 for each determination of marketing violations.
- Contract Termination: The State reserves the right to terminate the contract, in whole or in part, due to the failure of the CMO to comply with any term or condition of this contract, or failure to take corrective action as required by the OMPP to comply with the terms of this contract. The State must provide 30 calendar days written notice and must set forth the grounds for termination. See Section 9.1 of this Attachment for the basis upon which the State may terminate the contract.

Liquidated Damages

In the event that the CMO fails to meet performance requirements or reporting standards set in the CMO contract, it is agreed that damages shall be sustained by the State, and the CMO shall pay to the State its actual or liquidated damages according to the following subsections and subject to the limitations provided in 42 USC 1396u-2 (e).

It is agreed that in the event of a failure to meet specified performance or reporting requirements subject to liquidated damages, it is and will be impractical and extremely difficult to ascertain and determine the actual damages which the State will sustain in the event of, and by reason of, such failure; and it is therefore agreed that the CMO will pay the State for such failures according to the following subsections. No punitive intention is inherent in the following liquidated damages provisions.

The OMPP may impose remedies resulting from failure of the CMO to provide the requested services depending on the nature, severity and duration of the deficiency. In most cases, liquidated damages will be assessed based on the schedules in this section. Should the OMPP choose not to assess damages for an initial infraction or deficiency, it reserves the right to require corrective action or assess damages at any point in the future. The OMPP will assess liquidated damages for any of the areas of non-compliance listed in this section. or for any other areas of non-compliance, at the discretion of the OMPP.

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Section 15: Management Information Systems

Overview

The CMO must have a management information system (MIS) sufficient to support the *Care Select* program requirements. The CMO must have a plan for creating, accessing, storing and transmitting health information data in a manner that is in keeping with HIPAA confidentiality requirements, transmission, and maintenance of confidential medical data, including:

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

The CMO must develop, implement, and maintain an MIS with capabilities to perform the data receipt, transmission, integration, management, assessment, and system analysis tasks described in this policy. The CMO must have a mechanism(s) in place to link data into a relational database reflecting all functional area's data integration. The CMO must have policies and procedures to describe and support the MIS backup plans, and a disaster recovery plan. The CMO must have policies and procedures addressing auditing and monitoring subcontractors' data and performance. The CMO must integrate subcontractors' financial and performance data (as appropriate) into the CMO's MIS to accurately and completely report CMO performance and confirm contract compliance.

The CMO must make all collected information available to the Office of Medicaid Policy and Planning (OMPP) and, upon request, to the Centers for Medicare & Medicaid Services (CMS). In accordance with the *Code of Federal Regulations (CFR)* at *42 CFR 438, subpart H*, the CMO must submit all data under the signatures of its Financial Officer and Executive leadership (for example, President, Chief Executive Office, Executive Director) certifying the accuracy, truthfulness, and completeness of the CMO's data.

The CMO must comply with all Indiana Office of Technology (IOT) standards, policies and guidelines, which are available online at http:/oit.in.gove/architecture/. All hardware, software and services provided to or purchased by the State are compatible with the principles and goals contained in the electronic and information accessibility standards adopted under *Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d)* and *Indiana Code (IC) 4-13-1-3*. Any deviation from these architecture requirements must be approved in writing by IOT in advance.

Disaster Recovery Plans

The CMO must protect against hardware, software, and human error. The CMO must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file backups, and disaster recovery. The CMO must maintain full and complete backup copies of data and software, and must proficiently back on tape or optical disk and store its data in an approved off-site location. The CMO must maintain or otherwise arrange for an alternate site for its system operations in the event of a catastrophe or other serious disaster. (For purposes of this policy, *disaster* means an occurrence of any kind whatsoever that adversely affects, in whole or in part, the error-free and continuous operation of the CMO's or affects the performance, functionality, efficiency, accessibility, reliability, or security of the system.) The CMO must take the steps necessary to recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and the CMO jointly determine when unscheduled system downtime is to be elevated to a disaster status. Disasters may include natural disasters, human error, computer virus, or malfunctioning hardware or electrical supply.

The CMO's responsibilities include, but are not limited to:

- Supporting immediate restoration and recovery of lost or corrupted data or software.
- Establishing and maintaining, in an electronic format, a weekly backup and daily backup that are adequate and secure for all computer software and operating programs; database tables; files; and system, operations, and user documentation.
- Demonstrating an ability to meet backup requirements by submitting and maintaining a Disaster Recovery Plan that addresses:
  - Checkpoint and restart capabilities
  - Retention and storage of backup files and software
  - Hardware backup for the servers
  - Hardware backup for data entry equipment
  - Network backup for telecommunications
- In the event of a catastrophic or natural disaster, resuming normal business functions at the earliest possible time, not to exceed 30 calendar days.
- In the event of other disasters caused by such things as criminal acts, human error, malfunctioning equipment or electrical supply, resuming normal business functioning at the earliest possible time, not to exceed 10 calendar days.
- Developing coordination methods for required system operational activities with other the CMO, including backups of information sent or accepted.
- Providing the State with regularly updated business resumption documents, such as:
  - Disaster recovery plans
  - Business continuity and contingency plans
  - Facility plans
  - Other related documents as identified by the State

Member Enrollment Data Exchange (834)

The CMO is responsible for verifying member eligibility and reconciling with its payments from the States's fiscal agent for each eligible member. If the CMO discovers a discrepancy in eligibility or care management payments, the CMO must notify the OMPP and the State's fiscal agent within 30 calendar days of discovering the discrepancy and no more than 90 calendar days after the OMPP delivers the eligibility records. The CMO must return any care management overpayments to the OMPP. If the CMO receives either enrollment information or care management payment for a member, the CMO is responsible for managing the care of that member.

The CMO is required to accept enrollment data in electronic format via secure FTP as directed by the OMPP. The *Companion Guide – 834 MCE Benefit Enrollment and Maintenance Transaction* details the enrollment data exchange. The State's fiscal agent produces the enrollment rosters three times a month. (See *Appendix F: EDS CMO Jobs Schedule* for job run dates). Changes in enrollment may occur during the interim period between the production of the roster and the effective date. For example, a member who is auto-assigned to an CMO on the 20th day of the month with an effective date on the first day of the following month appears on the CMO enrollment roster produced on the 26th of the month. If that member loses eligibility in the *Care Select* Program, and that loss is reported between the 26th day and the end of the month, this deletion is included on the second enrollment roster of the month. Because the member lost eligibility prior to the effective date in the CMO network, he or she is reported as a deleted member on the next enrollment roster. If the CMO has questions about the 834 transaction the CMO can contact the fiscal agent's managed care director.

CMO Additional Function Indicator File

The CMO Additional Function Indicator (AFI) file contains any members enrolled in CMOs that have health needs indicated by an *Additional Function Indicator*. The State's fiscal agent produces the AFI files three times a month. (See *Appendix F: EDS CMO Jobs Schedule* for job run dates) The file layout for the AFI file can be found in the CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa/.)

Receipt of Claims Data from Fiscal Agent

The State will make available to the CMO, through its fiscal intermediary, claims and eligibility data for members enrolled in the Indiana *Care Select* Program. The fiscal intermediary enters this data into the State's MIS, Indiana*AIM*. The CMO will be able to access the Indiana*AIM* system on a real-time basis to capture these data and to perform prior authorizations. The State currently uses several reporting tools to generate its own financial and utilization reports based on this raw data, and would encourage the CMO to utilize these or other similar types of tools to enable the CMO to use this data for utilization management. Examples of the tools include Business Objects and OnDemand.

Prior Authorizations

The State will allow the CMO access to its Indiana*AIM* system on a real-time basis to submit prior authorization decisions to the fiscal intermediary. The CMO will also be able to view historical prior authorization decisions via this system. The State requires the CMO to receive prior authorization requests via regular mail, telephone, FAX and to provide Web-based access for providers wishing to submit prior authorization requests to the CMO.

Health Information Technology and Data Sharing

The CMO should develop, implement, and participate in healthcare information technology (HIT) and data sharing initiatives to improve the quality, efficiency, and safety of healthcare delivery in Indiana. The OMPP's requirements for HIT and data sharing vary by resources available in each region. The following are examples of HIT initiatives that CMO should consider developing:

- Electronic prescribing (e-prescribing)
- Electronic medical record (EMR)
- Inpatient computerized provider order entry (CPOE)
- Health information networks
- Benchmarking
- Telemedicine

NPI Crosswalk File

On a weekly schedule, the fiscal agent (EDS) provides the CMOs with an NPI to legacy provider identifier (LPI) crosswalk file. The CMOs can use this file to assist with identifying a provider's NPI or LPI when only one of these identifiers are available on various files or reports. A copy of this file layout can be found in the CMO Question and Answer Web site at http://www.indianamedicaid.com/ihcp/cmo/qa/.

Appendix A: Sample Written Referral Form

This form is a suggested format for written referrals. Its use is optional. Referrals must be documented in the patient's medical record. This form does not need to be submitted with the claim for the rendered service.

REFERRAL FOR CARE SELECT CARE MANAGEMENT MEMBER

Date: _____

To: _____

From: _____

Provider #: _____

Address: _____

Phone: _____

Patient's Name _____

Medicaid or RID #: _____

Purpose of Referral: _____

_____

_____

_____

Extent of Referral (Check one):

[ ] One time only

[ ] As needed for treatment. (A new form or verbal authorization must be obtained prior to every calendar quarter).

[ ] Other, please specify:

This member is enrolled with me as his/her Primary Medical Provider (PMP). Please keep me informed of the disposition of the patient following your contact. As the patient's PMP, my medical records must reflect a complete health history. If you wish to refer this patient to another treatment source that will be billing Medicaid, please contact me.

By: _____

Primary Medical Provider

Figure A.1 – Written Referral Form

Appendix B: PMP Disenrollment Timeline

Submission of PMP Disenrollment Requests to EDS

Each CMO provides the EDS Managed Care Unit with a list of representatives who are trained and authorized to submit PMP disenrollments and keep their lists updated as responsibilities change.

An CMO notifies the EDS PMP disenrollment coordinator of the intent to disenroll a PMP within five working days of receipt or issuance of the disenrollment request. EDS does not process the disenrollment until the CMO sends the disenrollment request. Advance notification allows EDS the opportunity to begin the coordination of enrollment in another network, if necessary.

CMOs submit fully completed requests for disenrollment to the EDS PMP disenrollment coordinator at least five working days prior to the 24th day of the month. CMO network disenrollments are processed on the 24th day of the month. The following table lists the last day on which the EDS Managed Care Unit must receive the request to be effective by the first day of the following month.

Table B.1 – PMP Disenrollment Request Deadlines

Effective Date	Received on or Before
January 1, 2008	December 17, 2007
February 1, 2008	January 17, 2008
March 1, 2008	February 18, 2008
April 1, 2008	March 17, 2008
May 1, 2008	April 17, 2008
June 1, 2008	May 19, 2008
July 1, 2008	June 17, 2008
August 1, 2008	July 17, 2008
September 1, 2008	August 18, 2008
October 1, 2008	September 17, 2008
November 1, 2008	October 17, 2008
December 1, 2008	November 17, 2008
January 1, 2009	December 17, 2008

Appendix C: Care Select Inquiry, Grievance, and Appeal Process

Table C.1 – Inquiry Process

Issue	Final Policy
1. Definition of an inquiry.	An inquiry is a concern or issue that is expressed orally by a member that will be resolved by the close of the next business day.
2. Time frame for resolution of an inquiry.	The CMO must resolve an inquiry by the close of the next business day.
3. Notice of a resolution to the member.	Members are notified of a resolution of an inquiry by the close of the next business day. An inquiry resolved by the close of the next business day does not require a written notice of resolution to the member. Inquires resolved after the close of the next business day require a written notice of resolution to the member.
4. Reporting requirement.	Report monthly using the inquiry reporting form. Report separately for children with special healthcare needs and all other members.

Table C.2 – Grievance Process

Issue	Final Policy
1. Definition of a grievance and an expedited grievance.	A member or provider on behalf of a member may file a grievance orally or in writing. A grievance is any dissatisfaction expressed by the member or a provider on behalf of a member of an CMO regarding the availability, delivery, appropriateness or quality of healthcare services and matters pertaining to the contractual relationship between an enrollee and an CMO or group individual contract holder for which the enrollee has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction. An inquiry that is not resolved by the close of the next business day becomes a grievance. An expedited grievance is defined as a grievance regarding an issue that would seriously jeopardize the life or health of a member or the member's ability to reach and maintain maximum function.
2. Time frame for initial submission of a grievance or an expedited grievance.	A member has 60 days from the day of the decision or event in question to file an oral or written grievance.
3. Time frame for an CMO to acknowledge receipt of a grievance or an expedited grievance.	The CMO must acknowledge receipt of an oral or written grievance within three business days after the grievance is filed.

Table C.2 – Grievance Process

Issue	Final Policy
4. Time frame for resolution of a grievance and an expedited grievance.	The CMO must resolve a written or oral grievance as expeditiously as possible, but not more than 20 business days after a grievance is filed. The grievance procedure must require an expedited grievance review if adhering to the 20-business-day time frame resolution would seriously jeopardize the life or health of a member or the member's ability to regain maximum function. Expedited grievance reviews must be resolved within 48-hours of the CMO's receipt of the review request.
5. Extension of the grievance resolution time frame.	If the CMO is unable to make a decision regarding a grievance within the 20-business-day period due to circumstances beyond its control, the CMO notifies the member in writing of the reason for the delay within the 20-business-day period. The CMO then must make a decision regarding the grievance within 10 business days after the date of the 20-business-day time frame expiration.
6. Notice of a resolution to the member.	The CMO must respond in writing to an enrollee within five business days after resolution of the grievance or expedited grievance. The resolution includes notice of the member's right to file an appeal, the process for requesting an appeal, the expedited review options, the right to continue benefits during the appeal as long as the request complies with timeliness standards, and an explanation of the potential for the member to pay costs of pending care if an adverse appeal decision is made, if applicable. The CMO must make a reasonable effort to provide oral notification of expedited grievance resolutions. If the CMO denies the request for an expedited review, the CMO must transfer the grievance to the standard grievance time frame, make a reasonable effort to provide the enrollee with prompt oral notification of the denial for an expedited review and follow-up with written notice within two calendar days.
7. Reporting requirement.	Report monthly using the grievance reporting form. Report separately for children with special healthcare needs and all other members.

Table C.3 – Appeal and Expedited Appeal Process

Issue	Final Policy
1. Definition of an appeal and an expedited appeal.	An appeal is a written request from a member or a provider on the behalf of the member to change a previous decision made by an CMO. An expedited appeal review is defined as an issue that would seriously jeopardize the life or health of a member or the member's ability to regain maximum function.
2. Time frame for submission of an appeal or an expedited appeal.	A member has 30-calendar days from the day of the decision or event in question to file an appeal.
3. Time frame for an CMO	The CMO must acknowledge in writing the receipt of an appeal within

Table C.3 – Appeal and Expedited Appeal Process

Issue	Final Policy
to acknowledge receipt of an appeal or an expedited appeal.	three business days after the request for an appeal is filed.
4. Time frame for resolution of a standard appeal or expedited appeal.	An appeal of a grievance decision must be resolved as expeditiously as possible with regard to the clinical urgency of the appeal. However, an appeal must be resolved within 30 business days. An expedited appeal review must be conducted within 48 hours of the CMO's receipt of the review request.
5. Extension of the appeal resolution time frame.	If the CMO is unable to resolve the appeal within 30 business days because of circumstances beyond its control, the CMO must notify the member in writing on or before the end of the 30-business-day time frame that it requires more time to complete the process. The CMO must provide an explanation of the reason for the delay. The CMO then must make a decision regarding the appeal within 14 calendar days after the date of the 30-business-day time frame expiration.
6. Notice of a resolution to the member.	The CMO must notify the member of an appeal or expedited appeal resolution in writing within five business days after resolution of the appeal. The resolution includes notice of the member's right to file an External Independent Review request the process for requesting an External Independent Review, the expedited review options, the right to continue benefits during the review as long as the request complies with timeliness standards, and an explanation of the potential for the member to pay costs of pending care if an adverse review decision is made, if applicable. The CMO must make a reasonable effort to provide oral notification of expedited grievance resolutions. If the CMO denies the request for an expedited review, the CMO must transfer the appeal to the standard appeal time frame, make a reasonable effort to provide the enrollee with prompt oral notification of the denial for an expedited appeal and follow-up with written notice within two calendar days.
7. Reporting requirement.	Report monthly using the appeal reporting form. Report separately for children with special healthcare needs and all other members.

Table C.4 – External Independent Review Process

Issue	Final Policy
1. Definition of a standard external independent review and an expedited external review.	The CMO establishes and maintains an external grievance process for the resolution of grievances regarding an adverse utilization determination, an adverse determination of medical necessity, or a determination that a proposed service is experimental. An expedited external review is defined as a review related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the member's life, health, or ability to reach and maintain maximum function.
2. Time frame for submission of a request	A member or a provider on behalf member may file a written request with the CMO for an appeal of the CMO's grievance resolution not later

Table C.3 – Appeal and Expedited Appeal Process

Issue	Final Policy
for an external independent review.	than 45 calendar days after the enrollee is notified of the CMO's resolution.
3. Time frame for the CMO to acknowledge receipt of a request for an external independent review.	The CMO must acknowledge receipt of a request for external independent review within three business days of receiving the request for an external independent review.
4. Time frame for resolution of an external independent review and expedited external independent review.	A standard external independent review should be resolved within 15 business days after the standard review is requested. An expedited external independent review will be resolved within 72 hours of receipt of the request.
5. Notice of a resolution to the member.	For a standard review, the member is notified within 72 hours of the external independent review panel's decision. The resolution includes notice of the member's right to request a hearing to be conducted by the state Medicaid agency, the process for requesting a hearing by the state Medicaid agency, the right to continue benefits during the review as long as the request complies with timeliness standards, and an explanation of the potential for the member to pay costs of pending care if an adverse review decision is made, if applicable. [1] For an expedited review, the member is notified within 24 hours of the external independent review panel's decision. The resolution includes notice of the members right to and the process for requesting a hearing to be conducted by the state Medicaid agency, if applicable.
6. Reporting requirement.	CMOs report quarterly. Report separately for children with special health needs and all other members.

[1] For CMO members, all interim procedures must be exhausted prior to filing a request for FSSA hearing.
Requests must be sent to the following address:
Indiana Family Social Services Administration
Hearings and Appeals Section, MS-04
402 W. Washington St., Room W392
Indianapolis, IN 46204-2773

Table C.5 – Medicaid Hearing and Appeal Process

Issue	Final Policy
1. Definition of a Medicaid hearing and appeal review.	A hearing for any person whose claim of assistance is denied or not acted upon promptly by the CMO – to include actions that the State Medicaid agency takes to suspend, terminate or reduce services.
2. Time frame for submission of a request for a Medicaid hearing and appeal review.	A request for a Medicaid hearing and appeal review must be in writing and be submitted within 30-business days of the initial action that is being reviewed.
3. Medicaid hearing and appeal review process. The hearing and appeal process needs be pursued in the following order: • Administrative Law Judge Hearing • Agency review • Request for an Administrative Law Judge Review	The member may request an Administrative Law Judge Hearing pursuant to the Indiana Administrative Code (IAC) *405 IAC 1.1-1-5.* Upon receipt of the Administrative Law Judge Hearing decision, the member may request an Agency review of the decision within 10 days of receipt of the administrative law judge decision. An Agency decision may be brought before a Judicial Review pursuant to *405 IAC 1.1-3-6.*
4. Time frame for resolution of the Medicaid hearing and appeal review.	Member appeal hearings are conducted at a reasonable time, place, and date. The Administrative Law Judge Hearing officer decision is due within 90 business days of the date that the request for a hearing is first made. Any party who is not satisfied with the decision of the Administrative Law Judge may request an Agency review of the decision within 10 business days of receipt of the Administrative Law Judge's decision. If a Medicaid applicant or member is not satisfied with the final action after agency review, he or she may file a petition for judicial review.
5. Extension of the Medicaid hearing and appeal review resolution time frame.	A continuance of hearing is granted only for good cause shown. Requests for continuance are in writing and accompanied by adequate documentation of the reason(s) for the request.
6. Notice of resolution to consumer.	The parties are issued a written notice of action taken as a result of agency review. If the decision of the Administrative Law Judge reversed, amended or modified, the secretary or designee states the reasons for action in writing.

Appendix D: After Hours/24 Hours Availability Audit Quality Improvement

Quality Improvement Activity

Activity Name

After Hours/24 Hours Availability Audit

Purpose or Description

The purpose of the After Hours/24 Hour availability audit is to determine if there is appropriate and easy access to the PMP outside regular business hours. The *Care Select* program ensures that members have the ability to obtain medical care 24 hours a day, seven days a week. PMP's are assessed on the process they have in place for the members to access a medical professional for urgent or emergent healthcare needs. The OMPP recommends that CMO include the following statement in PMP contracts and addendums:

"The PMP will be available 24 hours per day, seven days per week by telephone to the PMP, an employee, or designee of the PMP, an answering service, or pager system that immediately pages an on-call medical professional"

Audit or Reporting Schedule

This audit is performed quarterly. Findings are communicated in the Quarterly Report and in updates at the Quality Improvement Committee (QIC) meetings as indicated on the QIC schedule.

Selection Process

PMPs are randomly selected and the sample size is based on a 95 percent confidence rate with a plus or minus 5 percent margin of error.

Methodology

Each quarter a random sample of PMPs within each region is queried. Calls are made to the providers in the identified sample either before 8 a.m. or after 5 p.m. and on Saturdays, Sundays, and holidays. A call log is kept until the calls are completed. All calls are tabulated and the results posted with the noncompliance reasons stated and the corrective action identified.

Analysis

The goal is to have 100 percent compliance. Findings are summarized as indicated in Table H.1 below.

Table D.1 – Sample of Summarized 24-hour Availability Audit Results

Region	Number of Total PMPs called	Number of Satisfactory Results	Number of Unsatisfactory Results	Percent Compliance

Actions for Improvement

Providers noncompliant with the 24-hour availability requirement are notified and corrective action is required within 30 days of notification. Noncompliant providers are monitored in the following quarter to determine availability. These calls must be completed in addition to the quarterly monitoring sample.

Activities must be identified in the audit report as steps taken to communicate results to PMPs' offices and steps taken for any necessary actions to achieve future compliance.

Appendix E: OMPP Recommendations for Access Audit Process Update

Quality Improvement Activity

Activity Name

Primary Medical Providers Access Audit

Purpose or Description

The purpose of performing an access audit for the *Care Select* PMPs is to ensure that the participating PMPs provide timely and appropriate access to health services for established and new patients within a PMP's practice.

Audit Schedule

This audit is conducted annually by random sample.

Reported Time Period

An audit is performed during the fourth quarter of each year, reported in writing in the fourth quarter report, and reported verbally at the Quality Improvement Committee (QIC) meeting, as scheduled by the OMPP.

Sample Size

The sample size is determined based on the total population for each specialty by each care management organization (CMO). PMPs are randomly selected and the sample size is based on a 95 percent confidence rate with a plus or minus 5 percent margin of error.

Call Instructions

The auditor must perform the following actions when conducting a PMP access audit:

1. Place a telephone call to the PMP.
2. Document the date and name of the person taking the call.
3. Identify yourself as a representative for the *Care Select* program and state that you are conducting an access to care audit.
4. Request to speak with the person who does the appointment scheduling.
5. Ask the scripted questions relevant to the type of provider.
6. Document the actual date given for the appointment.

**	*If the next available appointment is with the nurse practitioner within a PMP office, that is acceptable.*

7. Document the results.

Quantifiers

The PMP in the random sample may need to be replaced with another PMP name in instances where:

1. The PMP is no longer in practice
2. The PMP was on medical leave

When a PMP needs to be replaced, all data representing the replacement is recorded. Choosing a replacement PMP is completed by identifying every third PMP on the non-sample list. This process provides consistency and maintains integrity of the randomized process. PMPs who are replaced are done so only due to issues unrelated to the access audit. Any problems encountered must be reported for follow-up activity.

- *Nurse practitioners*: A PMP office is considered to be in compliance with the appointment standards if available appointment dates fall within the recommended time frames. If there is a nurse practitioner in practice with the physician, appointment availability is based on the first available appointment with any medical provider in the office.
- *No response*: A PMP office that refuses to respond to the access audit is considered to be noncompliant with the appointment standards and must be recorded as No Response (NR).
- *Not Applicable*: There may be some circumstances in which a question does not apply. For example, an obstetrician (OB) who does deliveries but does not provide gynecological (GYN) services. If the question does not apply to the PMP office then it must be recorded as not applicable (NA).

Appointment Standards

The appointment standards used are those accepted by the *Care Select* QIC. The 10 standards listed in Table E.1 are used to evaluate appropriate access to care.

Table E.1 – *Care Select* Quality Improvement Committee Accepted Appointment Standards

	Appointment Type	Appointment Time frame
1.	Urgent or emergent care	24 hours
2.	Non-urgent symptomatic	72 hours
3.	Routine physical exam	Three months
4.	Initial appointment (non-pregnant adult)	Three months
5.	Routine gynecological exam	Three months
6.	New obstetric patient	Within one month of date of attempting to schedule an appointment

(Continued)

7.	Initial appointment well child	Within one month of date of attempting to schedule an appointment

Table E.1 – *Care Select* Quality Improvement Committee Accepted Appointment Standards

	Appointment Type	Appointment Time frame
8.	Children with special healthcare needs	One month
9.	Average office wait time	Equal to or less than one hour
10.	Specialist referral: Emergency Urgent	 24 hours 48 hours

The standard for children with special healthcare needs must be addressed for patients who have a medical condition lasting (or will last) more than one year, require special equipment, or have physical access concerns.

Analysis

The analysis of the data is to be presented by specialty types of practice for each appointment type (see Table E.2 example) and an additional summary table for compliance with all appointment types (see Table E.3 example). Individual providers who participate in the study are sent their individual results and the aggregate results of their peers. Any PMP who fails to meet the expected standards are forwarded to the appropriate MCE provider services department for program education. All results are reported to the OMPP in the table format below for **each** appointment access standard.

The percentages reported must represent the total for the type of practice for those who the standard is applicable. For example, if a total of 100 OB/GYNs were surveyed, but only 80 do routine gynecological exams, for the routine gynecological exam standard, the results would be divided by 80 to obtain the percentage of those who met the standard or did not meet the standard (including those who did or did not respond).

Table E.2 – Presentation of Data Analysis by Specialty Types of Practice

Appointment Type: [insert name of appointment type - provide one table for each type]								
Practice Type	**Met Standard**		**Did Not Meet Standard**				**Not Applicable**	
			Response Given		**No Response**			
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
OB/GYN								
Peds.								
FP/GP								

Table E.3 – Presentation of Data Analysis of Compliance by Appointment Types

Percent of Providers Who Did/Did Not Meet Standards For All Appointment Types								
Practice Type	**Met Standard**		**Did Not Meet Standard**				**Not Applicable**	
			Response Given		**No Response**			
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
OB/GYN								
Peds.								
FP/GP								

Actions for Improvement

1. A letter is sent to all PMPs audited, thanking them for their continued support in the activities for the *Care Select* Program.
2. Information about any PMP who did not meet the standards is forwarded to the EDS Member and Provider Relations Department and a copy of the letter sent to the physician is placed in the PMP file.

Reporting Activity

The final results are provided to the *Care Select* QIC.

Appendix F: EDS CMO Jobs Schedule

Schedule for Production Enrollment 834 Records and Reports

> *Note: Enrollment Roster jobs **always** run on the evenings of the 11th and 26th days of each month and the last day of the month. Barring problems with the run, the change files and affiliated summary reports are always available for download from the EDS bulletin board (BBS) midday on the 12th and 27th days of each month and the first of the following month. Audit files run after the 27th day of the month. Change files, audit files, and summaries are also available for download on the 27th* and the first day of the following month.

- January 12 – change
- January 27 – change and audit
- January 31 – change
- February 12 – change
- February 27 – change and audit
- February 28 – change
- March 12 – change
- March 27 – change and audit
- March 31 – change
- April 12 – change
- April 27 – change and audit
- April 30 – change
- May 12 – change
- May 27 – change and audit
- May 31 – change
- June 12 – change
- June 27 – change and audit
- June 30 – change
- July 12 – change
- July 27 – change and audit
- July 31 – change
- August 12 – change
- August 27 – change and audit
- August 31 – change
- September 12 – change
- September 27 – change and audit
- September 30 – change
- October 12 – change
- October 27– change and audit
- October 31 – change
- November 12 – change
- November 27 – change and audit
- November 30 – change
- December 12 – change
- December 27 – change and audit
- December 31 – change

The dates listed above are approximate dates of processing and are subject to change.

Schedule for AFI Data Files

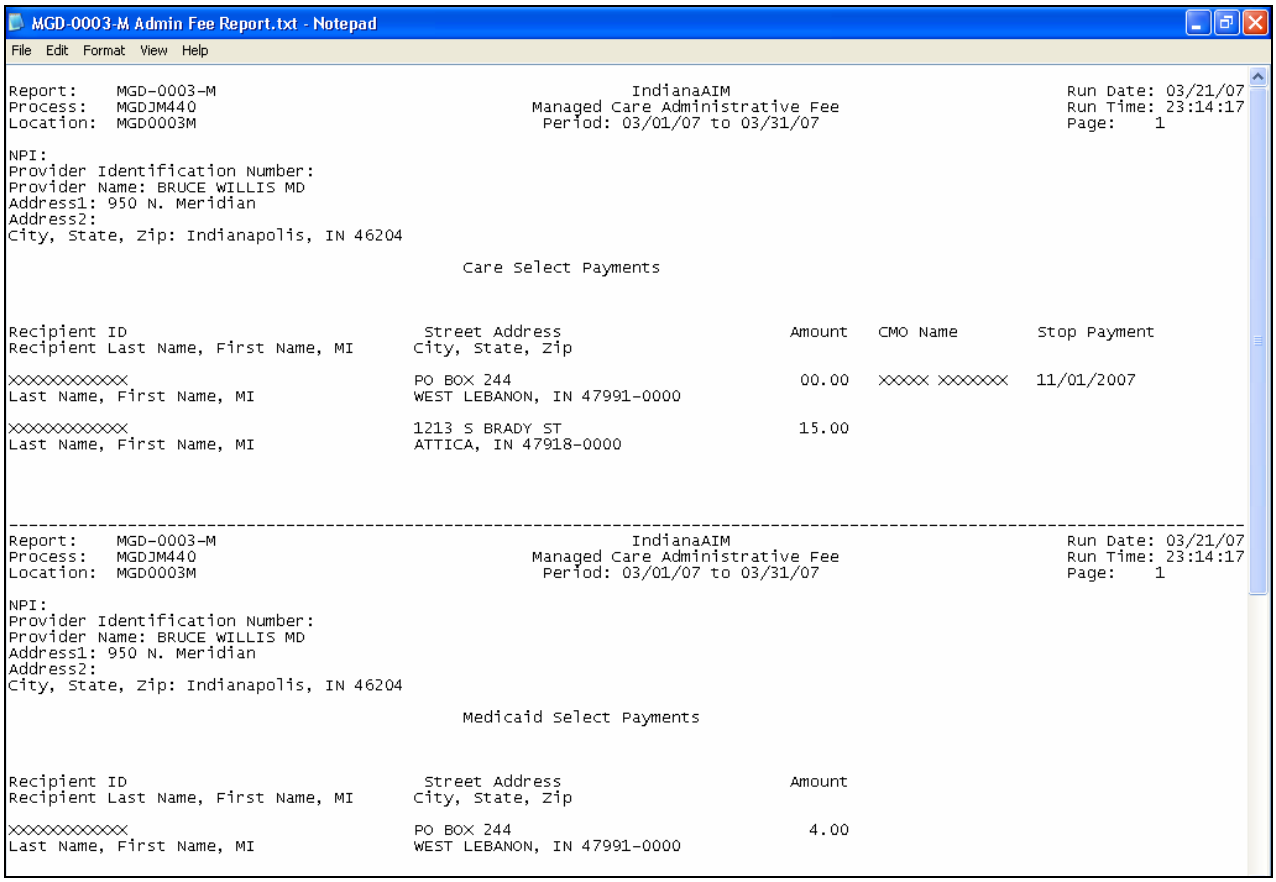
> *Note: AFI files are produced in conjunction with the 834 enrollment rosters.*

- January 12
- January 27
- February 12
- February 27
- March 12
- March 27
- April 12
- April 27
- May 12
- May 27
- June 12
- June 27
- July 12
- July 27
- August 12
- August 27
- September 12
- September 27
- October 12
- October 27
- November 12
- November 27
- December 12
- December 27

The dates listed above are approximate dates of processing and are subject to change.

Appendix G:Administration Fee Listing Layout

The following is the PMP Administration Fee Listing layout that is mailed to the PMPs on a monthly basis.



MGD-0003-M Admin Fee Report.txt - Notepad

File Edit Format View Help

```
Report:    MGD-0003-M                                    IndianaAIM                                    Run Date: 03/21/07
Process:   MGDJM440                          Managed Care Administrative Fee                         Run Time: 23:14:17
Location:  MGD0003M                           Period: 03/01/07 to 03/31/07                           Page:    1

NPI:
Provider Identification Number:
Provider Name: BRUCE WILLIS MD
Address1: 950 N. Meridian
Address2:
City, State, Zip: Indianapolis, IN 46204

                                          Care Select Payments


Recipient ID                             Street Address                      Amount   CMO Name        Stop Payment
Recipient Last Name, First Name, MI      City, State, Zip

XXXXXXXXXXX                              PO BOX 244                           00.00   XXXXX XXXXXXX   11/01/2007
Last Name, First Name, MI                WEST LEBANON, IN 47991-0000

XXXXXXXXXXX                              1213 S BRADY ST                      15.00
Last Name, First Name, MI                ATTICA, IN 47918-0000




-------------------------------------------------------------------------------------------------------------------------
Report:    MGD-0003-M                                    IndianaAIM                                    Run Date: 03/21/07
Process:   MGDJM440                          Managed Care Administrative Fee                         Run Time: 23:14:17
Location:  MGD0003M                           Period: 03/01/07 to 03/31/07                           Page:    1

NPI:
Provider Identification Number:
Provider Name: BRUCE WILLIS MD
Address1: 950 N. Meridian
Address2:
City, State, Zip: Indianapolis, IN 46204

                                          Medicaid Select Payments


Recipient ID                             Street Address                      Amount
Recipient Last Name, First Name, MI      City, State, Zip

XXXXXXXXXXX                              PO BOX 244                            4.00
Last Name, First Name, MI                WEST LEBANON, IN 47991-0000
```

Figure G.1 – PMP Administration Fee Listing

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