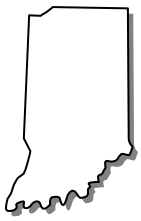
HP Managed Care Unit



INDIANA HEALTH COVERAGE PROGRAMS

Care Management Organizations Policies and Procedures Manual

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Version	Date	Reason for Revisions	Revisions Completed By
1.0	March 2008	New manual	HP Managed Care and Publications
2.0	June 2008	Semiannual updates	HP Managed Care and Publications
3.0	June 2009	Semiannual updates	HP Managed Care and Publications
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10.1	Policies and Procedures as of December 1, 2014 Published: January 15, 2015	Semiannual update	HP 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 Family and Social Services Administration (FSSA) 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 *Care Select*
- The policies and procedures specific to the CMOs' delivery of services to *Care Select* members
- The interfaces among the CMOs, the FSSA, 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 *Care Select*, its objectives, and its 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 *Care Select*, and the coordination of the health plans with the fee-for-service (FFS) program.
- *Care Select Program Design* provides an overview of the care management process steps, care coordination, care plans, levels of care, monitoring, reassessment and evaluation, and guidelines for specific member populations.
- *Disease Management* outlines the disease management program and the call center requirements for the disease management program.
- *Care Select Services* defines covered services, noncovered 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*, how 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.
- *Prior Authorization* describes the prior authorization (PA) process, state functions, and coordination activities.
- *Utilization Review* provides an overview of the utilization management processes.

- *Quality Improvement Program and Performance Reporting* describes the FSSA's expectations of the CMOs, performance monitoring, and reporting. Quality improvement and performance reporting is a critical aspect of care management.
- *Management Information Systems* describes reporting requirements of the CMOs related to general financial reporting, data extracts, and the CMO Payment Process 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 to the areas in which the CMOs have an interest.

This manual documents *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 as described in the following section. 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 FSSA provides many forums – formal and informal – designed to address the concerns of *Care Select* participants and refine its policies to reflect the input received.

Care Management Organization Orientation

When the CMO's contract with the FSSA is finalized, the FSSA schedules a series of orientation sessions with the CMO to review policy and technical procedures necessary to contract administration, including interfaces with the FSSA 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 FSSA designates members from its staff and contractor representatives to work with the CMO on implementation issues. During orientation, the FSSA and its *Care Select* contractors provide the CMO with a broad range of materials.

The fiscal agent provides the following:

- Claim processing edit and audit information
- The *IHCP Provider Manual* found on the *Manuals* page at indianamedicaid.com
- Schedules for generation of all other information to and from the CMO
- Indiana Health Coverage Programs provider news, bulletins, and banner pages
- Electronic file layouts and requirements for all data exchanges, including provider network files and member enrollment rosters, which are available on the *Care Select - Question and Answer* page at indianamedicaid.com.
  - The password is *cmoquestion.*

- Companion Guide for *834 MCE Benefit Enrollment and Maintenance Transaction* and *820 MCE Capitation Payment Information Transaction*, which are available on the *Companion Guide* page at indianamedicaid.com
- 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 *Care Select - Question and Answer* page at indianamedicaid.com
- Health plan primary medical provider (PMP) enrollment and disenrollment procedures and forms, which are available on the *Care Select - Question and Answer* page at indianamedicaid.com.
- *Care Select* administration fee payment and capitation processes

The FSSA or its designee provides the following:

- Orientation meeting schedule
- Telephone numbers for the FSSA, enrollment broker, and fiscal agent contacts
- Annual IHCP report and other program summary reports
- Care management meeting schedule
- Quarterly reporting requirements and schedule
- Schedule for medical policy meetings
- Readiness review criteria

The enrollment broker provides the following materials:

- *Care Select* member materials
- Enrollment broker script for member education and enrollment process
- In-service training opportunities
- Policies for member PMP assignments

Section 2: General Information

Overview

The Indiana Health Coverage Programs (IHCP) is the umbrella for Medicaid and other State programs such as the 590 Program (health benefits for institutionalized individuals) and the Children's Health Insurance Program (CHIP). 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 few 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 programs 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 for administration purposes. The Centers for Medicare & 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 offered by Indiana's program, including most of the optional and all 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 individuals with intellectual disability (ICF/IID)
  - Psychiatric hospital care for members younger than 21 years old or older than 65 years old
  - Community residential facilities for members with developmental disabilities (CRF/DD)
- Home health services – Including telehealth 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 eyeglasses
- Medical supplies
- Durable medical equipment (DME), including surgical appliances and prosthetic devices
- Home medical equipment (HME), including walkers and wheelchairs
- 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 between 21 and 65 years old in psychiatric facilities of 16 beds or fewer
- 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, defined as follows:

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

One additional covered service is available to *Care Select* primary medical providers (PMPs). The care management organization (CMO) coordinates with the *Care Select* PMPs to perform care coordination conferences to review a member's progress and care management plan. The PMPs are eligible for reimbursement for their time at these case conferences. See additional reimbursement information in *CMO and Provider Enrollment* of this manual.

Care Select – Care Management to the Indiana Health Coverage Programs

The state of Indiana has several goals for improving the quality and comprehensive nature of care for IHCP members. Historically, Indiana has classified its members based on aid category rather than tailoring a treatment plan to each member. However, Indiana implemented the *Care Select* program in 2007 to personalize and improve the quality of care provided by addressing members' needs holistically and by seeking input from medical providers, behavioral health experts, family members, and other caregivers. The *Care Select* program offers comprehensive disease management for eligible members. This includes improved clinical and functional status, enhanced quality of life, improved member safety, enhanced member autonomy, adherence to treatment plans, and control of fiscal growth/cost savings.

The CMO ensures that *Care Select* members receive, at a minimum, all benefits and services deemed medically reasonable and necessary (as defined in *405 IAC 5-2-17*) and covered under its contract with the State. The CMO coordinates services covered by the IHCP and ensures that services are provided in sufficient amount, duration, or scope to reasonably achieve the intended purpose of the furnished services. The CMO also works with members identified for the Right Choices Program (RCP).

All *Care Select* services encourage compliance with national care guidelines and incentivize healthy behaviors. The program comprises four major types of service:

- Disease Management – To help guide the care of members with chronic health conditions to improve the quality of care, adherence to care, and control healthcare costs. Supporting the practitioner-member relationship and plan of care, the disease management program emphasizes the prevention of the exacerbation of the condition and its complications using evidenced based practice guidelines.
- Care Management – To help guide the individual member in accessing care for needed health or social services to address the member's chronic health condition.
- Complex Case Management – To help members gain optimum health or improved functional capability, in the right setting and in a cost-effective manner. Complex case management includes active coordination of care and services while navigating the extensive systems and resources required for the member. It also involves comprehensive assessment, determination of available benefits, and development and implementation of a case management plan directed at the chronic health condition.
- Right Choices Program – The purpose of the RCP is to identify members who use covered services more extensively than their peers. The program is designed to monitor member utilization, and when appropriate, implement restrictions for members who would benefit from increased care coordination. This contract includes *Care Select* and Traditional (fee-for-service) Medicaid RCP members. CMOs manage their own *Care Select* members. Traditional (fee-for-service) RCP members are managed by ADVANTAGE Health Solutions[SM].

For the purpose of this manual, the term care coordination serves as a global reference for:

- Case management
- Care management
- Complex case management or any other term referencing the organization
- Synchronization and management of healthcare services for the benefit of the member.

Similarly, the term care manager is used for ease to describe the staff person performing the functions of:

- Disease management

- Case management
- Care management
- Complex case management when organizing, synchronizing and managing healthcare services for the benefit of the member.

In the *Care Select* delivery system, the Family and Social Services Administration (FSSA) pays contracted CMOs a monthly administrative fee to cover care management for each IHCP member enrolled in the CMO's health plan. The care of *Care Select* members enrolled in the CMO is managed by the CMO through its network of PMPs. Indiana has contractual agreements with the following entities to support and administer the *Care Select* program:

- Fiscal agent and premium collection vendor
- Enrollment broker
- Care management organizations
- Fee-for-service prior authorization broker
- External quality review organization

The State seeks continuous improvement of the quality and comprehensive nature of care for its IHCP members. Personalized and enhanced care provided by addressing members' needs holistically and seeking input from medical providers, behavioral health experts, family members, and other caregivers provides improved clinical and functional outcomes for Medicaid members.

Comprehensive Care Coordination

An improved quality of life is achieved through adherence to treatment plans, member autonomy, and fiscal controls. Toward that end, *Care Select* includes comprehensive care coordination for members not eligible for Medicare and not covered by IHCP managed care:

- Promotion of treatment regimens for chronic illnesses to better conform to evidence-based practices.
- Assistance to primary care providers to be more aware of and to incorporate knowledge of functional assessments, behavior changes, self-care strategies, and methods of addressing emotional or social distress into overall patient care.
- Promotion of care that is less fragmented and more holistic, which supports more communication across settings and providers.
- Support seamless transitions between multiple providers and care sites.
- Promotion of holistic care addressing physical, behavioral, medical, and social needs.
- Increased involvement and shared accountability of consumers, families, and providers.
- Increased connection with consumers in the management and treatment of chronic diseases through health risk assessments, education, and support.
- Promotion of preventive care to optimize member function, maintain function, or prevent further decline.
- Improve the quality of care and health outcomes for the *Care Select* population
- Manage the growth of healthcare costs for the *Care Select* population
- Appropriate utilization of community resources and reduced duplication of resources.
- Accessible and safe home environment.

- Appropriate and accessible healthcare.
- Increased understanding regarding medical conditions, treatments, and medications.
- Reduced emergency room (ER) visits and avoidable hospitalizations.
- Enhanced health promotion and disease prevention activities.
- Integration of the member and their family within the community.
- Cost savings

Care Management Component

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

- Increase understanding about:
  - Medical conditions
  - Treatments
  - Medications
- Assist primary care providers in being more aware of and incorporating knowledge of:
  - Functional assessments
  - Behavior changes
  - Self-care strategies
  - Methods of addressing emotional or social distress into overall patient care.
- Promote care that is less fragmented and more holistic, which supports more communication across settings and providers and addresses:
  - Physical
  - Behavioral
  - Medical
  - Social needs.
- Support seamless transitions between multiple providers and care sites.
- Provide more effective and ongoing health promotion and disease prevention activities.
- Increase involvement of consumers in the management and treatment of chronic diseases through:
  - Health risk assessments
  - Education
  - Support.
- Promote preventive care.
- Effectively tailor benefits to the individual's needs by using evidence-based medicine and best practices.
- Improve the quality of care and health outcomes for the *Care Select* population.
- Appropriately use community resources and reduce duplication of resources.
- Reduce ER visits and avoidable hospitalizations.
- Manage the growth of healthcare costs for the *Care Select* population.
- Provide cost savings.

Member Choice

The *Care Select* enrollment broker and the health plan provide information to aid the potential member in the selection of an appropriate physician to meet the member's needs. *Care Select* emphasizes the importance of establishing and maintaining a relationship with a PMP of the member's choice.

Information about each CMO is also discussed with the member in terms of the broad impact this choice has on access to services other than primary care. *Care Select* member education related to PMP and health plan selection is the responsibility of the enrollment broker. *Section 9*: *Member Eligibility and Enrollment* in this manual provides information about the member enrollment process.

Eligibility for *Care Select* Membership

Eligibility and coverage is based on the member's aid category in addition to disease state.

Care Select provides health coverage to the following members:

- Aged members who are not dually eligible for Medicare
- Blind
- Physically and mentally disabled
- Children receiving adoption assistance
- Wards of the court and foster children
- Children on adoption assistance
- Supplemental Security Income (SSI) members

The *Care Select* program is optional for members and focuses on disease management, particularly for those with chronic conditions. Members with a qualifying aid category with one or more of the following diseases have the option to participate in the disease management programs that the CMOs provide for their chronic conditions:

- Asthma
- Diabetes mellitus (DM)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)
- Hypertension (HTN)
- Chronic kidney disease (nondialysis)
- Severe mental illness (SMI)
- Serious emotional disturbance (SED)
- Depression
- Comorbidity of DM and HTN
- Comorbidities and/or combinations of any of these disease states
- Other serious or chronic medical condition, as approved by the FSSA

Members who meet the requirements for *Care Select* but opt out of *Care Select* are placed in traditional Medicaid.

The following IHCP members are **not** covered by *Care Select*:

- Members dually eligible for Medicare and Medicaid
- Members receiving Home and Community-Based Waiver Services

- Individuals receiving room and board assistance
- Members in nursing homes, intermediate care facilities for individuals with intellectual disability (ICF/IID) and State-operated facilities
- Members in the hospice program
- Members with a psychiatric residential treatment facility (PRTF) level of care
- Undocumented aliens
- Members enrolled in the 590 Program
- Members enrolled in the Breast and Cervical Cancer Treatment Services Program
- Members who are Qualified Medicare Beneficiaries (QMB) or Special Low Income Medicare Beneficiaries (SLMB) only (not in combination with another aid category)
- Medicaid for Employees with Disabilities (M.E.D.) Works members

Supplemental Security Income Member Eligibility

Effective June 1, 2014, IHCP members eligible for (SSI) who were currently enrolled in Hoosier Healthwise or Healthy Indiana Plan (HIP) under the risk-based managed care (RBMC) delivery system transitioned to Traditional Medicaid or *Care Select* under the fee-for-service (FFS) delivery system. Individuals who were receiving complex case management services from their managed care health plans under RBMC were transitioned to the optional *Care Select* program. This transition ensured uninterrupted access to these critical services. Members were transitioned as follows:

- Members enrolled with MDwise Hoosier Healthwise or MDwise HIP were transitioned to MDwise *Care Select*.
- Members enrolled in Anthem or Managed Health Services (MHS) Hoosier Healthwise, Anthem or MHS HIP were transitioned to ADVANTAGE Health Solutions *Care Select*.

Individuals not transitioned to *Care Select*, or who opted out of *Care Select*, were transitioned to Traditional Medicaid. Individuals who were enrolled in the Right Choices Program (RCP) under RBMC continued to have doctor, pharmacy, and hospital restrictions, as well as a care manager, when they transitioned to *Care Select* or Traditional Medicaid.

Member Enrollment Education

After the IHCP eligibility determination process, the enrollment broker ensures that all enrollees who choose to opt in 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 ER
- 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 health plans

The enrollment broker representatives explain to potential members that once eligible for the program, members have 60 days to choose a PMP. If they do not choose a PMP within 30 days, one is chosen for them.

The enrollment broker encourages potential members to select PMPs who provide, through ongoing member-PMP relationships, preventive and primary medical care and referrals for all medically necessary specialty services. A helpline is provided by the *Care Select* enrollment broker and is available for members to call with any problems or questions about the program. Helpline staff may refer 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 practice in one of the following medical fields (provider specialty codes are in parentheses):

- Family practice (316)
- General practice (318)
- Obstetrics and gynecology (328)
- General internal medicine (344)
- General pediatrics (345)

In addition, specialists such as cardiologists can serve as PMPs if requested by members. The specialist must be able to provide all preliminary and preventive care services (for example, Pap test, acute care visits for viral illness) and may request to limit his or 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. The PMP must be available 24 hours a day, seven days a week and must assume total management of the member's nonemergent medical needs. Physicians practicing in group settings may enroll to serve *Care Select* members as PMPs within particular groups. Group enrollment does not necessitate PMP enrollment in *Care Select.* One group can contain physicians enrolled as PMPs in *Care Select* and also 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 directory. Each CMO maintains its own provider directory. The CMOs are as follows:

- ADVANTAGE Health Solutions℠
- MDwise Inc.

Communication

Official IHCP policies are documented in the *IHCP Provider Manual* on the *Manuals* page at indianamedicaid.com, available to all providers enrolled in the IHCP. Supplements to this manual are distributed as needed. The following provide examples of communication tools available:

- CMOs must publish provider manuals.
- The *HealthWatch (EPSDT) Provider Manual* found on the *Manuals* page at indianamedicaid.com, published and distributed by the fiscal agent, is sent to providers who meet the licensing requirements and that are interested in providing EPSDT services to the IHCP population. All *Care Select* PMPs are HealthWatch providers. The *IHCP Provider Manual* on the *Manuals* page at indianamedicaid.com contains additional information about this program.
- IHCP provider bulletins and banner pages, published by the fiscal agent, provide policy changes or updates. Bulletins are addressed to providers affected by the changing policy addressed in the bulletin. For example, a change in the pricing methodology for home healthcare services is addressed to providers enrolled in the home healthcare provider specialty. Banner page articles are brief informational paragraphs published weekly. By virtue of enrollment as IHCP providers, CMO

health plan providers are notified of these communications based on the specialty under which they are enrolled in the IHCP. Subscription to the IHCP Email Notification System provides email notices when new banner pages and bulletins, IHCP notices, Web interChange notices, and Electronic Data Interchange (EDI) notices are available. Information regarding the IHCP Email Notification System is available at indianamedicaid.com.

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

Care Select Entities

Multiple organizations work in conjunction with each other to coordinate the *Care Select* program. These entities develop policy, coordinate the care of members, process claims, provide unbiased member education, and monitor the program for potential fraud.

Family and Social Services Administration

The FSSA administers the IHCP, including *Care Select.* The FSSA has the final responsibility for the *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 FSSA.

The FSSA monitors a CMO's activity and performance ensuring that the CMO complies with contract requirements and performance standards. A reporting manual is released each year to comply with contractual standards and obligations.

Care Management Organizations

The CMO is an entity that provides primary care case management, as defined by *42 Code of Federal Regulations (CFR) 438.2.* See *Care Management Organizations* for additional information.

Enrollment Broker

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, performs member-initiated PMP changes and member disenrollment, and enters member disease-state information based on Medicaid physician referrals.

Fiscal Agent

The fiscal agent for the IHCP, including *Care Select*, performs 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. The fiscal agent generates CMO and PMP monthly administration fee payments and enrollment rosters to CMOs three times a month.

Surveillance and Utilization Review

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 FSSA, the Indiana Medicaid Fraud Control Unit (IMFCU), and the IHCP Program Integrity Department. The CMO must report member fraud to the FSSA, the IHCP Program Integrity Department, the Indiana Bureau of Investigation, and the Office of the Inspector General.

Nonemployee Fraud Hotline

Fraud is an intentional deception or misrepresentation on the part of the provider or member, which could result in an unauthorized benefit, such as an improper payment being made to an IHCP provider. The following are some examples of fraud:

- Altering a member's medical records to generate fraudulent payments
- Billing for group visits, such as a provider billing for several members of the same family in one visit although only one family member was seen or provided medically necessary services
- Billing for services or supplies that were not rendered or provided
- Misrepresenting services provided (for example, billing a covered procedure code and providing a noncovered service)
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Submitting claim forms that have been altered or manipulated to obtain higher reimbursement

Any information related to IHCP abuse or fraud should be reported to the appropriate authorities. Suspected cases of abuse or fraud should be reported to the following:

Toll-Free: 1-800-457-4515 or 317-234-7710 (choose option 7) Email: Program.Integrity@fssa.in.gov (Adams, Allen, Benton, Blackford, Boone, Carroll, Cass, Clark, Clay, Crawford, Daviess, Dearborn, DeKalb, Delaware, Dubois, Elkhart, Floyd, Fountain, Fulton, Gibson, Greene, Harrison, Howard, Huntington, Jackson, Jasper, Jefferson, Jennings, Knox, Kosciusko, LaGrange, Lake, LaPorte, Lawrence, Madison, Marshall, Martin, Miami, Monroe, Newton, Noble, Ohio, Orange, Owen, Parke, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Ripley, St. Joseph, Scott, Spencer, Starke, Steuben, Sullivan, Switzerland, Tipton, Vanderburgh, Vermillion, Vigo, Wabash, Warren, Warrick, Washington, Wells, White, and Whitley)

Toll-Free: 1-800-457-4515 or 317-234-7710 (choose option 7) Email: Program.Integrity@fssa.in.gov (Bartholomew, Boone, Brown, Clinton, Decatur, Fayette, Franklin, Hamilton, Hancock, Hendricks, Henry, Johnson, Marion, Montgomery, Morgan, Rush, Shelby, Tippecanoe, Union, and Wayne)

Mailing Address:
FSSA Compliance Division
Office of General Counsel
Room E-442
402 West Washington Street
Indianapolis, IN 46204

Care Select Meetings

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

The CMO must attend and participate in the following meetings:

Hoosier Healthwise, Healthy Indiana Plan, and Care Select Technical Meeting

Facilitator – HP

Function – Attendees review, discuss, and monitor ongoing operations, initiatives, and processes of the overall program.

Frequency – Monthly

OMPP Quality Strategy Committee

Facilitator – OMPP

Function – Attendees evaluate the effectiveness of the CMOs' quality strategy activities. The Quality Strategy Committee establishes standards and guidelines for care provision and services within *Care Select* and Hoosier Healthwise.

Frequency – Quarterly

Health Services Utilization Management Committee

Facilitator –OMPP

Function – To review utilization issues related to behavioral health, Right Choices Program (RCP), prior authorization, or other topics. To evaluate the effectiveness of the CMOs' activities. The QIC establishes standards and guidelines for care provision and services within *Care Select.*

Frequency – Quarterly

Frequency – *Bimonthly Drug Utilization Review Board*

Facilitator – The FSSA's Drug Utilization Review (DUR) Board chairperson

Function – Attendees review and approve IHCP formularies. The DUR board was established under *IC 12-15-35* and is responsible for oversight of the current and proposed DUR program. See *Care Management Organizations* for more information about the DUR Board.

Frequency – Monthly

CEO Monthly Review

Facilitator –The FSSA

Function – The CMO's executive leadership must meet at least quarterly with the FSSA to review the CMO's performance, discuss the CMO's outstanding or commendable contributions, identify areas for improvement, and outline upcoming issues that may affect the CMO or *Care Select.*

Frequency – Monthly

Indiana Health Coverage Programs Provider Workshops and Annual Seminar

Facilitator – Fiscal agent

Function – Attendees from the FSSA and the fiscal agent provide Medicaid healthcare providers with information about the Medicaid program.

Frequency – Quarterly; fourth-quarter Annual IHCP Provider Seminar

Recommended Meetings

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

Neonatal Quality Subcommittee

Facilitator – OMPP

Function – Attendees review initiatives and work toward better outcomes for prenatal care and newborn deliveries.

Frequency – Quarterly

Indiana State Medical Association Medicaid Coalition

Facilitator – Indiana State Medical Association

Function – Attendees from the FSSA and the fiscal agent provide Medicaid healthcare providers with information about the Medicaid program.

Frequency – Meetings are in January, March, May, July, September, and November.

Optional Meetings

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

- Medicaid Advisory Committee (quarterly)
- Other professional provider associations (various)

Important Telephone Numbers

The *IHCP Quick Reference Guide*, which is available on indianamedicaid.com, lists telephone numbers that CMOs can call for general questions identified during daily operations or in ongoing management activities. CMOs must make enrolled providers and members aware of the appropriate telephone numbers and educate providers and members about the appropriate use of the numbers. Each PMP is required to have a 24-hour telephone number for members. CMOs may also provide a nurse line to assist with member questions and to direct members to the PMP's office. CMOs must inform the fiscal agent and the FSSA whenever a provider or member services telephone number is changed.

For Indiana*AIM* problems during off hours, such as nights and weekends, contact the fiscal agent Operations at (317) 488-5059. The Operations personnel will contact the on-call Production Support employee, who will work to verify and determine the cause of the problem.

Care Management Organization 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. *Care Select Services* provides detailed information about helpline requirements.

Family and Social Services Administration Holiday Policy for Call Centers

The FSSA authorized all managed care entity (MCE) call centers to be closed on the following holidays:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Christmas Day

Section 3: Care Management Organizations

Overview

Care management organizations (CMOs) participating in *Care Select* collaborate with the Family and Social Services Administration (FSSA) 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 responsibilities for enrolled members and providers that the State (or its designated contractor) performs for fee-for-service (FFS) enrolled members and providers.

CMO responsibilities are described in detail throughout this manual. The following list, while not all-inclusive, highlights the major responsibilities of the 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 FSSA on a regular basis

Care Management Organization Eligibility Requirements

To be eligible to participate, a CMO must 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 FSSA. The FSSA 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 Committee for Quality Assurance (NCQA) or The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations).

Staffing Requirements

The CMO must have in place sufficient administrative and clinical staff and organizational components to comply with all program requirements and standards. The CMO must maintain a high level of contract performance regardless of staff vacancies or turnover. The CMO must have an effective method to address and minimize staff turnover (for example, cross training, use of temporary staff or consultants) as well as processes to solicit staff feedback to improve the work environment.

The CMO must maintain descriptions for the positions discussed in this section that include the responsibilities and qualifications of the position such as, but not limited to, the following:

- Education, for example:
  - High school
  - College degree

  - Graduate degree
- Professional credentials,
  - Licensure
  - Certifications)
- Work experience
- Membership in professional or community associations

Key Staff and Key Contract Functions for *Care Select*

The CMO must have an office in the state of Indiana where, at a minimum, the key staff members physically perform the majority of their daily duties and responsibilities, and where a major portion of the CMO's operations take place. All key staff shall be accessible to the FSSA and its other program subcontractors via voicemail and electronic mail systems. The State reserves the right to require replacement of key staff positions. All changes of key staff shall be reported to the FSSA a minimum of five days before the vacancy occurs with a plan of how the coverage of duties shall be managed in the interim to filling the position.

Staffing allocations may be different during program roll-out and ramp-up periods than during normal contract operations. The following staff members do not have to be dedicated to the State's contract for *Care Select* Services unless noted as "dedicated." The CMOs must provide at least one full time equivalent (FTE) to each function listed as "dedicated." The employees filling these positions must be solely devoted to *Care Select* and not to any other of the organization's clients or other IHCP programs

The key staff members, responsibilities, and allocations for *Care Select* are described as follows:

- Chief executive officer – The chief executive officer or executive director has full and final responsibility for CMOs management and compliance with all provisions of the State's contract with the CMO. This is a full-time position.
- Chief financial officer – The chief financial officer (CFO) shall oversee the budget and accounting systems *Care Select*. The CFO is responsible for ensuring that the CMO meets the State's requirements for financial performance and reporting.
- Medical director – The CMOs employ the services of a medical director who is an IHCP provider. The medical director shall oversee the development and implementation of the CMO's and State's clinical practice guidelines, review any potential quality of care problems, oversee the CMO's care management program, nurse-care hotline (if applicable), and oversee administration of the health-needs assessments. This position serves as the CMO's medical professional interface with its provider network and directs the Quality Management and Utilization Management programs, including, but not limited to, monitoring corrective actions and other quality management, utilization management, or program integrity activities. The medical director is responsible for ensuring the clinical outcomes established by the State for *Care Select*. The medical director, in close coordination with other key staff, is responsible for ensuring that the medical management and quality management components of the CMO's operations are in compliance with the terms of the CMO's contract with the State. The medical director shall oversee the appeals for service denials.
- Psychiatrist – The psychiatrist shall 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 and are supported by evidence-based practices. The psychiatrist shall play a role similar to the medical director, but shall be focused primarily on behavioral health.
- Compliance officer –This individual shall be the primary liaison with the State (or its designees) to facilitate communications between the FSSA, the State's contractors, and the CMO's executive leadership and staff. This individual shall maintain a current knowledge of federal and state legislation, legislative initiatives, and regulations that may impact the *Care Select* Program. It is the

responsibility of the compliance officer to coordinate performance reporting to the State, as defined in *Section 14.0* of the Scope of Work, and to review and attest to the timeliness, accuracy, and completeness of reports and data submissions to the State. The compliance officer, in close coordination with other key staff, has primary responsibility for ensuring all CMOs functions are in compliance with the terms of the CMO's contract.

- Care management manager (dedicated) – The CMOs shall employ a full-time care management manager. This manager shall oversee the disease management, care management, and complex-case management functions, which include all areas of care coordination. The care management manager shall, at a minimum, be a registered nurse or other medical professional with extensive experience in providing care coordination to variety of populations. This individual shall work directly under the CMO's medical director to develop, expand, and maintain the care management program. The individual shall be responsible for overseeing care management teams, care plan development, and care plan implementation. The care management manager shall be responsible for directing the activities of the care managers. These responsibilities extend to physical and behavioral healthcare services for the entire *Care Select* population. This individual shall work with the medical director, provider and member services managers, and with State staff as necessary to communicate to providers and members. The care management manager shall provide input, as requested by the State, at State-level meetings and 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 – This individual shall oversee the CMO's IS and serve as a liaison between the CMOs, the State, the State's fiscal agent and the FSSA contractors, as needed, regarding member eligibility and enrollment, 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. This individual shall coordinate with the fiscal agent to access the claims data to manage the care and service utilization of this population. Even though this is not a dedicated 1.0 FTE, it is expected that the FTE allocation to this contract shall ensure timely submission of data for routine and ad hoc activities.
- Member services manager (dedicated) – This manager shall, at a minimum, be responsible for member helpline performance, member education and outreach, and the development, approval, and distribution of member's materials. The member services manager manages the member grievance and appeal process, and works closely with other managers, including the Quality/Utilization Management manager and medical director, and departments to address and resolve member grievances and appeals. The member services manager shall provide an orientation and ongoing training for member services helpline representatives, at a minimum, to support accurately informing members of how the CMOs operates, availability of covered services, benefit limitations, emergency services, PMP enrollment and assignment, specialty provider referrals, self-referral services, preventive and enhanced services, and member grievances and appeals procedures. The member services manager, in close coordination with other key staff, is responsible for ensuring that all the CMO's member services operations are in compliance with the terms of the contractors' contract with the State. This is a full-time position. For more information regarding the member services program requirements, see *Sections 2.0* and *4.0* of the Scope of Work.
- Provider services manager – This manager shall, at a minimum, be responsible for communication with providers, provider services helpline performance, facilitating provider disputes, physician incentives, and developing and distributing the provider manual and education materials. The provider network services manager, in close coordination with key staff, is responsible for ensuring that all the CMO's provider services operations are in compliance with the terms of the CMO's contract with the State.
- Quality management manager – The quality management manager shall, 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 healthcare delivery, including, but not limited to, internal

processes and procedures, provider engagement, service quality, and clinical quality. This manager shall assist the CMO's compliance officer in overseeing the activities of the CMO's operations to meet the State's goal of providing healthcare services that improve the health status and health outcomes of *Care Select* members.

- Case coordinators (dedicated) – The care coordination staff shall include qualified care managers and complex case managers who are registered nurses and/or licensed practical nurses, social workers, therapists, physician assistants, or other appropriately qualified individuals trained to meet the needs of the *Care Select* population.
- Information systems coordinator – This individual oversees the CMO's IS and serve as a liaison between the CMO, the State, the State's fiscal agent, and the FSSA contractors, as needed, regarding data transmission interface and management issues. The IS coordinator, in close coordination with other key staff, is responsible for ensuring all data transactions are in compliance with the terms of the CMO's contract with the State. This individual coordinates with the fiscal agent to access necessary data to manage the contractor's responsibilities under the contract.

Other Staff Positions

In addition to the required key staff described previously, the CMO must employ additional staff necessary to ensure the CMO's compliance with the State's performance requirements. The CMO's staffing responsibility shall be to assign sufficient and knowledgeable staff capable of contacting to and educating members about *Care Select* . The CMO shall seek prior approval by the State subcontractors. This may require several attempts and multiple outgoing calls per member.

Suggested staff for *Care Select* may include, but are not limited to, the following:

- Executive management to interface with the FSSA leadership, to coordinate and confer with the State on matters related to the CMO's participation in *Care Select.*
- Technical support services staff to ensure the timely and efficient maintenance of information technology support services, websites, production of reports, and processing of data requests.
- Care management staff, including personnel who provide care coordination services for members in the care management program. The CMOs offer a proposed care coordination model, anticipated member contact with the care management staff, and anticipated member-to-care manager ratio.
- Quality management staff dedicated to perform quality management and improvement activities, and participate in the CMO's internal quality management committee.
- Member services representatives to coordinate communications between the CMOs and members; respond to member inquiries, and to assist all members regarding issues such as CMO policies, procedures, general operations, benefit coverage, and eligibility.
- Provider representatives to coordinate communications between the CMOs and contracted and noncontracted providers.

Financial Requirements

The CMO must comply with all the applicable insurance laws of Indiana and the federal government throughout the term of the contract. No fewer than 90 calendar days before 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 following minimum coverage levels 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 fewer than 30 calendar days before the policy renewal effective date, the CMO must submit its certificate of insurance to the FSSA for review and approval of each renewal period.

The CMO must maintain accounting records specifically for performance of the *Care Select* contract. The records must incorporate performance and financial data of subcontractors, as appropriate. The CMO must maintain accounting records that are specific to *Care Select* 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 FSSA of any person or corporation with 5% or more ownership or controlling interest in the CMO and submit financial statements for these individuals or corporations.

Authorized representatives or agents of the state and federal governments must have access to the CMO's accounting records and the accounting records of its subcontractors, on reasonable notice and at reasonable times during the performance or retention period of this contract, for purposes of review, analysis, inspection, audit, 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 or federal representatives to carry out their audit functions at the principal offices of the CMO or other locations of such records. The 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 related 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 FSSA requires the CMO to produce the following financial information on request:

- Externally audited annual fiscal information
- Appropriate insurance coverage for:
  - General liability
  - Property
  - Workers' compensation
  - Medical malpractice
  - 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

> *Note: Medicaid enrollees are not liable for the entity's debt if the entity becomes insolvent.*

> *The CMO must not perform any activities related to third-party liability (TPL).*

The CMOs provide a performance bond of standard commercial scope issued by a surety company registered with the Indiana Department of Insurance (IDOI) in the amount of $1,000,000.00, to guarantee performance by the CMO of its obligations under this contract. The State reserves the right to increase the required bond amount if enrollment levels indicate the need to do so. If the CMO defaults, the State shall, in addition to any other remedies it may have under this contract, obtain payment under the Performance Bond for the purposes of the following:

- Reimbursing the State for any expenses incurred by reason of a breach of CMO's obligations under this contract, including, but not limited to, expenses incurred after termination of this contract for reasons other than the convenience of the State.
- Reimbursing the State for costs incurred in procuring replacement services.

Subcontractors

The term "subcontracts" 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.

Although the CMO is required to build a network of providers for the *Care Select* population, those providers are not subcontractors of the CMO. Those agreements must be formalized using a *Care Select Program Addendum to the 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 FSSA shall approve all subcontractors and any change in subcontractors or material change to subcontracting arrangements. All subcontracts shall be approved by the FSSA before being signed by the subcontractor and shall include acceptable *Health Insurance Portability and Accountability Act* (HIPAA) language. The State encourages the CMOs 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 that have signed addenda to participate in *Care Select*. The CMO is 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
- Changes in equity and/or fund balance

The CMO must make these documents available to the FSSA on request, and the FSSA will regularly review these documents during CMO site visits, which are likely to occur monthly. The CMO must comply with *42 CFR 438.230* and the following subcontracting requirements:

- The CMO must obtain the FSSA's approval before subcontracting any portion of the project's requirements. This approval must include detailed review of any subcontractor agreements. The CMO must submit a written request and a draft subcontract to the FSSA at least 60 calendar days before using a subcontractor. The CMO must obtain the FSSA'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 FSSA 60 calendar days before the revised contract effective date and submit the amendment for review and approval. The FSSA must approve changes before the CMO modifies any previously approved subcontracts.
- The CMO must evaluate prospective subcontractors' abilities to perform delegated activities before contracting with the subcontractor to perform services associated with *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 comply with all state of Indiana statutes and is 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. It must also conduct formal, periodic, and random reviews as directed by the FSSA. The CMO must 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. This provides a comprehensive evaluation of the CMO's performance compliance and identifies areas for its subcontractors' improvement, when appropriate. The CMO must take corrective action for deficiencies 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 Request for Services (RFS), whether or not characterized as a subcontract under this RFS, are subject to review and approval by the FSSA and must be sufficient to assure the fulfillment of the requirements of *42 CFR 434.6*. The FSSA may waive its right to review subcontracts, provider contracts, agreements, or other arrangements. Such waiver must not constitute a waiver of any subcontract requirement. In accordance with *IC 12-15-30-5(b)*, subcontract agreements for *Care Select* 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 FSSA reserves the right to audit the CMO's subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. The FSSA may require corrective actions, as specified in *Section 15.0* of the Scope of Work for noncompliance 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 a Party of Interest

The CMO, if not federally qualified, must disclose to the FSSA information about certain types of transactions the CMO has 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.*

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.*

Information, which must be disclosed in the transactions listed in subsection B between a CMO and a party of interest includes:

- *The name of the party of 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.*

Information disclosed about business transactions must be accompanied by a consolidated financial statement for the CMO and the party of interest.

If the contract is an initial contract with the FSSA 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 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 nonprocurement 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 section

The relationships include directors, officers, or partners of the CMO, persons with beneficial ownership of 5% 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 FSSA finds that the CMO is in violation of this regulation, the FSSA notifies the secretary of noncompliance and determines whether the agreement is to continue.

Section 4: Care Select Program

Overview

The state of Indiana has contracted with the care management organizations (CMOs) to continue to improve the quality of care and health outcomes for its Indiana Health Coverage Programs (IHCP) members. This includes:

- Improved clinical and functional status
- Enhanced quality of life
- Improved member safety
- Enhanced member autonomy
- Adherence to treatment plans
- Control of fiscal growth/cost savings.

Through *Care Select* , the State addresses the:

- Promotion of treatment regimens for chronic illnesses to better conform to evidence-based practices
- Assistance to primary care providers to be more aware of and to incorporate knowledge of:
  - Functional assessments
  - Behavior changes
  - Self-care strategies
  - Methods of addressing emotional or social distress into overall patient care
- Promotion of care that is less fragmented and more holistic, which supports more communication across settings and providers
- Promotion of holistic care addressing:
  - Physical
  - Behavioral
  - Medical
  - Social needs
- Increased involvement of consumers in the management and treatment of chronic diseases through:
  - Health risk assessments
  - Education
  - Support
- Promotion of preventive care
- The CMOs ensure that *Care Select* members receive, at a minimum, all benefits and services deemed medically reasonable and necessary (as defined in *405 IAC 5-2-17*) and covered under its contract with the State. The CMOs coordinates services covered by *Care Select* and ensure that services are provided in sufficient amount, duration or scope to reasonably expect that provision of such services would achieve the intended purpose of the furnished services. The CMOs also work with members identified for the Right Choices Program (RCP).

All *Care Select* services shall encourage compliance with national care guidelines and incentivize healthy behaviors. The four major types of service:

1. Disease management (DM) – To help guide the care of members with chronic health conditions to improve the quality of care, adherence to care and control of healthcare costs.

While supporting the practitioner-member relationship and plan of care, the DM program shall emphasize the prevention of the exacerbation of the condition and its complications using evidenced-based practice guidelines.

2. Care management – To help guide the individual member in accessing care for needed health or social services to address the member's chronic health condition.
3. Complex case management – To help members gain optimum health or improved functional capability, in the right setting and in a cost-effective manner. Complex case management includes active coordination of care and services while navigating the extensive systems and resources required for the member. Complex case management also involves:
   - Comprehensive assessment
   - Determination of available benefits
   - Development and implementation of a case management plan directed at the chronic health condition.
4. Right Choices Program – The purpose of the RCP is to identify members who use covered services more extensively than their peers. The program is designed to monitor member utilization, and when appropriate, implement restrictions for those members who would benefit from increased care coordination. This includes *Care Select* and Traditional (fee-for-service) Medicaid RCP members. CMOs manage their own *Care Select* members. Traditional (fee-for-service) RCP members will be managed by ADVANTAGE.

- The CMOs work with other Family and Social Services Administration (FSSA) contractors to ensure continuity of coverage for members. The CMOs shall not reimburse provider claims – this responsibility will remain with the State's fiscal agent. The Prior Authorization/Utilization Management (PA/UM) vendor shall authorize and manage prior authorization and utilization of covered services requiring PA/UM, including physical, behavioral and transportation services for members. Pharmacy services are not included; pharmacy is the responsibility of the pharmacy benefits manager. However, the CMOs are responsible for monitoring claims and for monitoring pharmacy utilization through the INSPECT reports. Table 4.1 summarizes the CMOs responsibilities in these areas.

Table 4.1 – CMO Responsibilities

Responsibilities		
Service Area		**Role**
1	Member enrollment	Enrollment broker
2	PMP assignment	Enrollment broker
3	Coordination with PMP	CMO
4	Reimbursement of provider claims	Fiscal agent
5	Monitor claims for right services in right amount at right time	CMO
6	Authorize and manage prior authorization and utilization of covered services requiring PA/UM	PA/UM vendors
7	Pharmacy services	Pharmacy Benefits Manager
8	Monitor pharmacy utilization through the INSPECT reports	CMO
9	Grievances and appeals	CMO

For the purpose of this manual, the term care coordination shall serve as a global reference for case management, care management, complex case management, or any other term referencing the organization, synchronization, and/or management of healthcare services for the benefit of the member. Similarly, the term care manager is used to describe the staff person performing the functions of DM, case management, care management, or complex case management when organizing, synchronizing, and/or managing healthcare services for the benefit of the member.

Disease Management and Care Coordination

The CMO develops and uses a multidisciplinary team to manage and coordinate the complex care of the *Care Select* population. While DM and care coordination may be performed by one qualified health professional, the process must involve coordination of different types of healthcare provided by multiple providers in all care settings, including the home, clinic, hospital, and subacute and long-term care institutions.

The CMO applies systems, science, incentives, and information to improve medical practice and help members of DM programs manage physical and behavioral healthcare more effectively. The overall goal is to improve patients' health and reduce the need for expensive medical services.

The CMO designs and implements DM services that are dynamic and change as members' needs change. The CMO addresses the following healthcare domains for its members:

- Medical
- Psychological
- Functional
- Social

The CMO is responsible for linking the member to services to address these four domains and for coordinating care, as needed, between these services.

DM is an umbrella term that encompasses but is not limited to the following components:

- Member risk assessment and stratification
- Design disease and/or care plan
- DM
- Care management
- Utilization management

The program requirements for each of these components are described in the following sections.

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

Once a Medicaid member is identified as being eligible for *Care Select*, the State's enrollment broker performs member outreach to determine whether the member wishes to opt in to *Care Select*. If the member opts in to the program, the enrollment broker enrolls the member by assigning him or her to a primary medical provider (PMP). Once the member is enrolled in *Care Select*, the CMO assesses the

member's PMP assignment and healthcare needs and develops, implements, reassesses, monitors, and evaluates the member's disease management and/or care plan. These steps are described throughout the remainder of this section.

Member Assessment

Within 30 days of being notified of the member's enrollment in *Care Select*, the CMO assesses the member's PMP assignment with the member and relevant caregivers and assists with a PMP change, if necessary. Within 30 days, the CMO also conducts an initial screening to identify the member's immediate physical and/or behavioral healthcare needs. Within 120 days, a comprehensive health risk assessment of the member's healthcare needs shall be conducted to develop and implement a comprehensive plan to meet the member's needs through one of the *Care Select* service types.

The CMO must also stratify the member to an appropriate care level and provide ongoing DM, care management, or complex case management, as appropriate. The screening and stratification must be completed within 120 days of a member's enrollment in the CMO. The 120-day period is effective on the member's CMO assignment date. The CMO must receive a CMO fee for 120 days. If the member is not stratified as of the 121st day, the member is changed from a tier level 1 to a level 0, and the CMO is not reimbursed.

The CMO 120-day stratification period is effective regardless of any gaps in eligibility. The days do not have to be consecutive. Members with gaps in eligibility over one year are treated as new to *Care Select*. A new health-risk assessment must be performed and the 120-day count starts over. If a member is assigned to a different CMO within the 120 days, the new CMO's 120-day stratification period starts over.

After a member is screened and stratified, the CMO receives a CMO fee for the member. The CMO receives the CMO fee for the member even if the screening and stratification took longer than the 120-day period. All CMO fees must be paid on a prospective basis, beginning in the month following the screening and stratification. One-half of the CMO fee must be paid if the member is eligible for 17 days of the month or less.

In addition to the responsibilities outlined in the previous paragraph, the CMO must review the member's PMP assignment with the member and relevant caregivers and assist with a PMP change if necessary. The FSSA encourages this review to occur at the same time the CMO makes contact with the member for an initial screening.

As part of the initial member assessment, the *Care Select* Contractor validates whether a *Care Select* member meets the following specifications for inclusion in *Care Select*.

- Use the following to ensure care coordination and management:
  - Claims data
  - Information gathered in screenings
  - Medical records
  - Other sources
- Identify gaps in members' care and communicate them to PMPs
- Identify immediate physical and/or behavioral health needs
- Determine need for care coordination and management
- Conduct comprehensive review of clinical history
- Perform stratification based on initial assessment and historical claims data
- Determine the following needs:
  - Clinical

  - Psychosocial
  - Functional
  - Financial

- Gather information regarding level and type of existing care management
- Review information to identify member's care strengths, needs, and available resources

The *Care Select* contractor reviews the data from the initial screening to stratify member level of service and ensure continuity of care.

The initial assessment shall 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, and illnesses and health conditions, as well as the member's psychosocial, support, and treatment needs. The CMOs use any screening tool of the CMO's choice, as long as the tool is approved by the FSSA and consistent with the other *Care Select* CMO.

The screening tool may differ for children/adolescents versus adults. The CMOs use the Child and Adolescent Needs and Strength (CANS) assessment process to prospectively or retrospectively assess the 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.

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

Based on that initial stratification, the details about care levels shall determine a time frame for and conduct a more detailed health needs assessment for each member in order to further identify what level of care coordination services are appropriate. The assessment shall be comprehensive and identify clinical, psychosocial, functional and financial needs of the participant. The details about care levels shall 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 Community Mental Health Center.

The CMO uses an assessment tool. The health needs assessment shall be conducted by a *Care Select* care manager. The CMOs collect and review medical and educational information, as well as family and caregiver input, as appropriate, to identify the member's care's strengths, health needs and available resources. A clinician on the CMO's care management team shall review the findings of the health needs assessment and provide the findings to the member's PMP, as well as the behavioral healthcare provider, if appropriate.

The CMOs use data from multiple sources, minimally claims data, data collected during the initial screenings, the follow-up health assessment, available medical records, Indiana Scheduled Prescription Electronic Collection & Tracking (INSPECT) and other sources, to ensure that the care for *Care Select* members is adequately coordinated and appropriately managed. Through data analysis and predictive modeling, the CMOs identify members who are at the highest risk for hospitalization or relapse, or high cost and/or high utilization in the future. The CMOs also identify gaps in the member's current treatment approach, and communicate those findings to the member's PMP.

The outcome of the health risk assessment shall determine the members' needs in the stratification process resulting in the members' assignment to a *Care Select* level of service.

- Level 2 (disease management).

- Level 3 (care management)
- Level 4 (complex case management – Member focus)
- Level 5 (complex case management – Provider focus)
- Level 6 (Right Choices Program members, *Care Select*, and fee-for-service)

A member must be assigned a tier level 1 for 120 days or until such time as an initial screening and stratification have been completed. The State must not provide a CMO fee for members assigned to level 0.

Before the contract's effective date, the CMO proposes to the FSSA a stratification methodology, which includes a "rush" designation for members with immediate needs. The FSSA must approve the stratification plan and any changes before stratification begins.

Based on that initial stratification, the CMO determines a time frame and conducts a more detailed health-needs assessment, as needed, for each member to further identify what care management services are appropriate. The assessment is comprehensive and identifies the participant's clinical, psychosocial, functional, and financial needs. For example, identification of a member with a potential gap regarding activities of daily living, in the initial assessment, indicates the CMO may need to complete a more thorough home health assessment.

The CMO gathers information about the level and type of existing care or case management services that the member may already receive, such as through a community mental health center (CMHC). The CMO uses an assessment tool, and the health-needs assessment is conducted by the care management staff (for example, care coordinators and care managers) employed by the CMO. The CMO collects and reviews medical and educational information and family and caregiver input to identify the member's care strengths, health needs, and available resources. The CMO's care management team reviews the health-needs assessment and provides the findings to the member's PMP and behavioral healthcare provider, if appropriate.

The CMO uses 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 *Care Select* members is adequately coordinated and appropriately managed. For example, through data analysis and predictive modeling, the CMO identifies members who are at the highest risk for hospitalization or relapse, high cost, or high utilization in the future. The CMO also identifies gaps in the member's current treatment and communicates those findings to the member's PMP. The CMO also works with the member to ensure that the member's needs are met.

Members in levels 2, 3, 4, or 5 must be reassessed as determined by the CMO. The current CMO and any CMO to which the member might be reassigned could use the current member assessment for up to an entire rolling calendar year, or whichever time period is appropriate for the member's level, from the time, that member became a member of the program or when that member completed his or her last annual assessment.

For example, if a member changes his or her CMO after completing the member assessment, which was completed within the last calendar year, the new CMO can request the member assessment completed by the previous CMO, and that assessment will meet the outlined performance requirement. The CMO is responsible for creating procedures for appropriately sharing this information that are in compliance with *Health Insurance Portability and Accountability Act* (HIPAA) regulations. Furthermore, if a member decides to change back to the first CMO, the original member assessment can be used to meet the member assessment performance requirement if the original assessment is less than one calendar year old.

Care Plans and Care Level

After the initial assessment, the CMO assigns members to a care level, develops a care plan for each member, and facilitates and coordinates the holistic care of each member according to his or her needs. Care plans for those outside complex case management may be a structured assessment or an electronic protocol and reminder system. The CMO helps the member, the family, and the PMP develop a care plan with specific objectives, goals, and action protocols to meet identified needs. The CMO initiates and facilitates specific activities, interventions, and protocols that lead to accomplishing the goals set forth in the care plan. The care plan includes, at a minimum:

- Clinical history
- Diagnoses
- Functional and/or cognitive status
- Immediate service needs
- Use of services not covered by the IHCP
- Accommodation needs (for example, special appointment times, alternative formats) and auxiliary aids and services
- Barriers to care (for example, language, transportation, and so on)
- Assigned PMP
- Care/case manager from a service delivery system, for members who have one
- Psychosocial support resources
- Local community resources
- Family member/caregiver/facilitator resources and contact information
- Mental health status
- Intensity of *Care Select* service
- Assigned *Care Select* case coordinator for DM, care management complex case management, or Right Choices Program (RCP)
- Member self-management goals
- Clearly identified, member-centered, and measurable short and long-term goals and objectives
- Key milestones towards meeting short-term and long-term goals and objectives
- Planned interventions and contacts with member, provider, and/or service delivery systems
- Assessment of progress, including input from family, if appropriate

The CMO has standard protocols in place to assess, plan, implement, reassess, and evaluate members, minimally including:

- 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

When developing the care plan, in addition to working with a multidisciplinary team of qualified healthcare professionals, the CMO ensures that there is a mechanism for members, their families and/or advocates to be actively involved in care plan development. If a member's PMP declines to participate in the care management team, the CMO ensures that the care management plan is provided to the member's PMP. The CMO develops a process for reviewing and updating the care plans with members on an as-needed basis, but no less often than annually. It is expected that members in complex case management and RCP have care plans reviewed and updated on a schedule more often than annually.

Services called for in the care plan are coordinated by the CMO's care coordination staff, in consultation with any other care managers already assigned to a member by another entity – for example, community mental health center (CMHC), county, provider, or a treatment facility. The CMO's complex case management teams are composed of licensed professionals with nonclinical duties delivered by support staff overseen by nurses and licensed social workers. The *Care Select* care managers for complex case management and RCP are licensed clinical professionals and have training, expertise, and experience in providing case management and care coordination services for individuals represented in each of the subpopulations in *Care Select*, including individuals with behavioral health needs and developmental disabilities. The CMO's care managers work in partnership with PMPs and other caregivers to ensure that members' overall care is coordinated and well-managed. Each complex case management member has an assigned care manager, and each of the CMO's care managers may be assigned to multiple members. However, for complex case management and RCP, the member-to-coordinator ratio should not exceed 100:1. Complex case management teams may include unlicensed staff working under the supervision of a licensed clinical professional.

Care plans delineate a variety of "low-touch" and "high-touch" interventions and approaches ranging from member educational mailings, telephone contacts with members and providers, face-to-face visits, in-home visits, and telephonic outreach. Interventions may range from passive mailings for preventive care reminders to home visits by the care manager. The CMO offers care plans and performs successful interventions and approaches.

Care plans indicate a member's current level of care stratification level. Members may move between groups over time as their needs change, so the CMO develops a protocol for re-evaluating members periodically to determine if their present care levels are adequate. The CMO also identifies triggers, which immediately move the member to a more assistive level of service. The care coordination classification system may be modified if the CMO receives written approval from the FSSA. The CMO provides the initial screening and risk assessment to all new patients and patients who have been in the program for five years. Additionally, any PMP can request a redetermination. If a health home

service becomes available, it will replace *Care Select* and the CMO will cease being involved in the care.

Level 0 Services

Level 0 members the CMOs are unable to reach after 120 days are assigned to level 0. The State must not provide a CMO fee for members assigned to Level 0. Level 0 services do not include DM or care management services. The CMO must make ongoing attempts to contact and perform an initial assessment of members assigned to Level 0.

Level 1 Care Coordination Services

Level 1 is a temporary classification that lasts no more than 120 days for members who have been enrolled in *Care Select* but who have not yet been assessed and stratified into a higher care level.

A new member must be assigned to level 1 until the initial assessment and stratification using the approved health risk assessment tool have been completed. A "new member" includes new members, members with gaps in eligibility over one year, and members re-enrolled in *Care Select.*

DM services must be provided to all level 1 members (as well as levels 2, 3, 4, and 5). DM services include all basic services, such as a customer call line for provider and community information, linkage to community resources, and disease-specific and general preventive health education and reminders. DM services are required for members with specific conditions. DM services may be provided by nonclinical staff with escalation to clinical staff, as indicated by provider request or change in clinical status.

Through DM services, the CMO provides information, resources, and referrals as requested by members, member advocates, and healthcare providers. Members must receive disease-specific educational materials, and general and disease-specific preventive care reminders. DM materials for level 1 members may be delivered electronically, by mail, or by telephone at the CMO's discretion.

The CMO must also provide assessment and stratification services to level 1 members. Continued payment for these members requires a completed assessment and stratification within 120 days.

Level 1 services typically result in brief, short-term encounters with members. The CMO reaches out to members and providers to assess and stratify the member and determine whether disease management and/or care management is appropriate going forward.

Level 2 Disease Management

Level 2 services include all aspects of level 1 services listed previously, plus the following.

DM services should assist members in understanding their chronic conditions, setting goals, and achieving self-selected outcomes through education, counseling, and ongoing support. DM plans can be fairly basic or more involved depending on member needs. The simplest of plans would contain documentation of a member's stratification level, the conditions for which the member should receive DM, the schedule of DM interventions for those conditions, and contact information for the member's PMP.

The CMO provides a customer call line for provider and community information, linkage to community resources and disease-specific and general preventive health education and reminders for members. DM services are provided to members with specific conditions and for prevention of related conditions. DM services may be provided by nonclinical staff with escalation to clinical staff as indicated by provider request or change in clinical status. Through DM services, the CMO provides information and specific preventive care reminders, resources, and referrals as requested by members,

member advocates, and healthcare providers. The CMO promotes evidenced-based practices for covered chronic disease conditions.

The CMO provides information, resources, and referrals as needed to all members, their families, and healthcare providers, as requested. DM services 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.

DM services address each member's medical and health concerns, specific medical information, and available community resources. Services typically result in brief, short-term encounters. The CMO reaches 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. Members in DM services are provided with contact telephone numbers to call with questions.

The CMO must develop a disease management plan for each level 2 member to assist with the execution of disease management activities, and to facilitate member and provider services calls from or about these members. Disease management plans should assist members in understanding their chronic conditions, setting goals, and achieving self-selected outcomes through education, counseling, and ongoing support. Disease management plans can be basic or more involved, depending on a member's needs. The simplest plan might contain documentation of a member's stratification level, the conditions for which the member should receive DM, the schedule of DM interventions for those conditions, and contact information for the member's PMP. No care plan is required for level 2 members. Clinical care managers must be available to consult regarding level 2 disease management plans, as appropriate.

The CMO must reassess level 2 members if a member's healthcare status is determined to have changed since the original screening. This is indicated by a change in clinical status as demonstrated by utilization or claims review, notification from PMP, or notification from the member or member's advocate. The CMO must conduct reassessments based on these factors and needs identified during the initial screening. Reassessments may be performed using any FSSA-approved tool; they do not need to use the health risk assessment used for the initial assessment. Reassessments of level 2 members may be performed by nonclinical staff.

Level 2 services typically result in brief, short-term encounters with members. At least one live-voice contact between the CMO and each level 2 member is required each rolling year based on the member's enrollment. The CMO reaches out to level 2 members and their providers as indicated by the member's disease management plan, when requested by the provider, or when a significant change in clinical status has occurred. Contact with members in level 2 services may be limited to mailings and/or telephone communications, or may be made through electronic mailings and/or text messages if the member has opted in to such communications. However, any text messages or other disease management communications must be at no charge to the member.

When providers contact the CMO for assistance with level 2 members, CMO staff answers questions appropriate to their level of training and refer calls to the care management unit for additional PMP needs. On PMP request, the CMO must conduct a PMP case conference based on a particular member's assessment and evaluation. The CMO must travel to the PMP's office to conduct the case conference or conduct it via teleconference, at the PMP's option. The CMO does not need to perform more than one PMP case conference per member, per rolling 12-month period.

Level 3 Care Management Services

Level 3 care management services include all elements of level 1 and level 2 DM services, as well as the following.

Care management is provided to help guide the individual member with access to care for needed health or social services to address the member's chronic health condition. Care management is a purposeful plan to reach members and impact their health and healthcare utilization. Care management refers to coordination of health and other services provided to *Care Select* members. Through care management, the CMO helps members improve their health outcomes. Members who are at risk for an acute or catastrophic episode in the future may be prioritized for complex case management services. In the interim, care management services are provided as a preventive measure. The CMO provides for comprehensive coordination services that are tailored to the individual, rely on sound medical practices, and include Medicaid-covered services. All members identified for care management services receive all the benefits of DM services in addition to the additional care management supports.

Newly referred members and persons with newly diagnosed conditions, increasing health services or emergency services utilization, evidence of pharmacy noncompliance for chronic conditions, and identification of special healthcare needs are considered for care management. Care management services include direct consumer contacts to assist members with scheduling, location of specialists and specialty services, transportation needs, use of a 24-hour nurse line, general preventive (for example, mammography) and disease-specific reminders, pharmacy refill reminders, tobacco cessation, and education regarding use of primary care and emergency services.

The CMO develops care plans for members in care management. Care plans may be a structured assessment or an electronic protocol and reminder system. The care plan identifies the problems, barriers, and issues related to the individual's healthcare needs. The care plan addresses goals, objectives, and interventions to meeting the needs of the individual. The CMO makes every effort to contact members in care management by telephone. Materials should be delivered to the member in a manner acceptable to the member, through postal and electronic mail direct to the consumer. Educational materials and telephonic contacts may use web-based education materials inclusive of clinical practice guidelines. Materials are developed at the fifth-grade reading level. All members with the conditions of focus receive materials no less than quarterly. The CMO is required to submit quarterly and annual data to document the number of persons with conditions of focus, with the number of active and passive contacts made to the member.

At the time they are enrolled in *Care Select*, members may be receiving case management services through the CMHCs. As such, the CMO works with the member and CMHC to determine where and how the member should receive care coordination or case management services. For example, the CMO works with the member and/or the member's PMP to decide whether the member receives 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 that the member receives appropriate services that are not duplicated.

Level 4 Complex Case Management (Member Focus)

The *Care Select* CMO assertively engages members and providers in the development of a case management plan to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. The member may opt in and choose to become actively engaged in learning about the condition of focus and participating with their medical team. Complex care management member focus is the active coordination of care and services with the member and between providers while navigating the extensive systems and resources required for the member. Level 4 involves comprehensive assessment, determination of available benefits, and development and implementation of a complex care management plan directed at the chronic health condition. The complex care management plan identifies the problems, barriers, and issues related to the individual's healthcare needs and identify strategies for best engaging the member in his or her own treatment. The plan addresses goals, objectives, and interventions for meeting the needs of the individual.

At a minimum, the CMO provides complex case management services for members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than 90 days following that

inpatient hospitalization. The CMO also provides complex case management services for any member at risk for inpatient psychiatric or substance abuse re-hospitalization; care managers contact members during an inpatient hospitalization, or as soon as practicable on receiving notification of a member's inpatient behavioral health hospitalization. The care manager works with the hospital discharge planner, provider case manager, and/or natural supports (for example, family) to ensure that an outpatient follow-up appointment is scheduled to occur no later than seven days following the inpatient behavioral health hospitalization discharge. The CMO ensures that lack of transportation is not a barrier to the member attending the appointment.

Complex case management includes all the services and benefits from DM and care management. In addition, all members with conditions of focus receive materials no less than monthly. Avoiding unnecessary emergency department and inpatient hospitalizations and increasing use of preventive healthcare are goals for complex case management.

Level 5 Complex Case Management (Provider Focus)

The CMO assertively engages members and providers in the development of a case management plan to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. The CMO is in contact with the member, but the member can opt out and choose not to be actively engaged in coordinating with his or her medical team. However, the member agrees to actively engage in learning about the condition of interest and follow the case management plan developed. Complex case management provider focus is the active coordination by the CMO of care and services between providers while navigating the extensive systems and resources required for the member. The plan involves comprehensive assessment, determination of available benefits, development and implementation of a complex case management plan directed at the chronic health condition. The complex case management plan identifies the problems, barriers and issues related to the individual's healthcare needs and recognize why, due to the person's condition or other reasons, the member cannot actively participate. The plan addresses goals, objectives, and interventions to meeting the needs of the individual.

At a minimum, the CMO provides complex case management services for members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than 90 days following that inpatient hospitalization discharge. The CMO also provides complex case management services for any member at risk for inpatient psychiatric or substance abuse re-hospitalization. Care managers contact members during an inpatient hospitalization, or as soon as practicable on receiving notification of a member's inpatient behavioral health hospitalization. The care manager works with the hospital discharge planner, provider case manager, and/or natural supports (for example, family) to ensure that an outpatient follow-up appointment is scheduled to occur no later than seven days following the inpatient behavioral health hospitalization discharge and transportation is not a barrier to attending the appointment.

Complex case management includes all the services and benefits from DM and care management. In addition, all members with conditions of interest receive materials no less than six times a year. Avoidance of unnecessary emergency department and inpatient hospitalizations and increased use of preventive healthcare are goals for complex case management – opt out.

Level 6 Right Choices Program

The purpose of the RCP is to identify members who use covered services more extensively than their peers. The program, set forth in *405 IAC 1-1-2(c)* and *405 IAC 5-6*, is designed to monitor member utilization, and when appropriate, implement restrictions for members who would benefit from increased care coordination. Program policies, set forth by the FSSA for the RCP, are delineated in the *Right Choices Program Policy Manual*, located at indianamedicaid.com. The CMO complies with the program policies set forth in the *Right Choices Program Policy Manual.*

The CMO is responsible for RCP duties for *Care Select* and Traditional fee-for-service Medicaid members, as outlined in the *Right Choices Program Policy Manual*, including, but not limited to, the following:

- Evaluate claims, medical information, referrals, and data to identify members to be enrolled in the RCP. Before enrolling a member in the RCP, the CMO ensures a physician, pharmacist, or nurse confirms the appropriateness of the enrollment
- Enroll members in the RCP
- Provide written notification of RCP status to such members and their assigned primary physicians, pharmacies, and/or hospitals
- Intervene in the care provided to RCP members by providing, at minimum, enhanced education, case management, and care coordination with the goal of modifying member behavior
- Provide appropriate customer service to providers and members
- Evaluate and monitor the member's compliance with his or her treatment plan to determine if the RCP restrictions should terminate or continue
- Notify the FSSA of members who are being reported to the FSSA Bureau of Investigation for suspected or alleged fraudulent activities
- Provide ad-hoc reports about RCP to the FSSA upon request
- Cooperate with the FSSA in program evaluation activities by providing data and/or feedback when requested by the FSSA
- Meet with the FSSA about RCP program implementation as requested by the FSSA
- Develop, for the FSSA approval, and implement internal policies and procedures regarding the CMO's RCP program administration

RCP duties listed previously are provided for *Care Select* members. The CMO is required to develop a treatment plan for the RCP members and monitor and document whether RCP restrictions should continue. The FSSA monitors the *Care Select* CMO's compliance with the RCP duties set forth in this section.

Table 4.2 – Summary of Tier Levels, Level 0 – Level 6

Tier	Component
0	Member not stratified within 120 days
1	New member, pre-stratification
2	Disease management
3	Care management
4	Complex case management (member focus)
5	Complex case management (provider focus)
6	Right Choices Program

Monitoring

Care managers regularly and routinely consult with 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 gathers information on the care plan's activities, interventions, and services to evaluate the care plan's effectiveness in reaching desired goals and outcomes. Feedback is provided to the primary care

physician, family, and others involved in the care. The CMO evaluates and communicates the plan's effectiveness. For DM members, a gap-in-care report is sufficient to meet the monitoring requirement for communicating with the PMP.

Reassessment and Evaluation

The CMO reassesses 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 evaluates the overall effectiveness of each care plan to achieve positive outcomes for member and families, and to improve the system of care for individuals in *Care Select*. The CMO conducts regularly scheduled team reviews with members of the multidisciplinary care management team for complex case management members who remain at risk, and modify care plans as necessary via feedback from members, protocols and recommendations from families, and feedback from primary care physicians and other providers. The CMO offers strategies for assessing individual member's progress.

At least quarterly, the CMO reports to the FSSA on health outcomes for prevention and disease-management efforts. The CMO develops procedures to monitor and assess its effectiveness in delivering quality healthcare to its Indiana *Care Select* members. The CMO submits performance data related to its quality of disease management, care management, complex case management, and RCP services in a manner consistent with the sample reporting templates. The CMO offers strategies for assessing the *Care Select*'s effectiveness.

The CMO develops clinical definitions and assessment tools to identify members who are seriously mentally ill, and incorporates these tools into initial member assessments. The CMO designs 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, care managers notify the PMP and behavioral health providers when hospitalization or emergency behavioral health treatment occurs. Care managers provide this notification within five days of the hospital admission or emergency treatment, dependent upon them having access to this data in real time. Care managers also monitor members receiving behavioral health services to ensure that members are expediently linked to an appropriate behavioral health provider, and that the member's access to appropriate behavioral health medication is not interrupted. The care manager monitors whether the member is receiving appropriate services and whether the member is at risk of over- or under-utilizing services.

Care managers regularly and routinely consult with 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 shares member medical data with physical and behavioral health providers and coordinates care for all members receiving physical and behavioral health services, to the extent permitted by law and in accordance with the member's consent. The CMO requires 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 both the CMO and the PMP or behavioral health provider, if applicable.

Care Management for Members with Behavioral Healthcare Needs

Many individuals in *Care Select* have significant behavioral healthcare challenges – mental health and substance abuse conditions. The CMO is responsible for managing the behavioral healthcare needs of its membership. The CMO does the following:

- Provides care that addresses the needs of *Care Select* members in a more holistic manner
- Increases communication between the PMP, the CMO, and the behavioral healthcare provider

- Better manages utilization of behavioral healthcare services

The CMO must employ or contract with care coordinators and care managers with training and experience in providing disease management, care management, and care coordination services for members receiving behavioral healthcare services.

The CMO manages behavioral healthcare 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 healthcare needs of enrollees, must be available to members.

Disease management services and case management services for members with behavioral health conditions address gaps in care and evidence-based outcomes and include integrated medical and behavioral disease management plans and care plans. The CMO receives a list of members with serious mental illness, serious emotional disturbance, or depression spectrum diagnoses, per the FSSA specifications.

For all members, the CMO provides prior authorization (PA) for behavioral health hospitalization. With the appropriate consent, care managers must notify PMP and behavioral health providers when hospitalization or emergency behavioral health treatment occurs.

The CMO must also monitor members with behavioral health diagnoses 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 CMO must monitor whether the member is receiving appropriate services and whether the member is at risk of over- or under-utilizing services.

For members with behavioral health needs, care managers consult with the member's physical and behavioral health providers when indicated by a gap in care or changes in the clinical situation 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. Information is exchanged only as permitted by law and in accordance with the member's consent. For these members, the CMO assesses the care plan's activities, interventions, and services to determine the plan's effectiveness in addressing gaps in care and reaching evidence-based goals and outcomes.

The CMO must send a comprehensive behavioral health profile for members with behavioral health needs to the respective PMP when indicated by a gap in care. The behavioral health profile may be sent electronically and lists the physical and behavioral health treatment received by that member during the previous reporting period.

The CMO assists members in arranging a follow-up visit within seven days of discharge from behavioral health hospitalization.

Many of the CMO's members receive services through the 31 community mental health centers in the state of Indiana. The CMO coordinates with CMHCs so that the CMO can better manage physical and behavioral healthcare, including the services provided through these centers. The CMO establishes mechanisms to ensure that individuals seeking services through the CMHCs are also receiving the appropriate primary healthcare services from medical care providers.

When members are enrolled in *Care Select*, they may be receiving case management services through the CMHCs. As such, the CMO works with the member and CMHC to determine where and how the member will continue to receive case management services. In all cases, the CMHC and CMO should work closely together to ensure that the member receives appropriate, unduplicated services and to coordinate physical health needs.

The CMO works with CMHCs and other behavioral healthcare providers and members to use evidence-based guidelines that help members work toward recovery.

Section 5: Disease Management

Overview

The primary component of *Care Select* is disease management under the Indiana Chronic Disease Management Program (ICDMP). The care management organization (CMO) provides disease management services that are population-based and target specific disease states identified via telephone and other interventions, as designed and approved by the Family and Social Services Administration (FSSA) under legislative mandate in *IC 12-15-12-19*.

The CMO must provide disease management to all assessed members with specific conditions, regardless of care level. Disease management must be coordinated into the member's *disease* management plan if a member is assigned to care level 2. Disease management must be coordinated into the member's *care* plan if a member is assigned to care level 3.The CMO must assign sufficient, knowledgeable disease management staff capable of contacting, assessing, supporting, and educating members with chronic conditions. Successful disease management is likely to require several attempts and multiple outgoing calls per member. Nonclinical staff may conduct the initial health risk assessment.

The CMO must maintain disease management programs for the following conditions:

- Asthma
- Diabetes
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease
- Hypertension
- Chronic kidney disease without dialysis
- Severe mental illness
- Serious emotional disturbance
- Depression
- The co-morbidity of diabetes and hypertension
- The co-morbidities and/or combinations of any of these disease states
- Other serious or chronic medical condition, as approved by the FSSA

The CMO must submit its disease management program protocols and all disease management materials to the FSSA for review and approval. All *Care Select* members are eligible for these disease management programs. The CMO must report, at least quarterly to the FSSA, the monitoring, workload, efficacy, and other performance-based measures for the disease management programs. The reporting format requires approval by the FSSA. In addition, the FSSA reserves the right to require the CMO to assist in the future development of disease management programs for additional conditions, such as chronic obstructive pulmonary disease. The FSSA provides three months' advance notice to the CMO if the FSSA decides to add new diseases to the disease management program requirements. As the disease management program is a legislative mandate, other disease states may be added due to changes in legislation.

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

- Substantiate the reasons for initiating such programs
- Secure the FSSA's approval for implementing the disease management programs
- Provide any reporting 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 disease management program require the FSSA's approval before being implemented for members. The FSSA maintains the overall program administration for the disease management program and can modify the program and approve or deny the CMO's recommendations.

General Requirements for the Disease Management Program

The CMOs are responsible for the following:

1. Obtain and maintain a disease management toll-free number to:
   - Serve as an information line, receiving inbound calls from members and providers
   - Triage calls to disease managers or care managers as appropriate
2. Interact with members:
   - Via inbound calls from members; answer questions, provide information about the program, and assist in communication between members and their care managers and/or disease managers
   - Via outbound calls to members; according to daily task lists provided by a tool designed by the CMO, conduct assessments of program members using the screening survey
   - Assist members in care coordination based on the results of the assessment and other relevant information
3. Interact with provider offices to request medical records via inbound or outbound calls, and send or receive member updates
4. Interact with care managers and/or disease managers to coordinate and communicate, as needed; support care managers and/or disease managers by making outbound calls, as needed
5. Train call center staff to use the CMO tool and to interact appropriately with members of the disease management program; enter data in the CMO-designed tool in real time
6. Train call center staff in the use of the CMO's computer software tool and appropriate interaction with the members of ICDMP
7. Enter data in real time
8. Maintain call center performance
9. Maintain qualified call center staff sufficient to manage the expected call volume
10. Maintain the appropriate number of call center supervisors to manage call center staff
11. Provide a registered nurse to handle medical-related questions from members and from doctor's offices
12. Prepare and deliver to the FSSA monthly monitoring reports, as directed by the FSSA, by the 15th of every month for the previous month's activities
13. Coordinate activities with care management
14. Meet as requested by the FSSA

Software and Data Requirements for the Disease Management Call Center

The CMOs are responsible for the following:

1. Maintain and be responsible for housing all necessary information within their proposed program tool
2. Provide sufficient information technology to maintain the disease management program data and trained staff dedicated to support the software program
3. Accept data transfers from HP, as necessary
4. Produce monthly monitoring reports of:
   - Enrollments
   - Call center statistics
   - Performance standards
5. Provide Internet capability to disease management call center representatives to validate information, such as Medicaid enrollment status and current address and telephone number

Physician and Member Outreach

The CMO must develop and distribute to members written ICDMP materials to provide information about disease management and care management services:

- On a member's agreement to participate in the disease management program
- On request by a:
  - Member
  - Provider
  - Care coordinator
  - Care manager
- On request of the FSSA

The CMO must reach out to Indiana Health Coverage Programs (IHCP) providers via site visits and mailings to inform them about the disease management program and encourage their participation.

Section 6: Care Select Services

Overview

Services covered by care management organizations (CMOs) are reimbursed by fee-for-service (FFS) payments for members enrolled in CMO health plans. Services must be furnished in an amount, duration, and scope that is no less than the Indiana Health Coverage Programs (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*, Children's Health Insurance Program (CHIP) (Package C) in *407 IAC 3*.

The following lists broad categories of services provided by the CMO health plan in a CMO arrangement with the Family and Social Services Administration (FSSA):

- 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 and 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
  - Telehealth services
- Pharmacy services
  - Legend drugs
  - Nonlegend drugs (selected over-the-counter drugs), as identified in the FSSA over-the-counter formulary
  - Insulin, nutritional and food supplements, and infant formulas
- Medical supplies and equipment
  - Medical supplies and durable medical equipment (DME)
  - Braces and orthopedic shoes
  - Prosthetic devices
  - Hearing aids
- Transportation services
  - Emergency transportation
  - Nonemergency transportation
  - Transportation to and from services covered by IHCP

- Dental services
- Diabetes self-management services
- Pregnancy care coordination
- Case management services targeted for members with human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS)
- Smoking cessation services
- Behavioral health services, such as:
  - Mental health
  - Substance abuse
  - Chemical dependency services
- Special provisions for specific types of service, coverage, and payment policies applying to some services and providers are discussed later in this section and include the following:
  - Emergency services
  - Out-of-plan services
  - Out-of-area services
  - Self-referral services
  - Federally Qualified Health Center (FQHC) and rural health clinic (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

The fiscal agent is 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 Indiana Code (IC) definition of "emergency medical condition," and the one used in this chapter, is a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent layperson 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:
   - The individual
   - In the case of a pregnant woman, the woman or her unborn child
2. Serious impairment of bodily functions
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*.

The IHCP does not reimburse hospitals and physicians for nonemergency services rendered in the emergency room (ER). Hospitals and physicians are reimbursed for a screen that is necessary to determine if the member had an emergency condition.

Services provided in the ER may be subject to prepayment and postpayment review. Documentation must support that the prudent layperson standard has been met for *Care Select* members when the PMP has not authorized the services.

For members presenting to ER with or without an emergency condition outlined previously, the IHCP has adopted the following guidelines.

Facility Billing

If the screening identifies that the member has a nonemergent medical condition, the facility may only bill Revenue Code 451 – *EMTALA-emergency medical screening service* and be reimbursed the lesser of the provider's submitted charge (usual and customary) or the emergency screening fee of $25. If the screen determines the member has an emergency condition, the hospital bills for medically necessary emergency services, using the appropriate revenue and Healthcare Common Procedure Coding System (HCPCS) codes. The screening revenue code may not be billed in conjunction with ER treatment services.

Physician Billing

If the physician determines that the member has a nonemergent medical condition, the physician may bill only one of the following Current Procedural Terminology (CPT) codes and is reimbursed the lesser of the provider's submitted charge (usual and customary) or the rate on file. If the screen determines the member has an emergency condition, the physician may bill the screening code, as well as medically necessary services.

Table 6.1 – Nonemergent CPT codes

CPT	Description
99281	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • A problem-focused history • A problem-focused examination • Straightforward medical decision-making
99282	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • An expanded problem-focused history • An expanded problem-focused examination • Medical decision making of low complexity
99283	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • An expanded problem-focused history • An expanded problem-focused examination • Medical decision making of moderate complexity

Primary medical provider (PMP) authorization is not required for ER screening services provided to *Care Select* members.

Out-of-State Services

The fiscal agent pays for services rendered by out-of-state providers, such as urgent or emergent care, while a member is traveling outside Indiana. See *Chapter 4: Provider Enrollment, Eligibility,* and *Responsibilities, Section 7: Out-of-State Provider Provisions* of the *IHCP Provider Manual* on the *Manuals* page at indianamedicaid.com for additional information regarding out-of-state services.

Seeking Care Through Referrals Through the PMP, Self-Referral Services, and Other IHCP Services

The CMO educates its members about the benefits of using the members' PMPs, such as enhanced care coordination and establishment of a medical home. The fiscal agent reimburses any provider's claim for authorized services provided to *Care Select* 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 prior authorization (PA) requests, must authorize care, and the fiscal agent must reimburse for services if the service is deemed medically necessary. Emergency care does not require PA, but claims for these services may suspend for medical review. The CMO must authorize all services in a timely manner. The State's fiscal agent makes all ER 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, and 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 *42 CFR 438* and *IC 12-15-12* on a self-referral basis and as described under *Emergency Services and Post-Stabilization Care 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 freedom of choice of providers and access to family planning services and supplies. Family planning services are services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy, including, but not limited to, birth control pills. *Care Select* members may not be restricted in their choice of family planning service providers.
- The CMO must allow its members to obtain birth control pills and other family planning services and supplies on a self-referral basis. The FSSA recognizes the need for appropriate management of prescription medication in the interest of the member's health; however, the FSSA 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 pharmacy benefits

manager (PBM), at a minimum, ensures that members can access 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 must defer to this PBM requirement when coordinating with the PBM for pharmacy utilization management.

- Chiropractic services are IHCP-covered services rendered by an IHCP provider enrolled with 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 an IHCP provider enrolled with specialty 140 (podiatrist) and practicing within the scope of 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 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 *Care Select*. The IHCP providers to which the member may self-refer are:
  - Outpatient mental health clinics
  - Community mental health clinics
  - Psychiatrists
  - Psychologists
  - Certified psychologists
  - Health services providers in psychology (HSPP)
  - Certified social workers
  - Certified clinical social workers
  - Psychiatric nurses
  - Independent practice school psychologists
  - Advanced practice nurses who, as stated in *IC 25-23-1-1(b)(3),* are 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 HSPP who directs outpatient mental health services for group, family, and individual psychotherapy when services are provided by one of the following midlevel practitioners:
  - Academy of Certified Social Workers (ACSW)
  - Certified clinical social worker (CCSW)
  - Advanced practice nurses who, as stated in *IC 25-23-1-1(b)(3),* are 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.
  - Registered nurse (RN) with a master's degree in nursing with a major in psychiatric and mental health nursing from an accredited school of nursing

  These midlevel practitioners may not be separately enrolled as individual providers to receive direct reimbursement. Midlevel 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 midlevel practitioners in an outpatient mental health facility when services are supervised by a physician or HSPP. Services rendered by midlevel 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. See *Chapter 8*: *Billing Instructions* of the *IHCP Provider Manual* found on the *Manuals* page at indianamedicaid.com for additional information about the claim billing policy for midlevel 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 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
  - 67311-67999 – Procedures on ocular adnexa including orbit, eyelids, brow, and related procedures
  - 68020-68899 – Conjunctiva and related procedures
- 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 members seek 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 must 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 available on a self-referral basis from any IHCP-enrolled provider. Immunizations are covered regardless of where they are received. For example, members may receive immunizations at a county health department, and the health department may bill the fiscal agent for the immunization administration fee.

The following ancillary services are allowed as self-referral:

> *Note: A complete list of provider types and specialties, including descriptions and enrollment criteria, is found in Chapter 4: Provider Enrollment, Eligibility, and Responsibilities of the IHCP Provider Manual found on the Manuals page at indianamedicaid.com.*

- 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 – Provider specialty 250
- Home Medical Equipment (HME) providers – Provider specialty 251
- Home health services – Provider specialty 050

The following outpatient therapy services are allowed as self-referral:

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

The following provider types and IHCP programs are also considered self-referral services:

- School corporations
- Medical Review Team (MRT)
- Pre-Admission Screening and Resident Review (PASRR)

Services Related to Self-Referral Services

Members may not self-refer to providers that are not enrolled in the IHCP. The CMO has 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

Because FQHCs and RHCs are essential safety-net providers, the FSSA 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 the CMO's requirements regarding the ability of these providers to provide quality services.

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

Indiana's EPSDT program is called HealthWatch and 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 ensures that children enrolled in *Care Select* receive age-appropriate comprehensive, preventive services. See the *IHCP HealthWatch/EPSDT Provider Manual* found on the *Manuals* page at indianamedicaid.com for details regarding components and recommended frequency of HealthWatch screenings.

The CMO works with prenatal clinics and other providers to educate pregnant women about the importance of EPSDT screenings and encourages them to schedule preventive visits for their infants. The CMO's care management staff ensures that all children in *Care Select* between nine months and six years of age are tested for lead poisoning.

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

Transportation Services

The CMO is responsible for arranging transportation services for its level 3 members. The CMO ensures that transportation services are provided through *Care Select* in the appropriate amount, duration, and scope. The State does not use a transportation broker, so the CMO is responsible for developing and maintaining a transportation provider network and authorizing services. Transportation vendors continue to submit claims to the State's fiscal agent. However, the CMO is encouraged to work with transportation brokers to ensure that members have access to transportation.

Pharmacy Services

The State's Pharmacy Benefit Manager (PBM), Catamaran, rather than the CMO, administers the pharmacy benefit (including conducting prior authorization and entering those decisions directly into Indiana*AIM*), and Catamaran Corporation pays pharmacy claims. The State's Preferred Drug List (PDL) is in effect for members.

The CMO receives the PBM's data and analysis about the population's use or appropriateness for the Right Choices Program (RCP). The RCP controls access to certain pharmaceuticals for individuals with abnormal use patterns. The RCP coordinates with the PBM as necessary to identify the appropriate PMP, hospital, and pharmacy to which a member should be restricted. At a minimum, information about a member's RCP status must be incorporated into the CMO's disease management plans and care plans.

The CMO monitors pharmacy claims and provides input regarding suggested changes and improvements to the pharmacy PDL, policies, and procedures to the State. The State may present that input to the Therapy Committee and the Drug Utilization Review (DUR) Board. As required by *Section 2.4* of the Scope of Work, the CMO attends all DUR and Mental Health Quality Advisory Committee (MHQAC) meetings.

The CMO must provide disease management insights gained by accessing and analyzing pharmacy claims data. The CMO also uses pharmacy data to ensure that members are refilling drugs appropriately and provides outreach to members who are not in compliance. The vendor should target specific populations, such as members with mental health issues and with specific disease states. The CMO manages this benefit by monitoring actual pharmacy utilization, member compliance with taking prescribed medications, and assisting members with medication management.

Indiana Health Coverage Programs – 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
- Members with dual eligibility (Medicare and Medicaid)

CMO members who qualify for long-term institutional care or hospice care services are disenrolled from their *Care Select* care management plan, according to the member disenrollment criteria outlined in *Member Eligibility and Enrollment*. CMOs must note that it is possible for a member's Indiana Pre-

Admission Screening/Pre-Admission Screening 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 60 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 60 days, the screening must be completed within 25 days after the last day of the short-term stay (except as specified for PASRR 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 under the subsection of this manual, *Care Select Members Pending Level of Care Determination*.

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. Information regarding Long Term Care Services and how to access the 450B form can be found in *Chapter 14* of the *IHCP Provider Manual* found on the *Manuals* page at indianamedicaid.com.

Continuity of Care

Care Select is committed to providing continuity of care for members as they transition among various IHCP programs such as FFS 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 continuity of care and coordination of medically necessary healthcare services for its *Care Select* members.

For members newly enrolled with the CMO, the CMO must ensure that an ongoing course of treatment is not interrupted or delayed because of the change to new providers. Medical records must be 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 *Care Select* provider. The CMO accepts services already authorized by the State or its PA vendor for up to 30 days after the member is enrolled in *Care Select*.

Transition of Care

The State emphasizes several critically important areas where the CMO addresses continuity of care. Critical continuity of care areas include, but are not limited to:

- Transitions from *Care Select* to another health plan or no coverage
- Transitions from fee-for-service to *Care Select*
- Transitions to or from Hoosier Healthwise
- Transitions for members receiving behavioral health services, especially for members who have received prior authorization for behavioral health drugs and/or inpatient stays
- Transitions and explanations of benefit changes for members recently disenrolled from the *Care Select*. The CMO's interactions with disenrolled members include communicating basic

information about the member's new healthcare options, including where to go for more information

- Transitions for members who become dual eligible for Medicare and IHCP

The FSSA 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. To achieve this objective, the CMO has a process in place to establish and coordinate a care plan before discharge for members who are ready to be discharged from an inpatient hospital or nursing home. The CMO tracks the implementation of this care plan. The CMO is required to work with and coordinate efforts, as necessary, with programs implemented through the FSSA's Division of Aging such as the Area Agencies on Aging to ensure continuity of care.

Prior Authorization Process During Transition of Care

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

- Transitions from FFS to *Care Select*
- Members hospitalized on the effective date of *Care Select*
- Transitions for members who become dually eligible for Medicare and the IHCP
- Members undergoing the IPAS/PASRR process for long-term care placement
- Members receiving behavioral health services, especially members who have received PA for behavioral health drugs from their previous CMO or through FFS
- The CMO arranges for covered services provided to newborn children of CMO members from the newborn's date of birth. The fiscal agent cannot control when newborn eligibility is transmitted from the Indiana Client Eligibility System (ICES) to Indiana*AIM*. There may be a delay of several weeks to several months before the fiscal agent can send newborn eligibility to CMOs because of 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 changes health plans during an inpatient stay, are treated as new admissions.
- Transitions and explanations of benefit changes for members recently disenrolled from *Care Select*

One of the CMO's last interactions with disenrolled members should be communicating basic information about the member's new healthcare 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 is responsible for ensuring a smooth transition after the member has been disenrolled from *Care Select* whenever the member disenrollment occurs during an inpatient stay. The CMO coordinates discharge plans with the member's new medical provider, if known.

The State's goal is to ensure that no member is discharged from inpatient services and admitted to a nursing home or other treatment setting when the individual could receive care in a less restrictive and more appropriate setting, such as home- and community-based services. The CMO must have a process in place to establish and coordinate a care plan 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 is required to coordinate efforts, as necessary, with IndianaOPTIONS. *IndianaOPTIONS* is

implemented through the Family and Social Services Administration's (FSSA's) Division of Aging, with direct services delivered through the Area Agencies on Aging.

Continuity of Care for Members Receiving Behavioral Healthcare

The following procedures and requirements apply specifically to those members receiving behavioral healthcare under *Care Select*. 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 follow members transitioning to different providers. The care manager must notify the PMP of the member's previous mental health treatment and must offer to provide the member's treatment plan, if available, to the new provider 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 before 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 healthcare provider or the CMO's behavioral healthcare manager contacts the member within three business days of the missed appointment.

Care Select Members Pending Level of Care Determination

The LTC facility, such as a nursing facility, a community residential facility for the developmentally disabled (CRF/DD), or the intermediate care facility for individuals with intellectual disability (ICF/IID) must verify the patient's IHCP eligibility and healthcare program when the patient is admitted or screened.

If the eligibility information indicates that the patient is enrolled in *Care Select*, the LTC provider must contact the CMO identified by the Eligibility Verification System (EVS). The provider must verify the patient's IHCP eligibility, not only at admission and screening, but again on the 1st and 15th of every month thereafter because the member may move from FFS Medicaid to a care management health plan.

If a care management member is undergoing screening for admission to an IHCP-certified LTC facility, the facility must complete the LOC paperwork and submit it to the appropriate agency. During the time that the facility or 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 can be found in *Chapter 14, Section 12,* of the *IHCP Provider Manual* on the *Manuals* page at indianamedicaid.com.

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 60 days, the claims submitted to the fiscal agent 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. The CMO is encouraged to provide enhanced services, such as health education classes, that target the IHCP population. The CMO must inform and receive approval from the FSSA at least 30 days before implementing or providing enhanced services. The FSSA reviews these enhanced services, and the CMO must receive FSSA approval before 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 incentives cannot have retail values of more than $10 individually. The annual maximum for member gifts or incentives is $50 per member. Additional benefits above the $10/$50 limits are allowed, as approved by the FSSA, for preventative health services.

Member Financial Responsibility

Copayments

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

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 the IHCP for a covered service. Providers must accept IHCP reimbursement as payment in full for 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 PA 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 before receiving the services, and must be retained as documentation in the patient's medical record. The *Care Management Organization and Provider Enrollment* section of this manual gives additional information about member billing.

Chapter 4, Section 6 of the *IHCP Provider Manual* on the *Manuals* page at indianamedicaid.com contains additional information about member billing.

Section 7: Member Services

Overview

The care management organization (CMO) must establish policies and procedures to ensure that materials are accurate in content and 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 Family and Social Services Administration's (FSSA's) review and approval of member materials and to 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 FSSA for review annually. The *CMO Reporting Manual* details the member materials reporting requirements. The FSSA maintains and distributes the *CMO Reporting Manual*.

The CMO must submit all marketing, promotional, educational, and outreach materials and other member and press communications to the FSSA for review and approval at least 30 calendar days before expected use and distribution. The CMO must receive approval from the FSSA before distributing or using materials. The CMO must receive the FSSA's approval to use or display the *Care Select* logo for each use. The CMO should not assume the FSSA's approval for use of the logo based on previous approvals. The FSSA reserves the right to assess liquidated damages or other remedies for the CMO's noncompliance in the use or distribution of any nonapproved member materials.

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

- Provider directory listing the CMO's providers in its network and identifying each provider's specialty, service locations, 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 two 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 the CMO offers
- CMO marketing and promotional brochures and posters
- Member handbook that describes the terms and nature of services offered by the CMO and contact information including the CMO's website address

General Information Requirements

The CMO must make written information available in English, Spanish, and other prevalent non-English languages, as identified by the FSSA, on the member's request. The CMO must identify additional languages that are prevalent among members. The CMO must inform members that information is available on request in alternative formats and how to obtain alternative formats. The FSSA 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 members that, on a member's request, the CMO provides information about the structure and operation of the CMO and, in accordance with *42 CFR 438.6(h),* provides information about the CMO's provider incentive plans.

The CMO is responsible for developing and maintaining member education programs designed to provide members with clear, concise, and accurate information about the CMO's program, the CMO's network, and *Care Select*. 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, 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 Work Improvement Plan Summary* report and annual *Quality Program Evaluation* report, as explained in the *CMO Reporting Manual*.

Website

The CMO must provide a user-friendly website to members, providers, and the community within six months of the effective date of the CMO's contract with the State. The website must be in an FSSA-approved format to ensure compliance with existing accessibility guidelines. The FSSA must preapprove the CMO's website information and graphics. The website information must be accurate and current, culturally appropriate, written at a fifth-grade reading level, and available in English and Spanish. The CMO must inform members that information is available on request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the website must avoid techniques or tools that require significant memory or disk resources or that require special intervention on the user side, such as installing plug-ins or additional software. The CMO must date each Web page, change the date with each revision, and allow users the ability to print the information. Such website information should include, but not be limited to, the following:

- The CMO's provider network identifying each provider's specialty, service locations, 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 and member grievances
- How to file an appeal with FSSA Hearings and 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 (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 and care coordination program, including case management services and chronic disease management programs
- The member's rights and responsibilities

- The member handbook
- The *Health Insurance Portability and Accountability Act* (HIPAA) privacy statement
- A list and brief description of each of the CMO's member and provider outreach and education materials
- The executive summary from the CMO's *Annual Quality Management and Work Improvement Plan Summary Report* and *Annual Quality Program Evaluation Report.*

Member Handbook

On enrollment in the CMO program, the CMO must make available by request a handbook containing written policies and information about the following:

- Rights and responsibilities of the members
- Benefits and services included and excluded for members of the CMO program and how to obtain services
- Special benefit provisions that may apply to services, for example:
  - Copayments
  - Deductibles
  - Limits
  - Rejection of claims:
- Procedures for accessing in-network services
- Procedures for obtaining out-of-area services, if applicable
- 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, if applicable
- Procedures for notifying members affected by termination or change in any:
  - Benefits
  - Services
  - Service delivery sites
- Procedures for appealing decisions adversely affecting members' coverage, benefits, or relationship with the CMO
- Procedures for changing primary medical providers (PMPs)
- Procedures for changing plans within *Care Select*
- Procedures for making complaints, filing grievances, or recommending changes in policies and services

Welcome Packets for New Members

The State's enrollment broker contacts new members within 10 business days of receiving the member enrollment roster by sending welcome packets including the following information:

- The member is now enrolled in the *Care Select.*
- The CMO is there to better manage and coordinate the physical and behavioral healthcare of the member.

- The member is eligible to participate in one of the CMO's disease management programs and may be appropriate for care management or complex case management; but *Care Select* is an "optional" program and the member may opt out.
- The member should use the CMO's member services helpline as the first resource for questions or concerns about:
  - *Care Select*
  - PMP issues
  - Benefits
  - CMO's policies
  - So forth.
- The availability of a nurse care hotline or other additional services offered by the CMO.

Welcome packets are available in English and Spanish at a minimum; the FSSA may designate additional languages with reasonable notice. All material in welcome packets shall be approved by the FSSA prior to use.

Welcome Packets for Previously Enrolled Members

The CMO is not required to send a welcome packet, including the member handbook, if the member was previously enrolled in the CMO and has received a welcome packet in the last 12 months. All materials must be given to members on request. The CMO must provide notification to its members of substantive changes to the member handbook, as provided in *Section 3.4.2* of the *Statement of Work*.

Education, Outreach, and Marketing Materials

Members shall receive disease specific educational materials and general information of healthy living and preventive care based on evidence-based practices from the CMO at least quarterly targeted at the disease state, preventive care, general tips on talking to your doctor/how to make the most of your doctor appointment and other topics identified in HRA. The educational materials and other member-directed tools shall be designed to aid the member in taking control of the member's own health and to promote consumer management and compliance with treatment for chronic diseases. All materials are subject to approval by the FSSA prior to distribution. Disease management materials and information for members and providers may be delivered electronically, by mail, or by telephone, as appropriate to the member or provider.

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

- The State must approve all education and outreach materials, including materials written by CMO subcontractors, before distribution.
- The State must approve all member, provider, and press communications before distribution.
- All materials must be on health and wellness issues pertaining to *Care Select*.
- The FSSA must review and approve any materials that use the *Care Select* logo before distribution for each material use. The CMO must cooperate with the FSSA to identify which materials require the program logo. The FSSA's decision about use of the logo is final.
- All brochures, presentation materials, and information packets must follow the standards established by the FSSA. 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 reading level and the measurement used to assess the reading level (such as the simple measure of gobbledygook (SMOG), Gunning fog index, or other method).

- Any educational, outreach, or marketing materials must be distributed within the entire service area specified by the CMO and approved by the FSSA.
- Marketing materials cannot contain any false or misleading information and must be approved by the FSSA before distribution.
- Literature about health and wellness promotion programs offered by the CMO is encouraged.
- All materials to be reviewed by the FSSA must be submitted to allow for a 30-day review period.

The FSSA 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 whom to call if a member is hearing impaired or needs an interpreter

The CMO must provide the FSSA with written notification immediately on discovery of an alleged or suspected marketing violation by marketing representatives. On notification, the FSSA 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 remedies.

The CMO must submit to the FSSA a member materials distribution plan annually. 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, and so forth) must be submitted to the FSSA for approval before distribution and in accordance with the FSSA policy. In addition, the CMO must notify the FSSA of any changes to the distribution 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 before selecting a PMP and enrolling the member in the CMO network:

- List of PMPs 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, and wellness programs

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 two 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 FSSA must review and approve newsletters before distribution, as it does 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 Indiana Health Coverage Programs (IHCP)-included and -excluded benefits and services and any enhanced services available in the CMO network
- Statement that all self-referral services can be obtained by any IHCP participating provider; additional information may be found regarding self-referral services by clicking the *Care Select Services* link.
- Description of the IHCP/CMO's 24-hour access to emergency care procedures
- Information about a member's rights and responsibilities under the CMO's plan, including participation in member satisfaction surveys
- Information about grievance procedures and the rights of members with respect to filing 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 Appeal and Hearing Procedures

Prior authorization (PA) administrative review and appeal procedures are outlined in the following sections of the *Indiana Administrative Code* (*IAC*):

- *405 IAC 5-7*
- *470 IAC 1-4*

Members receive a *Notice of Appeal Rights,* along with the PA decision letter that outlines the definitions and process.

Appeals for PA issues are conducted in accordance with *470 IAC 1-4.* Hearings and appeals and administrative reviews are administratively completed by the PA vendor. Member appeals and requests for a hearing must be submitted to the FSSA Office of Hearings and Appeals. A provider first submits an administrative review to the PA vendor. After the administrative review, the provider may request a hearing and appeal through the FSSA Office of Hearings and Appeals. If the administrative review is submitted to the incorrect CMO or FFS organization, the request is returned to the provider for submission to the appropriate organization. If the member has been assigned to a different program since the request for PA was denied, providers can appeal to the PA vendor for the administrative review that denied the request *or* submit a new PA request for review to the PA vendor.

For additional information regarding this process, see *Chapter 6, Section 12 of the IHCP Provider Manual* on the *Manuals* page at indianamedicaid.com.

Care Management Organization 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 an eight-hour business day, at a minimum, 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 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 24-hour oral interpreter services 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.

Note	*Effective November 1, 2010, the CMOs, ADVANTAGE Health Solutions℠ and MDwise, no longer arrange for translation services for healthcare-related services in the provider's service location for Care Select members. This change has no impact on a provider's existing obligation under federal civil rights laws to ensure access to services for members with limited English proficiency (LEP).*

The CMOs continue to access Language Line for member calls. MDwise and ADVANTAGE have contracted with AT&T's Language Line to furnish the services of a language interpreter to customer service representatives needing assistance communicating with *Care Select* members who speak a primary language other than English. AT&T's Language Line provides interpreters for more than 140 languages, 24 hours a day, seven days a week.

For hearing-impaired services, ADVANTAGE and MDwise use Indiana Relay Service.

The CMO must maintain a system for tracking and reporting the number and type of member calls and inquiries it receives during business hours and nonbusiness hours. The CMO must monitor its member services helpline and report its telephone service performance to the FSSA 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
- Procedures for filing a member appeal with FFSA Hearings and Appeals
- Potential fraud or abuse
- Changing PMPs
- Quality of care

When a member enrolls 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 CMOs shall provide nurse triage telephone services for all *Care Select* members to receive medical advice 24 hours a day, seven days a week from trained medical professionals. The 24-hour Nurse Call Line should be well publicized and designed as a resource to members to promote appropriate care in the appropriate setting at the appropriate time. Members would be strongly encouraged by the CMO to contact the nurse care line before going to the ER. This resource shall also be a primary source of averting inappropriate ER utilization. The CMO shall inform *Care Select* members of this available resource and shall encourage its use it to promote appropriate care in the appropriate setting at the appropriate time. The 24-hour Nurse Call Line shall have a system in place to communicate all issues with the member's PMP. In addition, 24-hour oral interpreter services shall be provided.

Right Choices Program

The purpose of the RCP is to identify members who use covered services more extensively than their peers. The program, set forth in *405 IAC 1-1-2(c)* and *405 IAC 5-6*, is designed to monitor member utilization, and when appropriate, implement restrictions for members who would benefit from increased care coordination. Program policies, set forth by the FSSA for the RCP, are delineated in the *Right Choices Program Policy Manual* on the *Manuals* page at indianamedicaid.com. The CMO must comply with the program policies set forth in the *Right Choices Program Policy Manual*. *Care Select* and Traditional Medicaid members in RCP are in tier level 6. This tier level ensures a CMO fee is paid. Members in this tier level do not generate payment in other *Care Select* tier levels.

The CMO is responsible for RCP duties, as outlined in the *Right Choices Program Policy Manual*, including, but not limited to, the following:

- Evaluate claims, medical information, referrals, and data to identify members for possible enrollment in the RCP
- Ensure that a physician, pharmacist, or nurse confirms the appropriateness of the enrollment before enrolling a member in the RCP
- Enroll members in the RCP, which includes the following responsibilities:
  - Provide written notification of RCP status to members and their assigned primary physicians, pharmacies, and hospitals
  - Intervene in the care provided to RCP members by providing, at minimum, enhanced education, case management, and care coordination with the goal of modifying member behavior
  - Provide appropriate customer service to providers and members
  - Evaluate and monitor the member’s compliance with his or her treatment plan to determine whether the RCP restrictions should terminate or continue – the State must make available utilization data about the CMO’s RCP members to assist the CMO in its monitoring duties
  - Notify the FSSA about members who are reported to the FSSA Compliance Division or FSSA Chief of Investigations for suspected or alleged fraudulent activities
  - Provide ad-hoc reports about RCP to the FSSA on request
  - Cooperate in evaluation of program activities by providing data and/or feedback when requested by the FSSA
  - Meet with the FSSA, as requested, about RCP program implementation

- Develop, obtain FSSA approval, and implement internal policies and procedures for the CMO's RCP program administration

The CMOs use Web interChange to perform the administration tasks and provide documentation for their assigned members. Policies and procedures related to the program are available in the *Right Choices Program Policy Manual* found on the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion*.

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 *Care Select*, 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 counseling or referral services 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 about 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 about 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 FSSA 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 before the enrollee becomes a member in the CMO's program.

Prohibiting CMO outreach to *Care Select* members applies equally to enrollees who apply for the program at a Division of Family Resources (DFR) office or at any other outstation location. Except as provided herein, the CMO may not offer gifts or incentives greater than $10 for each individual and $50 per year per individual. The CMO may petition the FSSA, in the manner prescribed by the FSSA, for authorization to offer items or incentives greater than $10 for each individual and $50 per year per individual if the items are intended to promote the delivery of certain preventive care services, as defined in *42 CFR 1003.101*. Such incentives may not be disproportionate to the value of the preventive care service provided. Petitions to provide enhanced incentives for preventive care must be reviewed on a case-by-case basis, and the FSSA must retain full discretion in determining whether the enhanced incentives will be approved. The CMO is subject to penalties under the *Social Security Act Section 1128A(a)(5)* regarding inducements, remunerations, and gifts to Medicaid recipients. The CMO must comply with all marketing provisions in the *42 CFR 438.104* and federal and state regulations regarding inducements.

The CMO must submit a member materials distribution plan to the FSSA quarterly. All member outreach, marketing, and education materials must be submitted to the FSSA for approval before distribution and in accordance with FSSA policy. Any outreach and marketing activities (written and oral) must be presented and conducted in an easily understood manner and format, must be 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 enrollment decision.

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 inches by 17 inches) promotional materials to the FSSA for approval. After receiving the FSSA's approval, the CMO can make these posters available to the local county office of the DFR and enrollment centers for display in an area where *Care Select* application or member enrollment occurs. Each local county office of the DFR 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 FSSA must pre-approve all promotional and informational brochures or flyers, and all graphics before display or distribution.

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

Section 8: Care Management Organization and Provider Enrollment

Overview

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

All providers, including out-of-state providers, that render services to *Care Select* members in a CMO health plan, must be enrolled in the Indiana Health Coverage Programs (IHCP). 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 providers to sign the *Care Select* addendum to the IHCP Provider Agreement to participate in *Care Select*. The addendum is available on the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion.*

Care Management Organization Enrollment

After the execution of a contract between the FSSA and the CMO, the FSSA submits a written request to the fiscal agent to enroll the CMO.

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's 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* informs the fiscal agent of additional addresses and telephone numbers for supplemental functions not included in the *CMO Care Select Enrollment Form*. If changes occur to the previous enrollment information, the CMO must complete the *CMO Care Select Enrollment Update Form* and submit it to the fiscal agent.

The *CMO Care Select Enrollment Form, CMO Supplemental Contact Information Enrollment Form,* and the *CMO Care Select Enrollment Update Form* are available on the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion.*

After verification of the required information, the fiscal agent enrolls the CMO and sends confirmation letters to the FSSA and the CMO. The letters contain the CMO's unique identification (ID) number which comprises10 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 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 IDs and Region Identifiers

CMO IDs	
ADVANTAGE XXXXXX220	**MDwise XXXXXX500**
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 primary medical providers (PMPs) about provider requirements and responsibilities such as:

- The CMO's prior authorization (PA) policies and procedures
- Clinical protocols
- Rights and responsibilities of members
- Claim dispute resolution process
- Pay-for-performance programs
- Reporting and coordination with the care management staff
- 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 aware of the cultural diversity of the *Care Select* population. The CMO must be competent in respectfully and effectively interacting with individuals with racial, ethnic, and linguistic differences.

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

- Care management processes
- Various types of chronic conditions and disabilities prevalent among *Care Select* members
- Various screening and assessment tools used in *Care Select*
- 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

- Barriers faced by adults with physical, sensory, communication disability, developmental, or mental health needs and the resulting need for access and accommodations

The CMO must submit all promotional, training, educational, outreach materials and other provider communications to the FSSA for review and approval at least 30 calendar days before 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 FSSA's review and approval process. After receiving the FSSA'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 the 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 verify the following:

- 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 it is a 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 about the practitioner, as applicable:

- Information from the National Practitioner Data Bank (NPDB). The NPDB is not applicable to chiropractors or 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 PMPs, 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 evaluating the medical record-keeping practices at each site to ensure conformity with the maintenance of medical records. *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 actions taken include:

- Continuation in the CMO
- Required participation in continuing education
- Required supervision
- Clear plan for improvement with the practitioner
- Evidence of changes in the scope of practice
- 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 its members. 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 about 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 FSSA 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 grievance 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 that providers are aware of the grievance process. Policies and procedures must include mechanisms to ensure that providers are treated fairly and uniformly.

Provider Service Locations

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

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

Physicians can download IHCP applications from indianamedicaid.com. Provider enrollment applications must be submitted via paper enrollment forms through the U.S. Mail. CMOs must verify that the physician is IHCP-enrolled before submitting a PMP enrollment through Web interChange. PMPs can treat *Care Select* members at any enrolled service location. PMPs participating in a CMO can have service locations in any Indiana county allowed by the CMO's state contract.

Out-of-State Providers

To enhance access to primary care in areas with an inadequate number of PMPs, the FSSA permits out-of-state PMPs to enroll in the program in areas where limited access is 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 only to those with FSSA out-of-state designations. Other out-of-state PMPs receive only self-selections. The FSSA out-of-state designations are defined in *405 IAC 5-5-2* and are delineated as cities that reside outside the state of Indiana, that are excluded from out-of-state PA requirements, and that are required to follow in-state PA requirements. The cities defined as FSSA out-of-state designations are as follows:

- Chicago, Illinois
- Danville, Illinois
- Watseka, Illinois
- Louisville, Kentucky
- Owensboro, Kentucky
- Sturgis, Michigan
- Cincinnati, Ohio
- Hamilton, Ohio

- Harrison, Ohio
- Oxford, Ohio

Residency Programs

To promote long-term doctor-patient relationships for *Care Select* members, physicians practicing in group residency programs are not eligible to enroll as PMPs in *Care Select*. 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 the IHCP 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. The IHCP eligibility verification system provides that doctor's name as the PMP.

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 the IHCP and do not bill the IHCP for the services the clinics 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 before providing services, as needed. Services provided in school-based clinics are usually limited to Early and Periodic Screening, Diagnosis, and Treatment (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 FSSA 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 *Care Select* through face-to-face training sessions, brochures, and videos. The FSSA must approve before distribution all education and outreach materials designed for distribution to physicians interested in becoming PMPs.

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

- *Care Select* goals
- Member PMP selection and PMP change processes
- Practice requirements of a PMP, including the following:
  - Panel size limits
  - On-site availability requirements
  - Twenty-four-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
- 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 before submitting PMP enrollment through Web interChange. If the prospective PMP is not IHCP- enrolled, the CMO must tell the physician to contact the fiscal agent for an enrollment application, or the physician (or physician's group) can download the appropriate application from* indianamedicaid.com.

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* – The fiscal agent provides member enrollment roster information to the member's contracted health plan PMPs. The CMO can retrieve a complete list of enrolled members (Enrollment Roster 834) with PMP assignments from the fiscal agent. Enrollment rosters are described in *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. *Care Select* 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 *Care Select Services*.
- *Provider claims dispute* – This information is described in *Table C.3*.
- *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 *Network Development, Services and Data* of this manual
  - Quality improvement requirements, as described in *Quality Improvement Program and Performance Reporting* of this manual
  - Billing requirements
  - Eligibility issues
  - Preventive health standards and requirements (including EPSDT)
- *Reassigning a member to another PMP* – This process, as initiated by the provider, is described in *Member Eligibility and Enrollment*.

Provider Enrollment

The CMO components of *Care Select* are subprograms of the IHCP. As such, participating providers must be IHCP-enrolled. The CMO is responsible for ensuring that all its providers are IHCP-enrolled at the service location where they wish to participate as PMPs. 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 *Care Select* and all its health plans.
- Once enrolled in the IHCP, PMPs contract with the CMOs for their health plans. PMPs may 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 FSSA 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 in *Care Select*, a provider must be enrolled as an IHCP provider. A provider is enrolled in the IHCP when all 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 FSSA.
- 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 its National Provider Identifier (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 before enrolling as a PMP at that location.

There are two types of IHCP providers:

- Billing providers (sole proprietorship or 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 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 *Care Select* are enrolled as IHCP

providers. Providers complete the initial enrollment by submitting the *Indiana Health Coverage Programs Provider Agreement* via the U.S. Mail. The *Agreement* is available on indianamedicaid.com. Providers must submit the paper *Agreement* by mail to:

HP 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, Chapter 4* found on the *Manuals* page at indianamedicaid.com. Providers may also contact Customer Assistance by telephone at 1-877-707-5750 to request enrollment applications and to obtain answers to questions about provider enrollment in the IHCP.

After completing IHCP enrollment, CMOs can enroll PMPs to participate in a CMO health plan.

Care Management Organization Primary Medical Provider Enrollments and Updates

The CMOs can submit individual PMP enrollments for their health plans through **Web interChange > PMP Enrollment**.

The CMOs can also update the existing PMP's scope-of-practice, panel-hold status, and panel-size information. Panel-size and network updates require effective dates that are future dates – 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 Web interChange. They are viewable in **Web interChange** > **Provider Profile**.

1. Access Web interChange from indianamedicaid.com. All CMOs must enroll in Web interChange as group administrators and establish Web interChange user IDs and passwords. The CMO group administrator has the ability to assign users and to assign users 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* on the *Manuals* page at indianamedicaid.com.
2. After logging into Web interChange, you must click the **Provider Profile** link. You have the option to view the provider profile, enroll a PMP, update PMP information, view a list of the fiscal agent provider field consultants, and download program forms, such as the PMP Enrollment and Update forms. Only users who are assigned access to the PMP Enrollment Membership task see *Enroll a PMP, Update PMP,* or the *PMP Enrollment and Update Forms* section on the provider profile menu. You also have access to Help text to assist with the processes for PMP enrollment and update.
3. The CMO must complete the PMP election process by entering the NPI or group or billing ID, selecting a service location and, if a group provider, selecting the applicable rendering provider. After the selection of the PMP, the CMO must enter the 24-hour telephone number, scope-of-practice information, and panel size. Once the CMO data entry is complete and has passed the system cross editing, the CMO must click **Submit**. A confirmation Web page appears with the statement that the PMP enrollment has been successfully processed. The window also includes the submission date, enrollment date, CMO name, provider number, group number, and alpha service location ID. To confirm that 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 to use 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 on **Web interChange > PMP Enrollment** page and the IHCP website at the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion*.

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

1. On receipt of the CMO's PMP enrollment forms, the fiscal agent PMP enrollment coordinator enters the data into Indiana*AIM*, verifying the following information:
   - Valid provider 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
2. The fiscal agent PMP enrollment coordinator confirms the disposition of the enrollments by sending an email confirmation to the submitter.

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

Care Select Provider Addendums

On behalf of the State, CMOs are required to obtain a signed *Care Select* provider addendum for each provider enrolled in *Care Select*. The addendums should include the provider's original signature. 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 on indianamedicaid.com and on the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion*.

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

HP Provider Enrollment
950 North Meridian Street, Suite 1150
Indianapolis, IN 46204-4288

Each addendum must include the provider's name and the NPI used in the Web PMP enrollment or ancillary provider file process. The provider numbers assist in the correct identification of the *Care Select* provider.

Changes to Primary Medical Provider 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
  - 65 years 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 **Web interChange** > **Provider Profile** > **Update a PMP**. If 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 determines the maximum.

PMPs who request an increase to their panel sizes must maintain acceptable quality and access standards, such as 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 requires 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 PMHoosier HP 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 cannot 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. However, four PMPs who are a part of a billing group 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 Primary Medical Providers

Currently, enrolled PMPs can increase their panel sizes at any time by submitting written requests to the CMO. After receiving a PMP's request for a panel-size increase, the CMO should submit the panel-size update with the effective date of the new panel size through the PMP Update process located in **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 on the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion.*

PMPs can also request decreases in their panel sizes at any time by submitting written requests to the CMO. However, the number of members assigned to the PMP's panel does not immediately drop. When a PMP submits a request to reduce panel size, members are not removed from the PMP's panel. CMOs must understand this and communicate it 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 **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 maximum increment can be relaxed at the request of the PMP, allowing a PMP with a full panel to add members as follows:

- The member has a previously established relationship with the PMP, as determined by the enrollment broker's established criteria.
- The family member of a current panel member (identified by a common case number) selects the PMP.
- 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. The panel hold applies to assignments by selection or default auto-assignments. CMOs must educate their PMPs that panel holds do not stop assignments of members with the same case IDs or members who have had previous relationships with a 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 to manipulate a PMP's panel with regard to a specific member assignment. The reasons for panel hold requests 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 PMPs 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 **Web interChange > Provider Profile > Update a PMP**. The panel-hold update is effective the day the submission is 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 Primary Medical Provider Panel-hold Request

The following are examples of acceptable reasons for granting PMP panel-hold requests:

- The PMP has a personal situation, such as maternity leave or short-term disability.
- The PMP is temporarily unable to accept new assignments for professional reasons, such as moving practice location.
- The PMP is taking a temporary leave of absence from the practice.
- The 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. Because this requires a manual intervention of the panel hold, the CMO must be aware of the following processing requirements:

1. The CMO forwards the member's request to enroll with 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 coordinates with a fiscal agent Managed Care Unit representative to temporarily update the PMP's panel to *No hold.*
4. The enrollment broker enrolls the approved *Care Select* member to the PMP as requested, updates the panel to *Panel Hold,* and immediately notifies the CMO when the enrollment is complete.

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 panel-hold requests prevent self-selection and most auto-assignments of new members. PMPs with panel holds continue to appear on provider lists from which potential *Care Select* members make PMP selections. Except for members with previous relationships with *Care Select* PMPs or with family members (identified by a common case number) of current panel members, new members are not assigned during the temporary panel-hold period. It is important for CMOs to communicate this to their PMPs.

Provider Disenrollment

A PMP can be disenrolled from *Care Select* for various reasons. The PMP disenrollment process was designed to provide continuing care for *Care Select* members when PMPs leave *Care Select* and are no longer available to its members. A timing guide for this process is contained in *Primary Medical Provider Disenrollment Time Line*.

Overview of Primary Medical Provider Disenrollment Reasons

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

Other disenrollment processes are designed to allow an orderly transition of care for *Care Select* members assigned to PMPs who become unavailable due to retirement, a move to a different health plan, or other circumstances that are known in advance. 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 before the date the current PMP becomes unavailable. The new assignment is processed as a PMP change and is submitted to the enrollment broker for entry into Indiana*AIM*.

PMP disenrollments fall into two general categories:

- Disenrollment without re-enrollment occurs in circumstances in which 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 *Care Select* for any other reason, or IHCP provider enrollment termination. Members linked to a PMP who is disenrolled without re-enrollment are usually notified to self-select a new PMP within the CMO and are linked through a systematic batch 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* health plan or service location to the same PMP in a different *Care Select* health plan 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 health plan or service location.

Submitting the Primary Medical Provider Disenrollment Request

CMOs are responsible for submitting PMP disenrollments to the fiscal agent for processing in Indiana*AIM*. The disenrollment request includes the following information submitted on the transmittal forms on the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion*.

- CMO name
- 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. The signed letter from the PMP should contain a requested effective date. If the PMP declines to provide the disenrollment reason in writing or the PMP is unavailable to sign (for example, the PMP moved and did not leave contact information or has died), the CMO can provide the disenrollment reason in a cover letter requesting the disenrollment.
- Contact information 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 the fiscal agent 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 service location with the same address as a 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 health plan 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 health plan.

CMOs must fully understand the PMP disenrollment process and use it within *Care Select*'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 illustrate how the Managed Care Unit and Indiana*AIM* process PMP disenrollments. CMOs and the enrollment broker need only identify the disenrollment scenario. The fiscal agent assigns the appropriate disenrollment reason code based on the scenario provided.

Primary Medical Provider Disenrollment without Re-enrollment from the Care Management Organization

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

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

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

- Immediately notifies the fiscal agent in writing of the PMP's intent to disenroll
- Facilitates member assignments to other PMPs within the health plan
- Forwards member PMP changes to the enrollment broker for systematic processing in Indiana*AIM*
- Must provide the fiscal agent written notice specifying the projected end date at least five working days before the 24th of the month before 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
- Contact information 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 FSSA must approve all customized letters. On receipt of notification from the CMO of the PMP's intent to disenroll, the fiscal agent 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 requester
- 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 - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion.*
- Sends a PMP disenrollment confirmation letter to the PMP, as shown in Member and PMP Correspondence of the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion.*
- Sends the PMP disenrollment confirmation letter to the CMO, as shown in Member and PMP Correspondence of the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion.*
- 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 health plan PMPs if the PMP is not otherwise available in the *Care Select* health plan. The CMO is responsible for all members assigned to a disenrolling PMP until another PMP selection has been made.

Primary Medical Provider Disenrollment with Re-enrollment from the Care Management Organization

Disenrollment with re-enrollment of a PMP from *Care Select* may be required. PMP disenrollments with re-enrollment are processed if the disenrolling PMP is available to members in a different *Care Select* health plan. 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 using the appropriate *Managed Care Disenrollment Request Form* provided on the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion.*

On notification of a disenrollment, the fiscal agent 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
- Re-enrolls PMP to the new relationship, as noted previously
- Notifies members with a letter about their PMP update. 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 on the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion*.
- Notifies the PMP with a letter outlining the change
- If the disenrolled PMP is not available to members in *Care Select*, the fiscal agent auto-assigns members who have not been reassigned by the 25th day of the month in which the disenrollment occurs to new PMPs within the CMO's health plan (if possible).
- 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

Indiana Health Coverage Programs Disenrollment and Primary Medical Provider Disenrollment

If the fiscal agent Provider Enrollment Unit 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.

Primary Medical Provider Panel Transfer Requests

Policy

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

The enrollment broker 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 the fiscal agent that the request has been approved. The fiscal agent 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 members may make other selections 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 conflict of interest. For example, the PMP may be leaving a group practice and opening a solo practice. The PMP and the group may want to keep the members. However, because members are linked to a PMP and not to 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* 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 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, the request may take longer to process because the enrollment broker must attempt to confirm the request and that the PMP wishes for his or her panel to be transferred.
- When the request is approved, the enrollment broker sends an email notification of the approval to the requesting CMO and the fiscal agent.
- When the request is denied, the enrollment broker sends an email notification to the requesting CMO. This email outlines the reasons for the denial.
- The enrollment broker submits a written notification of approval or denial to the CMO.
- The approval document ***must*** accompany the disenrollment paperwork the CMO sends the fiscal agent. This approval form confirms that the fiscal agent should suppress the member notification letters of the PMP's disenrollment.
- After 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 assignments.

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. Appropriate reasons could include death, serious illness, or relocation with no forwarding address or telephone 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 CMO's *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 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, the request may take longer to process because the enrollment broker must attempt to confirm the request and 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 the fiscal agent. This approval document confirms whether or not the fiscal agent should suppress the member notification letters of the PMP's disenrollment.
- On receiving approval, the CMO should submit the PMP changes to the enrollment broker on the appropriate form with the appropriate change reason code for systematic processing into Indiana*AIM*.
- As determined by the approval process, members 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
- Medical history
- Immunizations
- 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 the *Health Insurance Portability and Accountability Act* (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 FSSA or the CMO, a summary or copy of the member's medical records to another PMP when 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 *42CFR 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, coinsurance, and copayments).

Care Management Organization 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 before notifying its provider network of the changes. The FSSA 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 website to inform network and out-of-network providers and make payment policies available to noncontracted providers on 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 website for network and out-of-network providers within three months of the effective date of the CMO's contract with the State. The FSSA must preapprove the CMO's website information and graphic presentations. The CMO may choose to develop a separate provider website or incorporate it into the home page of the member website. The provider website 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
- State's preferred drug list

- Claim submission information, such as the State's submission and processing requirements, paper and electronic submission procedures, emergency room (ER) auto-pay lists, and frequently asked questions
- Prior authorization procedures
- Appeal procedures
- PMP and specialty network listings
- Links to the State's website for general IHCP or *Care Select* information
- HIPAA privacy policy and procedures
- Fiscal agent contact information for claim payments or denials
- 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 FSSA, 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 in its service areas and in the annual provider seminar.

An appropriate representative must be available to make formal presentations and respond to questions during the scheduled times. The FSSA 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 its *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 following:

- American Academy of Pediatrics (AAP)
- American Academy of Family Physicians (AAFP)
- American Society of Internal Medicine (ASIM)
- American College of Physicians (ACP)
- American College of Obstetrics and Gynecology (ACOG)
- U.S. Preventive Services Task Force
- American College of Surgeons
- National Cancer Institute (NCI)
- 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 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.

FSSA Recommendations for Access Audit Process Update outlines details of performing an access audit for the *Care Select* PMPs that ensures that the participating PMPs provide timely and appropriate access to health services for established and new patients within a PMP's practice.

> *Note: Additional evidence-based clinical practice guideline information is available on the National Guidelines Clearinghouse's Website.*

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

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 AAP. The AAP publishes a schedule of recommendations for screening components, frequency of 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, see *Section 6* in the *HealthWatch/EPSDT Provider Manual* on the *Manuals* page at indianamedicaid.com.

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

Prenatal and Pregnancy-Related Care

The FSSA has implemented pregnancy-related standards of care that are applied to all members in 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-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 *Chapter 8* of the *IHCP Provider Manual* found on the *Manuals* page at indianamedicaid.com.

Members who enroll with a CMO, voluntarily or by auto-assignment, in the third trimester of pregnancy must be given particular attention about continuity of prenatal care. *Care Select Services* in this manual 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
- Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)
- Asthma
- Diabetes
- Hypertension
- Sexually transmitted diseases
- Cholesterol screening
- Prevention of influenza
- Smoking prevention and cessation
- Immunizations
- Domestic violence

These standards, developed by the FSSA's QIC, were based on consultation with and recommendations from the following:

- IHCP physician providers
- Indiana medical community at large
- External Quality Review Organization (EQRO) and the Healthcare Effectiveness Data and Information Set (HEDIS)
- Federal Agency for Healthcare Research and Quality (AHRQ)
- 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 FSSA.

Reimbursement Overview

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

- *Care Select* continues to reimburse providers directly, based on the standard IHCP fee-for-service (FFS) schedule through the Indiana fiscal agent. For additional information on all requirements for *Care Select* claims processing, the CMO should reference *Chapter 8* of the *IHCP Provider Manual* found on the *Manuals* page at indianamedicaid.com.
- PMPs receive a monthly $6 case management fee for each *Care Select* member enrolled with the PMP, in addition to the FFS reimbursement.
- The PMPs are eligible to be reimbursed for the CMO care coordination conferences. The CMOs coordinate with *Care Select* PMPs to perform care coordination conferences to review a member's progress and care management plan.

Reimbursement for Primary Medical Providers

Providers who are providing services to *Care Select* members should continue to bill *Care Select* via the fiscal agent. Reimbursement for these services is based on the standard *Fee Schedule*.

The care management conferences are intended to be used to review the member's plan of care with the member's assigned PMP and care manager and to initiate any appropriate changes to that plan of care.

Reimbursement for the *Care Select* Care Coordination Conference service requires the service be performed by the member's assigned PMP, a physician assistant, or a nurse practitioner in the same group as the *Care Select* PMP. If a provider other than the member's assigned *Care Select* PMP, a physician assistant, or a 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 member is enrolled in Care Select. Care management service must be billed by the member's assigned Care Select PMP, physician assistant, or nurse practitioner in the same group as the Care Select PMP.*

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

Services must be billed using Current Procedural Terminology (CPT) code and modifier 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 his or her 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 a provider number, the service is billed using the PMP's provider number. 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 and does not have his or her own 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 enrolled with his or her own IHCP provider number, but with a provider number not associated with the *Care Select* PMP's group billing number, are 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.*

Providers should bill physician assistant services with the HN, bachelor's degree, or HO, master's degree, modifier applicable to the level of education of the physician assistant. Claims for *Care Select* Care Coordination Conference services that exceed the program limitation are 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

The fiscal agent processes 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 *Care Select*. ADVANTAGE Health Solutions[SM] – FFS is responsible for reviewing claims that suspend for medical policy-related audits for services rendered to members in FFS.

PMPs enrolled in the *Care Select* health plan, not receiving cost-based reimbursement (that is, not in a Federally Qualified Health Center [FQHC]), receive a $6 per member monthly administration fee. Reimbursement is sent automatically the Tuesday following the third Wednesday of each month. The administration fee is not a separate payment. The administration fee is included on the physician's Remittance Advice (RA) for all active members assigned to the PMP's member panel when the administration fee job runs for the month, along with other claims payment the provider may receive. The RA includes a reference line for the total amount paid for administrative fees.

Administrative management fees are not prorated for members who are effective with the PMP for only half the month. FQHCs and other providers receiving cost reimbursement do not receive the $6 case management fee.

The fiscal agent creates an administrative fee listing report for each PMP that is mailed to the PMP or group provider's mailing address. *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 paid to a PMP for a specific member due to noncompliance of the care management of a member. The FSSA, with the coordination of the CMOs, is creating business rules that 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. The CMOs can view, create, or modify only the current and historical information of their assigned members. The CMOs must assign users access to the *Admin Fee Stop Payment Maintenance* window, so they can perform the data entry. To assign users to the window, complete the *IndianaAIM Access Security Form* found on the *Care Select - Question and Answer* page at indianamedicaid.com. All users accessing Indiana*AIM* must complete the State's HIPAA training requirements.

After entering a stop-payment record for a member, the administration fee is discontinued for the PMP until the stop-payment record has expired. The administration fee listing records the member with a zero in the amount paid and includes 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 FSSA's fiscal agent using the appropriate claim-filing methodology when requesting reimbursement for medical services rendered to *Care Select* members. For specific detail, see *Chapter 8* of the *IHCP Provider Manual* found on the *Manuals* page at indianamedicaid.com.

Non-PMP Billing

Reimbursement for care provided to a *Care Select* member follows the same procedures whether the rendering provider is a resident, a midlevel practitioner, or another physician who is not the member's PMP. Providers rendering services to *Care Select* members are reimbursed under the existing *Fee Schedule*.

Providers of ancillary services should submit claims for reimbursement to the 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 the fiscal agent. Providers of these types of service must continue to complete and submit PA requests to the PA vendor for members in *Care Select*, as directed in the *IHCP Provider Manual, Chapter 6* found on the *Manuals* page at indianamedicaid.com.

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 copayments and any other patient liability payment, as authorized by law.

The *IHCP Provider Manual* on the *Manuals* page at indianamedicaid.com 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 the IHCP does not cover the service and accepts financial responsibility before receiving a service that is not covered by the program. The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that it is not covered by the program.

- The services provided are covered or noncovered embellishments or enhancements to covered services. These services can be considered and billed separately from the basic service only if a separate procedure code, revenue code, or National Drug Code (NDC) exists for the enhancement. Otherwise, a service in its entirety is considered covered or noncovered.
- 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 are subject to the same policy outlined previously for IHCP-enrolled providers. While the FSSA and the 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 FSSA discourages this practice. If a CMO elects to permit its contracted providers to bill members under any circumstance, the CMO must do all 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 before 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 health plan 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 member of the member's 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, 4, and 5.
   - 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 nonspecific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of noncovered 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 develops a pay-for-outcomes program that focuses on rewarding physicians' efforts to improve health outcomes for *Care Select* members.

Pay-for-outcomes programs are performance-based payment systems that offer financial and nonfinancial incentives to health plans, providers, and members for meeting quality performance targets. The CMO establishes a performance-based incentive system, at a minimum, for high-volume providers and for members. The FSSA defines high-volume providers as the top 10% of the CMO's contracted PMPs based on member enrollment. The FSSA identifies the priority areas to be addressed by the provider and member incentive system. These priority areas may change from time to time, and the FSSA determines these priority areas based on State and federal priorities, and with input from the CMO.

Disclosure of Physician Incentive Plan

The CMO may implement a physician incentive plan 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
- The CMO meets requirements for stop-loss protection, member survey, and disclosure requirements under *42 CFR 438.6*, to the extent that it applies

Federal regulations *42 CFR 438.6*, *42 CFR 422.208*, and *42 CFR 422.210* provide information regarding physician incentive plans, and the Center for Medicare & Medicaid Services (CMS) provides guidance on its website. The CMO complies with all federal regulations regarding the physician incentive plan and supplies to the FSSA information on its plan as required in the regulations and with sufficient detail to permit the FSSA to determine whether the incentive plan complies with the federal requirements. The CMO provides information concerning its physician incentive plan, on 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 should include the following:

- The CMO reports whether services not furnished by physician/group are covered by incentive plan
- The CMO reports type of incentive arrangement (for example, withhold)
- The CMO reports percent of withhold, if applicable
- The CMO reports panel size, and if patients are pooled, the approved method used
- If the physician/group is at substantial financial risk, the CMO reports proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss

Section 9: Member Eligibility and Enrollment

Overview

The eligibility process begins at the Family and Social Services Administration/Division of Family Resources (FSSA/DFR) Service Center or the member enrollment center. The FSSA/DFR Service Center uses the Indiana Client Eligibility System (ICES) to determine eligibility.

Potential members can enroll by any of the following methods:

- Contact the FSSA/DFR Service Center at 1-800-403-0864.
- Provide information at the enrollment center, which then submits documentation to the FSSA/DFR Service Center. A list of enrollment centers can be found at the FSSA website.
- Complete the application online or request a mail-in application from the FSSA website.
- For further enrollment instructions, potential members can call the *Care Select* helpline at 1-866-963-7383.

The DFR or the FSSA/DFR Service Center is also responsible for updating member eligibility and personal data for continuing members (such as changes in household, including births, deaths, and so forth) at periodic eligibility redeterminations. The data is entered into ICES.

The fiscal agent receives member eligibility updates daily through an interface between ICES and Indiana*AIM*. Member data in Indiana*AIM* is used to confirm eligibility for various Indiana Health Coverage Programs (IHCP) programs, including *Care Select*, during claims processing. Providers may view enrollee eligibility data through Indiana*AIM* using the Eligibility Verification System (EVS). A member does not appear as *eligible* for the IHCP in Indiana*AIM* until the fiscal agent receives the member's ICES record.

The enrollment broker enrolls potential members in *Care Select* care management by establishing a link between enrollees 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 the assignment of the member's aid category.

The State requires the care management organization (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.

Indiana Health Coverage Programs Enrollees Not Eligible for Care Select

There are some classifications 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*, including members with a psychiatric residential treatment facility (PRTF) level of care
- Members who receive IHCP hospice care
- Members receiving Home and Community-Based Waiver Services
- Medicaid for Employees with Disabilities (M.E.D. Works) participants
- Other members and potential members determined by the FSSA

Members in these subgroups 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 (ID) card. This card identifies IHCP members and provides current benefit information to their providers. New members are assigned a recipient identification number (RID) on initial entry in ICES. The RID is unique to each member and is a randomly generated ID number assigned for life. The fiscal agent produces and mails ID cards to new members within three days of eligibility 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 systematically, as necessary, to reflect changes in eligibility status. The ID 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 the enrollment service center or the local county office of the DFR or call the *Care Select* helpline at 1-866-963-7383.

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

- Member's name and gender
- A 12-digit RID 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 ID card.

Even when a member presents a Hoosier Health Card, the provider is responsible for verifying eligibility before rendering services. Additional information about eligibility verification can be found later in this section. *Chapter 2*: Member Eligibility and Benefit Coverage of the *IHCP Provider Manual* found on the *Manuals* page at indianamedicaid.com provides detailed information about the Hoosier Health Card.

> *Note: Possession of a Hoosier Health Card does not guarantee current eligibility. Before rendering services, providers must verify eligibility each time they see IHCP members.*

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 multiple active RIDs must contact the FSSA Service Center at 1-800-403-0864 with the information.

CMOs may present and distribute their own health plan ID cards for *Care Select* members enrolled in their health plans. However, CMOs may **not** require *Care Select* members to produce a health plan card to receive services within the health plan. 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 is eligible for Hoosier Healthwise, and therefore is automatically assigned to a managed care entity (MCE) in risk-based managed care (RBMC). Typically, the newborn's effective date with the MCE is prospective because the mother-to-be belonged to a CMO versus an MCE at the time of birth. However, newborns are assigned retroactive to the date of birth (DOB) if the mother was enrolled in a CMO at the time of the newborn's birth, and there is an appropriate PMP available in the health plan.

Potential table IHCP members who qualify for *Care Select* but who are not enrolled are placed on the potential table in Indiana*AIM*. The enrollment broker uses this information for outreach to potential members. The following are the criteria for a potential record indicating outreach is required by the enrollment broker. A potential record that requires outreach contains a reason code of "5."

- The member must be newly eligible for *Care Select*. Eligibility requirements follow. "Newly eligible" includes members who had a break in eligibility of more than 365 days.
- The member must not have an open opt-out record on file. Opt-out records over 24 months in duration are end dated to trigger additional outreach, if still eligible.

Care Select Enrollment

Once each quarter, Medicaid members who are identified as being eligible for the *Care Select* are passively enrolled into the program. The State's enrollment broker enrolls the member by assigning them to a primary medical provider (PMP). The PMP assignment takes into account the member's physical and behavioral health needs and physician expertise, not merely geography.

Twice a month, the CMO receives a member enrollment roster from the State's fiscal agent. The CMO accepts all members as enrolled, including all individuals appearing on the enrollment rosters or enrollees for whom the CMO receives care management payment. The CMO is responsible for reconciling the member enrollment roster and the care management payment file. If a CMO receives enrollment information or a care management payment for a member, the CMO is responsible for the care management of that member.

The CMO does not discriminate against individuals eligible to enroll on the basis of health status or need for healthcare services, race, color, or national origin, and does not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

Using the member enrollment roster provided by the fiscal agent, the State's enrollment broker contacts new members within 10 business days of receiving the member enrollment roster by sending welcome packets including the following information:

- The member is now enrolled in *Care Select.*
- The CMO is there to better manage and coordinate the physical and behavioral healthcare of the member.
- The member is eligible to participate in one of CMO's disease management programs and may be appropriate for care management or complex case management; but *Care Select* is an "optional" program and the member may opt out.
- The member should use the CMO's member services helpline as the first resource for questions or concerns about *Care Select*, PMP issues, benefits, CMO policies, and so forth.
- The availability of a nurse care hotline or other additional services offered by the CMO.

Welcome packets are available in English and Spanish at a minimum; the FSSA may designate additional languages with reasonable notice. The FSSA approves all material in welcome packets before use.

Following the distribution of the welcome packet, the CMO contacts each member within 30 days to conduct the initial screening and risk assessment, and to assist members with selecting a PMP, if the member has not yet contacted the CMO to select one. If a member has been auto-assigned a PMP, the CMO reviews that assignment to be sure that the PMP selection meets the member's needs.

During initial outreach efforts, the CMO and the State's enrollment broker educate members about the benefits of primary and preventive care, and the importance of choosing a PMP and establishing the PMP and member relationship. The CMO also facilitates the initial enrollment process by educating members about:

- The usefulness of primary and preventive care.
- PMPs and other providers available within a 30-mile radius of the member's residence.
- The importance of choosing a PMP and having a medical home.
- The appropriate use of the emergency room.

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 health plan 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*, which contains the PMP's name, address, telephone number, and the CMO health plan, and telephone number and 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 DOB is included later in this section.

Medicaid Physician Referral

Effective July 1, 2011, Medicaid physicians are able to refer Traditional Medicaid members who have qualifying disease states to the *Care Select* program by providing the disease state information to the enrollment broker. The enrollment broker can immediately enroll a member with a PMP once diseases have been entered, the member has consented, and the member is in a qualifying aid category.

Medicaid physicians can fax the *Provider Referral Form* to the enrollment broker at (317) 238-3120. See *Appendix A: Sample Written Referral Form* of this manual for more information.

Members with Third-Party Liability

Medicaid is intended to be the insurer of last resort for any past, present, or future member. To that end, if a current member of a Medicaid program (including *Care Select)* is also enrolled with a private insurer, the private insurance should be used first. If the private insurance ends or if the resources are exhausted, the Medicaid program should take over.

Care Select requires a PMP link for each member. If a member has private insurance and his or her current PMP is not enrolled in *Care Select*, the PMP should be encouraged to enroll the member in *Care Select*. If that PMP decides not to participate, the member must select another PMP currently enrolled in *Care Select*. The *Care Select*-enrolled PMP could provide a referral to the PMP covered by the private insurance or any other referral provider.

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. 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 regional requirements:

- Auto-assignments do not occur when a PMP's service location is greater than 30 miles from the member's address. Only self-selections are allowed to override the 30-mile geographic limits.
- Auto-assignments occur outside the member's region, if within the 30-mile geographic limit.
- 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 receive only self-selections. FSSA 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:
  - Chicago, Illinois
  - Danville, Illinois
  - Watseka, Illinois
  - Louisville, Kentucky
  - Owensboro, Kentucky
  - Sturgis, Michigan
  - Cincinnati, Ohio
  - Hamilton, Ohio
  - Harrison, Ohio
  - Oxford, Ohio

Auto-assignment is designed to consider several factors in linking members 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 on the *Care Select - Question and Answer* page at indianamedicaid.com.

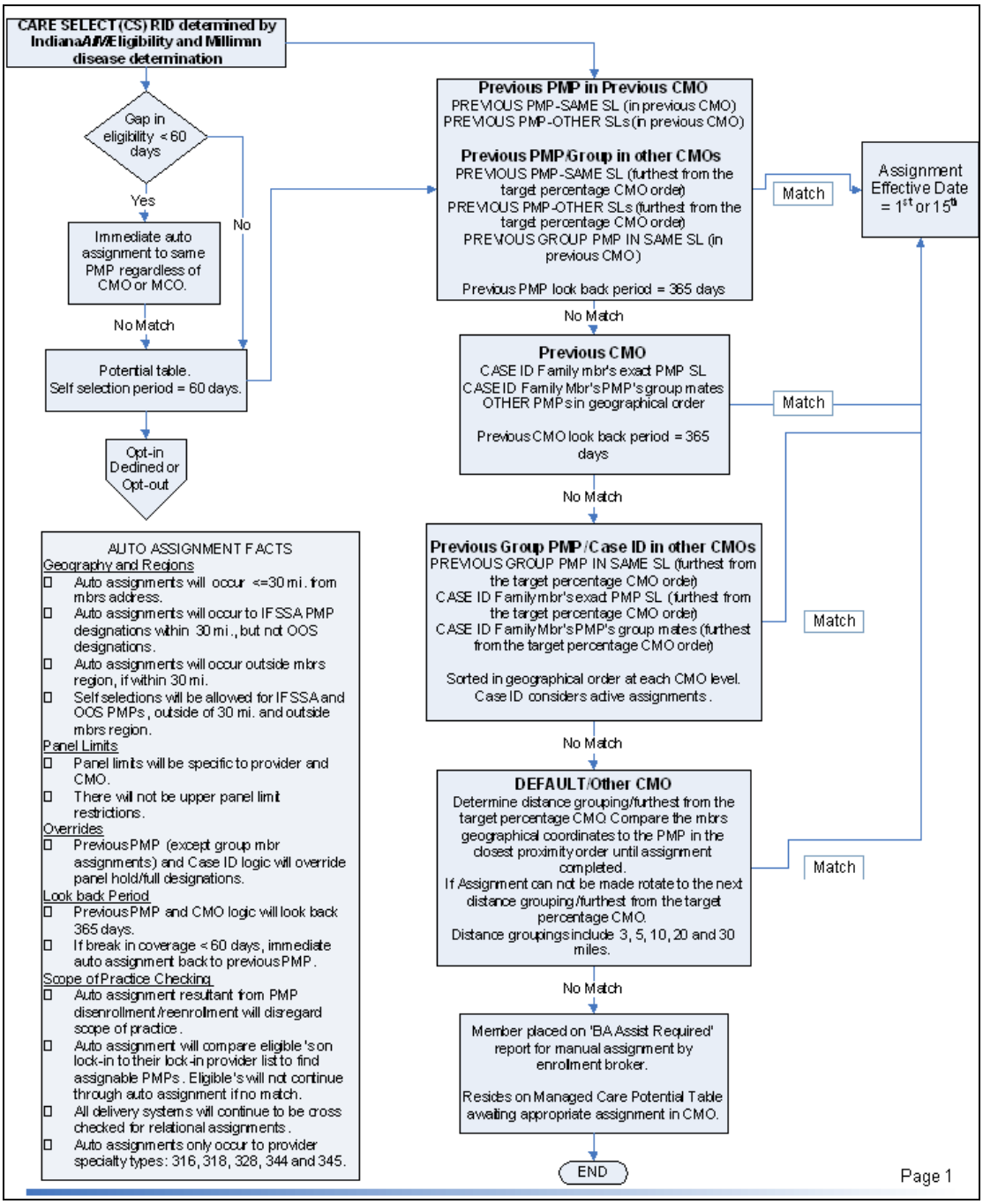


Figure 9. 2 – Auto-Assignment Process

General Auto-Assignment

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 *Care Select*, the reassignment of members to their previous PMPs takes precedence over other auto-assignment logic in Indiana*AIM*. The previous PMP auto-assignment logic considers the following when making an assignment:

   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, the assignment is made.
   2. *Previous PMP with Other Service Locations* – If the member's previous PMP is found at a different service location, the assignment is made.

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

   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, the assignment is made.
   2. *Previous PMP with Other Service Locations* – If the member's previous PMP is found at a different service location, 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, the assignment is made. If a PMP is not found in the previous CMO, the next CMO is reviewed.

c. *Previous CMO/Previous Health Plan* – If there is not a previous PMP relationship, the auto-assignment logic looks for a previous relationship with a CMO. The auto-assignment logic attempts to assign the member to an appropriate PMP in the health plan by geographical order at each hierarchical level for a look-back 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, 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, the assignment is made.
   3. *Previous health plan* – If a PMP is found based on geographical order in the previous health plan, the assignment is made.
   4. *Other PMP* – If other PMPs are found based on geographical order, the assignment is made.

d. *Previous Group PMP/Case ID in Other Plans* – If there is not a previous CMO relationship, the auto-assignment logic looks in the CMO furthest from the target percentage for the case ID that identifies PMPs for family members with the same case ID. The previous PMP auto-assignment logic considers the following when making an assignment determination:

   1. *Previous Group PMPs in the Same Service Location* – If a PMP in previous group in the same service location is found, the assignment is made.
   2. *Case ID – Family member's exact PMP Service Location* – If the family member's PMP is found at the same service location, the assignment is made.
   3. *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, the assignment is made.

e. *Default* – If previous PMP, CMO, and Case ID auto-assignment logic attempts fail to make an appropriate PMP assignment, the default level of the auto-assignment logic is set to determine distance groupings and in the CMO precedence order (furthest from the target percentage). The logic compares the member's geographical coordinates to PMPs in the closest proximity order until an assignment can be completed. If assignment cannot be made, the logic rotates to the next distance grouping and CMO. Distance groupings include three, five, 10, 20, and 30 miles. If no match is available in the CMO, the logic continues to the next CMO. When the auto-assignment logic has searched all available distance groupings and CMOs and has not found an appropriate PMP match, the member's name appears on the potential table for manual PMP assignment by the enrollment broker. 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 CMO.

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 1st and the 10th of the month, the PMP assignment start date is the 15th of the current month. If the day that the auto-assignment is processed falls between the 11th and the 25th, 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, the PMP assignment start date is the 15th of the next month.

Following are the auto-assignment nuances:

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 is immediately subjected to auto-assignment. If the gap in coverage is greater than four months, the member is provided 30 days to self-select a PMP/CMO.
   - 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 a CMO or service location and has an active service location in the same or different CMO, 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, preselection is allowed.

- Newborns are assigned retroactive to the DOB only in the instance where the mother was enrolled in a 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 the 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 the 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.
6. *Geography and Regions*
   - *Care Select* auto-assignment occurs outside the members' regions if within 30 miles.
7. *Z Stop*
   - A Z stop is an action performed by the enrollment broker to prevent a member from being auto-assigned.
8. *Opt-out*
   - Members can opt out of *Care Select* any time by contacting the enrollment broker.
9. *Opt-in Declined*
   - Members never enrolled in *Care Select* can elect not to participate when contacted by the enrollment broker.

Figure 9.3 is the opt-out and opt-in declined process flow.

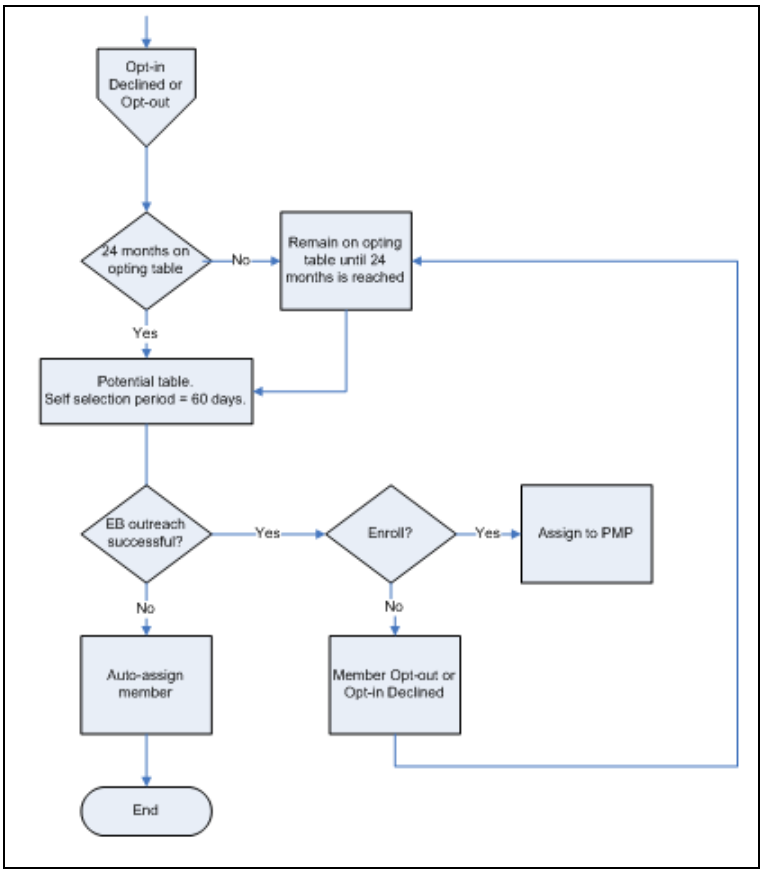


Figure 9. 3 – Opt-out and opt-in declined process flow

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 noncare management aid category maintain the PMP relationship.

Members who have had a gap in care management eligibility of less than 60 days are automatically assigned back to their previous PMP. Members with a gap in eligibility greater than or equal to 60 days are processed as new members for auto-assignment purposes – that is, they are given 60 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 previously.

Member Rights

The CMO has written policies regarding the members' rights specified in this section, including:

- Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

- Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Each member is guaranteed the right to participate in decisions regarding his or her healthcare, including the right to refuse treatment.
- Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in *45 CFR Part 164*.
- Each member is free to exercise his or her rights, and the exercise of those rights will not adversely affect the way the CMO and its representatives or the FSSA treat the member.

Member Request to Change Primary Medical Provider

If a member wishes to change PMPs and override the auto-assignment selection, a change may be made within 90 days of assignment or annually at open enrollment. Members may request a PMP change at any time for just cause. The enrollment broker tracks reasons for requesting a PMP change. Examples are:

- Access to care
  - The member moved out of the area.
  - The PMP's office is not accessible on public transportation, or an IHCP-reimbursable transportation provider is not available in the service area.
  - The member waits in the office for one hour or more for a scheduled appointment on two occasions.
  - The member experiences excessive delay between the request for an appointment and the scheduled appointment.
  - The member experiences difficulty contacting the PMP for care after normal business hours.
- Continuity of care
  - The 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 *Care Select*.
  - The member is in the late stages of pregnancy and wishes to continue care with the current doctor through the pregnancy.
- Quality of care or service
  - The member expresses dissatisfaction with treatment from the doctor or staff.
  - The member requires specialty services because of language, cultural, or other communication barriers with his or her current PMP.
  - Ongoing, unresolved provider or member conflict exists.
  - The member no longer fits into the provider's scope of practice.
- The 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 *Care Select* is to encourage a positive and continuous relationship between a member and PMP. In rare instances, a PMP may request reassignment of a member to another PMP within the CMO's health plan. 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 that the CMO's guidelines and policies are consistent with *Care Select* and to improve the overall program quality.

The following, developed and finalized by the *Care Select* Quality Improvement Center (QIC), provides guidelines for the situations outlined previously:

- *Missed appointments* – A member may miss at least three scheduled appointments without defensible reasons before a PMP requests 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, which is accessible to the PMP and staff. On documentation of the third missed appointment for no defensible reasons, the CMO may approve the PMP's request for the member's reassignment within the CMO health plan.

  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 *Care Select.*
- *Member fraud* – Member reassignment due to member fraud must be restricted to 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 that 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 health plan 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 (ER) 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 relinked 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 health plan 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 include the following:

- *For good cause* – This term is used for member-initiated PMP change requests.
- *Noncompliances 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 previously.
- *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 before Care Select enrollment* – PMPs may not initiate member transfer requests because of unpaid medical bills incurred before *Care Select* enrollment. PMPs can pursue charges outstanding before *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 IHCP and *Care Select*:

- The member was enrolled in error or due to a data entry error.
- The member loses eligibility in the IHCP.
- The member no longer has a qualifying disease as reported by the Optum quarterly disease file upload.
- The member no longer wishes to participate in *Care Select.*

A CMO enrollee may disenroll from a CMO while retaining eligibility in *Care Select*. 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 FSSA due to circumstances, which, in the judgment of the FSSA, 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 FSSA has ultimate authority for allowing eligible members to disenroll from the program.

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

- Member fraud or abuse.
- Persistent uncooperative or disruptive behavior from the member or the member's family.
- Member accessing care from providers other than the selected or assigned PMP.
- Member insists on medically unnecessary medications.
- Member determined to be ineligible for care management under the terms of the state of Indiana 1915(b) waiver.
- Change in aid category causes the enrolled member to become ineligible for care management.
- Member no longer has a qualifying disease, as reported by the Milliman quarterly disease file upload.
- Residency change causes an enrolled member to become ineligible for care management. *Care Select* members who have out-of-state addresses are systematically identified and disenrolled by the fiscal agent. 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 and Resident Review (IPAS/PASRR) processes. *Care Select* members who are in a long-term care (LTC) facility for more than 60 days

can be disenrolled from the program. After a member has met IPAS/PASRR criteria, the appropriate level of care (LOC) 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 program is financially responsible for all long-term care charges, excluding ancillary services, if the member meets the criteria for long-term LOC. CMOs must monitor the care of members who are potential candidates for long-term care, so the CMOs can help facilitate disenrollment from care management. The CMO must work with the facility to ensure that the LOC process is completed (for example, submits 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 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 that the appropriate LOC can be entered in Indiana*AIM*. The hospice analyst at ADVANTAGE Health Solutions [SM], Inc. 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 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 *Care Select*.
- 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 because of a documented reason or circumstance, the member can be disenrolled from *Care Select* and placed in the IHCP FFS program. This action must be approved by the FSSA on a case-by-case basis.
- 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 FSSA.

The CMO submits the disenrollment request to the FSSA after providing to the member at least one verbal and at least one written warning of the full implications of the member's actions. The CMO may not request disenrollment of a member because of:

- An adverse change in the member's health status
- The member's utilization of medical services
- Diminished mental capacity
- Uncooperative or disruptive behavior resulting from the member's special needs (except when the member's continued enrollment in the *Care Select* seriously impairs the entity's ability to furnish services to this particular enrollee or other enrollees).

To be voluntarily disenrolled, the member (or his or her representative) submits an oral or written disenrollment request to the FSSA. The FSSA has the ultimate authority for allowing eligible members to disenroll from the program. The FSSA discourages members from disenrolling and switching programs frequently. In accordance with *42 CFR 438.56(d)(3)*, the disenrollment automatically is considered approved within the time frame stated in the federal regulation.

Restricting Disenrollment

Federal regulation *42 CFR 438.56* allows Medicaid programs the option of CMO lock-in periods up to 12 months. Members are encouraged to stay with the PMP to establish a relationship, but they may change PMPs or health plans at any time for a just cause reason.

Other requirements apply as follows:

- Members must be allowed to change CMOs without cause at any time within the first 90 days of enrollment.
- Members must be notified at least 60 days before the end of the enrollment year of their opportunity to change CMOs at 12 months.

Member Enrollment Rosters

On behalf of the FSSA, the fiscal agent 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 auto-assignment, the fiscal agent generates HIPAA 834 CMO benefit enrollment and maintenance transactions, also known as the enrollment roster, three times a month. See the *834 MCE Benefit Enrollment and Maintenance Transaction Companion Guide*, which is available on the *Companion Guide* page at indianamedicaid.com, 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 near the end of each month listing all 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 834 change files:

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

In addition to the eligibility status and demographic information, the CMO member enrollment roster includes auto-assignment. The auto-assignment indicator is used to identify members who were auto-assigned regardless of the auto-assignment reason (previous PMP, case ID, default). 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 member's benefit package is also included on the *834 MCE Benefit Enrollment and Maintenance Transaction Companion Guide*, which is available on the *Companion Guide* page at indianamedicaid.com.

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 are 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 Indiana*AIM* from the 26th day of the month through the 10th day of the following month are processed on the 11th and are 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.

Electronic Transmission of the Care Management Organization Member Disease File

Each CMO receives an extract that contains member information (RID and name), disease state, and disease state origin. This extract is delivered on the same schedule as the 834 transaction file. Up to 10 possible diseases can be reported for each member. Disease state origin indicates whether Optum determined the disease state or the PMP has reported to the enrollment broker a disease that qualifies the member for *Care Select*.

Electronic Transmission of the Care Management Organization 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 of the 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.

Electronic Transmission of the Dual Special Needs Program Eligible Members

Dual Eligible Special Needs Plans (D-SNPs) enroll beneficiaries who are entitled to Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

The fiscal agent provides an outbound extract of D-SNP eligible members, as well as an error file. These files are compressed into a single zip file and posted to File Exchange to the CMOs monthly on the fifth business day. All files are pipe delimited.

Primary Medical Provider Enrollment Rosters

PMP member enrollment rosters are printed the 11th and 26th of every month and mailed to the PMP's *pay to* address. The roster includes any new, continuing, or terminated panel members by CMO ID linked to each PMP's individual or group PMP affiliation. The new enrollee column includes new and redetermined members. The redetermined members are identified by their start dates. The start date for redetermined members is the first date the member was assigned to that PMP with new members having more recent dates. Groups receive rosters under their group names and provider numbers. The roster is sorted by the provider number of participating PMPs.

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 help provide 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 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 before 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 of 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. CMOs must use the form (*State Form 44151*) to report changes to the DFR. The CMO must complete only the name of the 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.

The contact information for the FSSA/DFR Service Center follows:

FSSA/DFR Service Center
P.O. Box 1810
Marion, IN 46952
Call Center Telephone Number and Fax Number: 1-800-403-0864

The CMO notifies the DFR or call center 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
- Date of death

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

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 East 30th Street

Indianapolis, IN 46219

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

Eligibility Verification

Enrollment transactions reflect a member's status in Indiana*AIM* as of the day the roster was produced. As explained previously in this section, ICES eligibility is updated daily in Indiana*AIM*. 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. The EVS provides an inquiry verification number that must be recorded if it is required for subsequent transactions. CMOs must assume all telecommunication and hardware costs associated with this system.

Options for Eligibility Verification

The EVS consists of two real-time, interactive options:

- Automated Voice Response (AVR) System
- Web interChange

Effective April 1, 2014, the Omni 380 terminals are no longer supported as an option for verifying member eligibility in the Indiana Medicaid program.

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

Section 10: Network Development, Services, and Data

Overview

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 care management organization's (CMO's) provider network is critical.

The CMO must ensure that its provider network is available, is geographically accessible, and provides adequate numbers of primary medical providers (PMPs) to provide high-quality covered services for its members, in accordance with *42 CFR 438.206*. The CMO must also ensure that all its contracted providers are Indiana Health Coverage Programs (IHCP) providers and can respond to the cultural, racial, and linguistic needs of the *Care Select* population. The network must be able to handle the unique needs of *Care Select* members, particularly those with special healthcare needs.

The Family and Social Services Administration (FSSA) regularly and routinely monitors network access, availability, and adequacy. Failure to demonstrate a complete and comprehensive network before the contract effective date may result in a delay of initial member enrollment. Failure to meet the PMP, specialist, and ancillary provider network standards may result in corrective action plans and liquidated damages, as determined by the FSSA. The FSSA monitors the CMO's PMP provider network to confirm that the CMO is maintaining the required level of access to care. The FSSA 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 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 do not receive members through the auto-assignment process. Specialist PMPs receive members only if the member actively chooses that physician as a PMP.

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

The *Care Select* network consists of PMP providers directly contracted or subcontracted with the CMO. The CMO must provide new members with a network directory at enrollment and on request. The directory must include PMPs. The directory must also include providers' names, addresses or geographic locations, telephone numbers, office hours, description of office accessibility, spoken languages, and physician types, including certification and scope of practice. The network directory must be updated monthly, or as needed, using addenda or reprints.

Physician Extenders

According to *IC 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:

- Educating providers about the benefits of physician extenders
- Educating providers about reimbursement policies for physician extenders
- Offering financial or nonfinancial incentives to providers who increase their use of physician extenders to increase access

Specialist and Ancillary Provider Network Requirements

In addition to maintaining a network of PMPs, the CMOs shall ensure that its provider network is available and geographically accessible and provides adequate numbers of facilities, physicians, specialists, 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 ensures that all of its providers are IHCP providers and can respond to the cultural, racial, and linguistic needs of the *Care Select* population.

The network must be able to handle the unique needs of *Care Select* members particularly those with special healthcare needs.

The CMOs ensure that specialists are maintaining the medical care standards and practice guidelines detailed in the *IHCP Provider Manual*. The FSSA requires the CMOs to monitor medical care standards to evaluate access to care and quality of services provided to enrollees and to evaluate providers regarding their practice patterns. The FSSA requires the CMOs to develop and maintain a comprehensive network of specialty providers. However, the CMO network shall include, at a minimum:

- Two specialty providers of each following provider type who have locations of service within 60 miles of each member's residence; or
- A combination of two specialty providers for each following type in any one of the following combinations:
  - One of each type of specialty provider with a service location in each county, and
  - One of each type of specialty provider with a service location in a contiguous county, or
  - One of each type of specialty provider with a service location within 60 miles from the member's residence ZIP Code

For the purposes of its initial network development, the CMO demonstrates its specialty providers' service locations are within 60 miles of each member's residence.

The CMOs must include a minimum of two specialists of each the following within the access standards described previously:

- Physician specialties
  - Cardiologists
  - Orthopedic surgeons
  - Physiatrists
  - Psychiatrists
  - Urologists
  - Nephrologists
  - Ophthalmologists
- Ancillary providers
  - Durable medical equipment providers
  - Home health providers
  - Transportation providers
  - Skilled nursing facilities

Due to the nature of the services some ancillary providers render, the FSSA requires the CMOs to maintain different network access standards for the following listed ancillary providers:

- Two durable medical equipment providers shall be available to provide services to the CMO's members.
- Two home health providers shall be available to provide services to the CMO's members.
- In addition, the CMOs shall include providers who have training, expertise, and experience in providing smoking cessation services.
- The CMOs coordinate with the Indiana Hemophilia and Thrombosis Center or a similar FSSA-approved, federally recognized treatment center. This requirement is based on the findings of the Centers for Disease Control and Prevention (CDC), which illustrate that persons affected by a bleeding disorder receiving treatment from a federally recognized treatment center require fewer hospitalizations, experience fewer bleeding episodes, and experience a 40% reduction in morbidity and mortality.

Regional Network Development

On 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 FSSA or its contractor conducts a readiness review of the provider network before 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
- The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific IHCP populations enrolled in *Care Select*
- 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 PMPs accepting newly enrolled members
- Detailed process for credentialing and recredentialing providers to ensure that quality care is maintained

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 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 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.

Care Management Organization Responsibilities for Primary Medical Provider Requirements

When a physician elects to participate in *Care Select*, he or she may contract as a PMP with one or more CMOs.

The CMO must ensure that each member has a PMP who is responsible for providing ongoing primary care appropriate to the member's needs. PMPs must coordinate each member's care. The FSSA requires CMOs to provide access to PMPs within at least 30 miles of the member's residence or 60 miles for members in rural areas.

The CMO's PMP contract, or addendum, 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 FSSA 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. PMPs must have mechanisms in place to ensure that members are able to make direct contact with their PMPs, or with PMPs' qualified clinical staff, through a telephone number 24 hours a day, seven days a week. *After Hours and 24-Hour Availability Audit Quality Improvement* outlines the audit process to determine if there is appropriate and easy access to the PMP outside regular business hours.

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 provides *live voice* coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The 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 *Chapter 4* of the *IHCP Provider Manual* found on the *Manuals* page at indianamedicaid.com. The FSSA 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 provides the FSSA and all members with the following information about its network providers, or otherwise uses the IHCP Provider Directory and assists members in locating appropriate providers:

- Lists of PMPs, the PMPs' service locations (including county), telephone numbers, office hours, type of PMP (for example, family practice, general practitioners, general internists, obstetricians and gynecologists, and cardiologists) and whether the PMPs are accepting new members
- Lists of specialty providers (including behavioral health providers and community mental health centers), their service locations (including county), telephone numbers, office hours, and type of specialty
- Lists of hospital providers, pharmacies, home care providers, and all other network providers
- Languages spoken by the provider or the provider's office personnel
- Provider accessibility information (for example, access information related to parking, building walkway/access, examining tables, restrooms, reception/ waiting areas, and so forth)

The CMO includes provider network information in an FSSA-approved format on its member website. The CMO lists provider network information by county on the CMO's website and updates the information monthly. Network provider information is available to print from a remote user location.

Section 11: Prior Authorization

Overview

Prior authorization (PA) is a mechanism to determine the medical necessity of selected nonemergency, Medicaid-covered medical services before delivery (and retroactively in special cases). Providers submit requests for PA to perform specified services.

ADVANTAGE Health Solutions[SM] is responsible for processing PA requests and updates for all *Care Select* and Traditional Medicaid fee-for-service (FFS) members. Catamaran Corporation is the pharmacy PA contractor. For pharmacy PA information, contact Catamaran's Clinical/Technical Help Desk at 1-855-577-6317.

Providers are responsible for submitting their PA request to the PA vendor. The policy and PA examples can be found in the *Care Select CMO Policy and Procedure Manual* on the State's SharePoint site.

The responsibility for processing and completing a PA request is determined by the member's enrollment status on the date the PA request is received by the PA vendor. If a PA request deviates from this policy, the PA request is rejected and the PA vendor must submit a letter to the provider through Indiana*AIM* as notification of the rejection. This policy applies to retroactive PAs; normal PA requests; and home health, hospice, and other PAs, as necessary.

In addition, this policy is applicable for certain PAs for the Hoosier Healthwise population, specifically for services carved out of Hoosier Healthwise and for services rendered during retro-eligibility coverage for those members. If a member is FFS on the dates of service, but is enrolled with Hoosier Healthwise at the time ADVANTAGE receives the retroactive PA, or if the PA is for a carved-out service, ADVANTAGE (FFS) is responsible for processing and completing the PA request.

Note: Additional information must be submitted to the PA vendor.

If a provider has received PA from a Hoosier Healthwise managed care entity (MCE), a copy of the MCE's written authorization must be submitted to the PA vendor. Authorizations are valid for 30 days from the date of eligibility in *Care Select* or for the remainder of the PA dates of service, whichever comes first. Providers are encouraged to fax PA requests to the PA vendor for efficient PA processing.

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 an Indiana Health Coverage Programs (IHCP) PA request via telephone (depending on the service), Web interChange, fax, or in writing. More information about PA requests follows.

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 is available via *Web interChange* at indianamedicaid.com.

278 Electronic Transaction

The 278 transaction provides standard data requirements and content for all users who request and respond to authorization or certification requests. The 278 transaction supports the following information:

- Submission of initial electronic requests
- Submission of updated or revised electronic requests
- Submission of paper attachments for electronic requests
- Submission of retroactive submission of electronic requests
- Submission of out-of-state electronic requests
- Submission of electronic administrative reviews
- Response with approval
- Response with modified approval
- Response with denial of a previous request
- Response with follow-up action code
- Response with action code

Health Insurance Portability and Accountability Act (HIPAA) legislation mandates that many of the major healthcare electronic data exchanges, such as electronic submission of PA requests and the electronic response, are standardized national formats for all payers, providers, and clearinghouses. All providers that submit affected data electronically to the IHCP must use the mandated HIPAA formats. HIPAA specifically names several electronic standards that must be followed when certain healthcare information is exchanged. These standards are published as *National Electronic Data Interchange*

(EDI) Transaction Set Implementation Guides – commonly called Implementation Guides (IGs). An addendum to each IG was also published and must be used with the IG to properly implement each transaction.

The IHCP has developed technical companion guides to help users understand the IHCP requirements for each new electronic transaction and to assist during the implementation process. In most cases, the existing data exchange format has changed, such as electronic claim submission. In other cases, a new transaction is available, such as the PA request and response transaction. The information in the IHCP companion guide is intended only to supplement the adopted IGs and provide guidance and clarification as the information applies to the IHCP. The IHCP companion guide is never intended to modify, contradict, or reinterpret the rules established by the IGs.

Providers must obtain a copy of the IHCP companion guide for the 278 transaction if submitting electronic PA requests. The companion guide provides detailed information about the 278 submission and response requirements for IHCP nonpharmacy services. A copy of the IHCP *Companion Guide: 278 Prior Authorization Review Request and Response Transaction* is available for download from the EDI Solutions section on indianamedicaid.com.

All healthcare organizations exchanging HIPAA transaction data electronically with the IHCP are required to establish an EDI relationship. Entities with this EDI relationship are referred to as trading partners. The IHCP has prepared information to help entities become IHCP trading partners. Trading partner information is available on the EDI Solutions page on indianamedicaid.com. In addition, providers wanting to submit electronic PA requests must follow the testing requirements as outlined by the IHCP. Providers may also contact the Electronic Solutions Help Desk by email at INXIXtradingpartner@hp.com or by telephone at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182.

Chapter 6 of the *IHCP Provider Manual* found on the *Manuals* page at indianamedicaid.com provides further details of the 278 transaction.

Telephone PA Requests

Telephone PA requests do not require request forms 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 by which the request was received. Once reviewed, the contractor staff updates Indiana*AIM*, which produces a Notification of Approval, Modification, or Denial (the provider receives this information verbally if the request is made by telephone), and the requesting provider receives a system-generated *Indiana Health Coverage Programs Prior Authorization Request Form* indicating the approval status of his or her request. If the approval is "other than approved," the form is accompanied by an explanation of the decision and a description of the provider's administrative review and/or appeal rights. Members also receive notice of the decision and a description of appeal rights. Spanish appeal rights are available by member request through the fiscal agent Customer Assistance Unit and via indianamedicaid.com in the Prior Authorization section. The member appeal form is also available on the *Forms* page at indianamedicaid.com.

A detailed flowchart of the PA letter process, example PA decision letters, appeal rights letter, and appeal form can also be found on the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion.*

Notification of approval or denial is given when the telephone call is made for the following services:

- Inpatient hospital admission and concurrent review, when required under this rule
- Continuation of emergency treatment for conditions listed in *Section 13* of this rule on an inpatient basis. The request was originally without PA and subject to retrospective medical necessity review.

Prior authorization may be obtained by telephone, provided a properly completed PA request form is subsequently submitted for the following services:

- Medically reasonable and necessary services or supplies to facilitate discharge from or prevent admission to a general hospital
- Equipment repairs necessary for life support or safe mobility of the patient
- Services when delay in beginning the services could reasonably be expected to result in a serious deterioration of the patient's medical condition

For ongoing conditions, a provider may request an update (for example, extension of service, change of member 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

The *Indiana Health Coverage Programs Prior Authorization Request* form, *Prior Review and Authorization Dental Request* form, and the *Prior Authorization-System Update Request* form are located on indianamedicaid.com. The forms include a member information section that allows a provider to select the program to which the member is assigned based on the information provided by the eligibility verification system. A field located in the requesting provider area is available 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. If you fail to complete this field and you do not have a service location, your PA decision letter will not be produced and sent. A provider ID and service location in the requesting and mailing provider ID and service location fields enables the mailing provider ID information to be selected as the mailing address for the PA decision letter.

The fiscal agent has established a link in the contents website of indianamedicaid.com for providers to easily access the PA vendor contact information. It is important for providers to know that this information is always retrieved from real-time data available in Indiana*AIM*. Therefore, this information may be more current than information available in the *IHCP Quick Reference Guide*.

Prior Authorization Number Format

Modifications have been made to all Eligibility Verification System (EVS) options, as well as to Web interChange, to accommodate the alphanumeric PA number.

Prior Authorization Process

The review of PAs remains consistent to serve as a utilization management measure, allowing payment only for treatments and services that are medically necessary, appropriate, and cost-effective. *Care Select* emulates the PA requirements established for the Traditional Medicaid FFS population.

PA requests must be submitted to the PA vendor. PA updates that are submitted for review must also be submitted to the PA vendor.

> *Note: If the required documentation is not received in a timely manner, the PA is modified to reflect the date of receipt of the documentation.*

Rejected Prior Authorization Requests

If a provider submits a paper or faxed PA request to the incorrect organization, the provider receives a PA decision letter informing him or her of the rejected status of the PA request. For PA requests submitted via the 278 transaction PA Request and Response to the incorrect CMO, the PA request is rejected, regardless of the certification type, with reason code *78 – Subscriber/Insured not in Group/Plan identified*, and a PA decision form is not generated. When providers receive notification that a submitted PA request has been rejected, a new PA or PA update request must be submitted to the PA vendor, ADVANTAGE Health Solutions.

Suspension of Prior Authorization Requests for 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 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. If a PA is in the suspend status and the member is re-assigned between *Care Select* and the Traditional Medicaid FFS program, the supplemental documentation that has been submitted for review is forwarded to the PA vendor for review and approval.

Additional information submitted by the provider must be sent to the PA vendor, ADVANTAGE Health Solutions.

Outstanding Prior Authorizations

If a member changes programs between Traditional Medicaid FFS, *Care Select*, and Hoosier Healthwise, or between Hoosier Healthwise and *Care Select* plans, all existing PAs are honored for 30 days. This requirement applies only if the member is re-assigned between Hoosier Healthwise and *Care Select* or the Traditional Medicaid FFS program. PAs that are approved by the PA vendor are available in Indiana*AIM* for claims processing by the fiscal agent. 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.

If the provider received PA from a Hoosier Healthwise MCE, a copy of the MCE's written authorization must be submitted to the PA vendor. Authorizations are valid for 30 days from the date of eligibility in *Care Select* or for the remainder of the PA dates of service, whichever comes first. Providers are encouraged to fax PA requests to the PA vendor.

Prior Authorization Modifications

The modification of a PA request is defined as the following: "*A PA request that has been changed after the initial receipt of the request*." If a new service is being requested, a new PA must be submitted. A new PA request is defined as the following: "*An initial provider-submitted request for PA to perform specified services and a mechanism to determine the medical necessity of selected nonemergency, Medicaid-covered, medical services prior to delivery (and retroactively in special cases).*" Furthermore, data entry changes or error corrections to any current PA are considered an update versus a modification.

Modification is only to occur in the following circumstances:

- When an inpatient stay is increased or decreased for a unique inpatient visit
- Any transplant procedure
- Home health plans of treatment in which the dates of service are changed

- Mental health services that are changed mid-procedure due to a change in diagnosis
- Physical therapy and occupational therapy services that are changed mid-procedure due to a change in diagnosis
- Transportation for currently requested dates of service

If a request to change, add an additional service to, or extend a PA does not meet the preceding criteria, a new PA must be entered in Indiana*AIM*, which requires a new request form to be submitted along with the appropriate documentation.

Please see the PA modification policy and examples in the *Care Select CMO Policy and Procedure Manual* on the State's SharePoint site for further clarification.

Psychiatric Residential Treatment Facility – Prior Authorization Clarification

Effective January 1, 2011, or another date as indicated by the FSSA, individuals with a Psychiatric Residential Treatment Facility (PRTF) level of care (LOC) must be disenrolled from Indiana *Care Select* and receive care through the FFS Medicaid program. Members can opt in to *Care Select* after their PRTF LOC is removed if they have one or more of the appropriate diagnoses.

Prior Authorization Processing Timelines

After the PA request and all required documentation are received, a PA decision is issued within five business days, excluding holidays, for members enrolled in FFS and *Care Select.* Examples of the PA decision letters, the Notice of Appeals letter, the member appeals form, and the PA decision letter process can be found on the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion.*

Emergency Requests

If the request warrants emergency review, you must contact the PA vendor to request an emergency PA. The PA request is placed in a pending status, awaiting all required documentation noted previously. This documentation can be mailed or faxed to the PA vendor. All documentation must be submitted within 14 business days from the date of the initial request for emergency review. After the documentation is received, a decision is issued within five business days for FFS *Care Select.*

- If the admission is approved, the approval reflects the date of the initial telephone or fax request for admission.
- If the admission occurred before the date on which the PA was initially requested, the PA is modified to reflect an untimely request unless the member is eligible for retroactive consideration.
- If the request for admission is denied, the provider is not reimbursed by the IHCP for any of the days of the PRTF stay. A provider may request an Administrative Review (AR) of a modification or denial of a PRTF stay.
- If the AR upholds the original decision, the provider may choose to appeal the decision. See *Chapter 6* of the *IHCP Provider Manual* found on the *Manuals* page at indianamedicaid.com for additional information regarding the AR and appeals process.

Hearing and Appeal and Administrative Review

Hearings and Appeals, as well as Administrative Reviews, are completed by the PA vendor. The policies and procedures regarding Hearing and Appeal or Administrative Review remain the same as

currently published. This information is distributed to the provider and member on generation of the PA decision letter or PA update. Further information regarding Hearing and Appeal and Administrative Review can be found in *Chapter 6, Prior Authorization* of the *IHCP Provider Manual* on the *Manuals* page at indianamedicaid.com.

Prior Authorization System Support

The PA vendor is responsible for providing hardware, software, and communications links for contractor staff to meet the requirements set forth by the FSSA and to use the capabilities and functionality present in Indiana*AIM*.

Indiana*AIM* performs the following functions to support the PA process:

- Maintains all PA requests online (Indiana*AIM* stores all PA requests regardless of current status [for example, under evaluation, approved, and denied])
- Decrements PA units during claims processing
- Maintains an authorization history for all members with PAs on file
- Links PAs to relevant claims history against approved PAs
- Maintains all PA Administrative Review and Appeal Information online
- Produces a variety of daily, monthly, and quarterly reports for 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 Home and Community Based Services (HCBS) plans of care
- Provides an audit trail of changes to the PA file
- Supports authorization of dollars, units, or period of time

Section 12: Utilization Review

Overview

The care management organization (CMO) must maintain a utilization management (UM) program that integrates with other functional units as appropriate and supports the Quality Management and Improvement Program. The UM program may include functions such as:

- Identify instances of over- and underutilization of emergency room (ER) services and other health services. The CMO is responsible for
  - Incorporating ER claims into the care management plans for members
  - Including outreach to members about appropriate ER use
  - Informing primary medical providers (PMPs) and behavioral health providers of ER visits
  - So forth.
- Identify aberrant provider practice patterns, especially related to:
  - ER
  - Inpatient services
  - Transportation
  - Drug utilization
  - Preventive care
  - Screening exams
- Ensure active participation of a utilization review committee
- Evaluate efficiency and appropriateness of service delivery
- Facilitate program management and long-term quality
- Identify critical quality-of-care issues

In addition, the UM program may have policies and procedures to assist UM staff to:

- Perform concurrent review of inpatient and ER services at high-volume facilities, as defined by the CMO and approved by the Family and Social Services Administration (FSSA)
- Incorporate subcontractor's performance data

For all programs under the UM function, the CMO must maintain updated policies and procedures. The CMO's UM program policies and procedures must meet all stated National Commission for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) standards, must include appropriate time frames., The CMO must operate and maintain its own UM program. With the FSSA'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:	*Although pharmacy UM continues to be conducted through the State's current pharmacy benefit manager, the FSSA 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 must 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 overall program costs.

The CMO must provide the following UM services for physical and behavioral health services requiring PA:

- *Identification of Members Appropriate for Case Management, Care Management, or Disease Management Services* – As part of the initial assessment, the CMO must determine if referral to services such as care management or disease management is appropriate.
- *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 that the member receives appropriate post-hospitalization care. The CMO's involvement in discharge planning is particularly critical to avoid unnecessary nursing home placements. The CMO must also coordinate with the Area Agency on Aging (AAA) for IndianaOPTIONS counseling, as appropriate.
- *Retrospective Review* – The CMO must provide 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 within 30 days, home health services, and specific diagnosis-related groups (DRGs) that are often upcoded. This also assists in clarifying and setting future medical policy recommendations.
- *Development and Review of Clinical Criteria* – The CMO must annually review, update, and revise clinical criteria under the direction of the CMO's Medical Director and Clinical Advisory Panel and obtain authorization from the OMPP's Medical Policy unit via the OMPP policy evaluation team 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 CMO's member policies and procedures manual provide information on access to preventive services.
- *Provider Education* – The CMO must provide feedback to PMPs regarding the PMP's panel's utilization profile.
- *Identifying, Monitoring, and Addressing Potential Over- and Underutilization* – 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 underutilization.

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. These criteria and guidelines must also consider the needs of the CMO's members. The CMO's UM and case management staff must consist of licensed, experienced healthcare professionals. These professionals must have the clinical expertise and training to interpret and apply UM criteria and practice guidelines to providers' requests for healthcare or to 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 website, and make the guidelines available to members on request.

Utilization Management for Behavioral Health Services

The CMO must manage behavioral healthcare utilization through concurrent and retrospective reviews. The CMO must share member medical data and coordinate care for all members receiving 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 implements programs to reduce inappropriate utilization of the ER through some or all the following strategies:

- Making a nurse hotline available 24 hours a day, seven days a week, to help members appropriately use the ER and to assist staff at ER departments who are rendering care to members. The CMOs 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
- Tracking the emergency services notification to the CMO of a member's presentation for emergency services by:
  - ER provider
  - Hospital
  - Fiscal agent
  - Member's PMP
- Documenting a member's PMP's referral to the ER
- Alerting a member's PMP to the member's presentation for emergency services within 48 hours

CMOs must educate members about appropriate use of the ER. The CMO must 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.

Emergency Room, Outpatient Surgery, and Inpatient Admissions Notification

In line with the goals for *Care Select*, it is essential that CMOs are notified when a *Care Select* member receives services in a hospital setting, including the ER department, outpatient surgery, or inpatient care. Effective October 1, 2009, providers who serve *Care Select* members in a hospital setting should notify the members' CMOs, so the appropriate care coordination can take place.

The hospital staff is responsible for checking member eligibility on treatment or admittance to the facility. Providers that use Web interChange to check member eligibility see a *Care Select* Notification button appear for *Care Select* members only. Hospital staff must click ***Care Select* Notification** and type the following information in the space provided within 48 hours:

- Date of treatment
- Type of treatment
- Presenting signs, symptoms, and/or diagnoses

Once the hospital staff clicks **Save** and the CMO has subsequently been notified, the CMO assesses the nature of the visit for follow-up. If the member's situation appears to be complex or additional details are needed for case management, the CMO's care manager contacts clinical personnel at the hospital. The CMO works with the hospital staff to notify the member's PMP and other key physicians on the member's case.

The CMOs are responsible for contacting hospital discharge planning staff, as appropriate, to offer assistance in discharge planning and to obtain treatment plans and the necessary details to assist with facilitation of appropriate care and resources on discharge. Providers are encouraged to make contact with each CMO to communicate the appropriate contact person and /or department within each facility.

The CMOs should review the report on a daily basis via Web interChange. The following outlines the process.

1. After the CMO user logs on to Web interChange, the **CS Notif Inquiry** button and link appears.

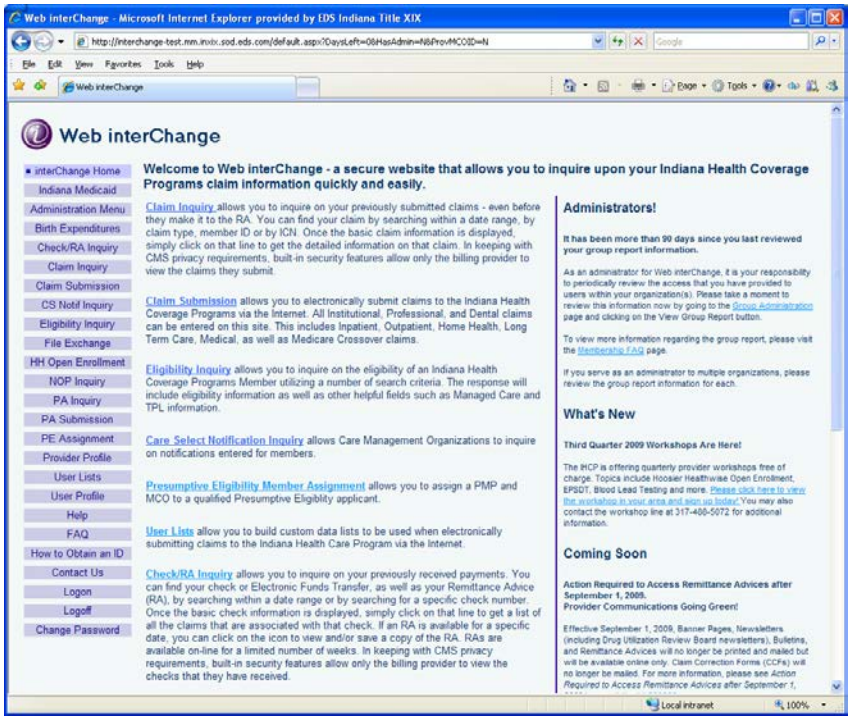


Figure 12.1 – Web interChange Window

2. The user enters the search criteria and clicks **Search**. The member information is displayed for the criteria selected. The user can also export the data into an Excel comma-separated values (CSV) format by selecting **Export List**.

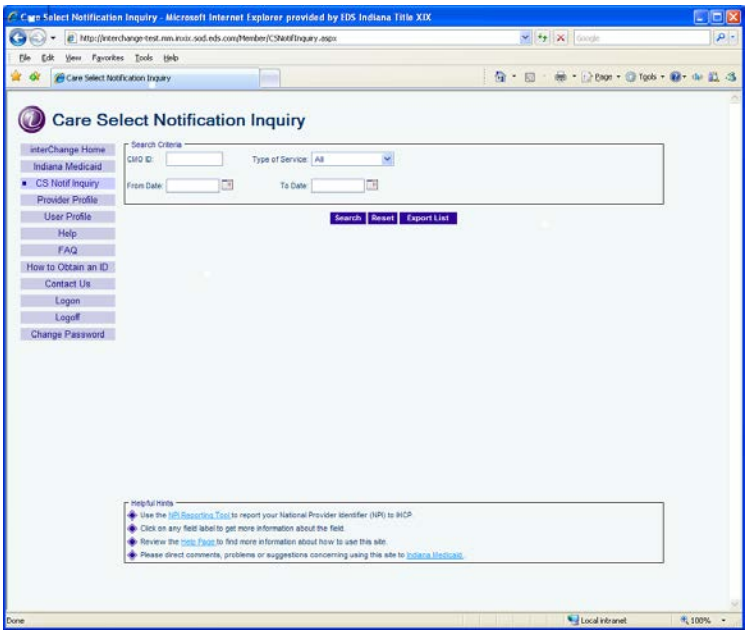


Figure 12.2 – *Care Select* Notification Inquiry Window

The report includes the following information:

- *Date of Treatment:* Display valid date of mm/dd/ccyy.
- *Type of Service:* Display member's type of treatment.
  - Emergency Room displays as "E."
  - Inpatient Care displays as "I."
  - Outpatient Surgery displays as "O."
- *RID:* Display 12-digit numeric.
- *Member's Information:*
  - Name – Display member's name.
  - Address – Display member's home address.
  - Telephone – Display member's telephone.
- *Signs, Symptoms, Dx:* Display member's signs, symptoms, or diagnosis.
- *Facility's Information:*
  - Name – Display facility's name.
  - Address – Display facility's address.
  - Telephone – Display facility's telephone.
  - NPI – Display facility's NPI.
- *PMP's Information*:
  - Name – Display PMP's name.
    Telephone – Display PMP's telephone.

Note: The Care Select Notification Inquiry page displays 25 notifications per page.

Utilization Management Committee

The CMO must have a UM committee directed by the CMO's medical director. The committee is responsible for:

- Monitoring providers' requests for rendering healthcare services to its members
- Monitoring the medical appropriateness and necessity of healthcare 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 UM that conform to industry standards, including methods, time lines, and individuals responsible for completing each task

Drug Utilization Review Board

The Indiana Drug Utilization Review (DUR) Board is appointed by the governor to serve in an advisory capacity to IHCP with regard to the prescription and dispensing of drugs by Medicaid providers and the use of prescribed 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 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 FSSA 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, see *IC 12-15-35-46*.

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

Section 13: Quality Improvement Program and Performance Reporting

Overview

The care management organization (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 Office of Medicaid Policy and Planning (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 Centers for Medicare & Medicaid Services (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 and Quality Improvement (QM/QI) Program, the CMO must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare 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 uses 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 uses other data to assess the effectiveness of its QM program, such as the following:

- Member satisfaction surveys (particularly surveys including issues specifically relevant to people with disabilities and chronic conditions, behavioral health conditions, and so forth)
- Provider satisfaction surveys
- Access and availability audit information
- The reliability of the CMO's data and information technology (IT) systems
- Other data, as appropriate

As a key component of its Quality Management Program, the CMO develops incentive programs for providers and members that are based on the OMPP-designated quality improvement targets, with the ultimate goal of improving health outcomes of *Care Select* 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 following requirements, in developing its quality management program. In doing so, it must 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 meet the following criteria:

- Includes developing and maintaining an annual quality improvement plan that:

  - Sets goals.
  - Establishes specific objectives.
  - Identifies the strategies and activities to undertake.
  - Monitors results.
  - Assesses progress toward the goals.

- Includes policies and procedures for quality improvement that describe methods, time lines, and individuals responsible for completing each task.
- Incorporates 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.
- Participates appropriately in clinical studies and periodically (at least annually or more frequently, as directed by the OMPP, assesses the quality and appropriateness of care provided to members in accordance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch requirements.
- Collects measurement indicator data related to areas of clinical priority and quality of care. The Quality Improvement Committee, in collaboration with the OMPP, establishes areas of clinical priority and indicators of care. These areas may vary from one year to the next and reflect the needs of the *Care Select* population. Examples of areas of clinical priority include:
  - Behavioral health and physical healthcare coordination
  - Emergency room (ER) use
  - Access to care
  - Special needs care coordination and use
  - Hospital use
  - Disease management
  - Pharmacy use
  - DME use (examine equipment repair rates for members with disabilities, identify members with faulty equipment, and discuss potential resolutions)
  - Hospitalization for ambulatory-sensitive conditions. Use the Agency for Healthcare Research and Quality (AHRQ) Ambulatory Sensitive Conditions list as a starting point for identifying which preventable hospitalizations data to collect. For example, conditions such as 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 on 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 website contains an example of available protocols.
  - Develop and maintain a physician pay-for-performance program based on clinical and service outcomes priorities set by the OMPP.
  - Develop a member incentive program to encourage members to be personally accountable for their own healthcare and health outcomes. Targeted areas of performance could include the appropriate use of ER services, keeping appointments, 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-Related Incentive Programs

As a key component of its Quality Management Program, the CMO develops incentive programs for providers and members that are based on the OMPP-designated quality improvement targets, with the ultimate goal of improving health outcomes of *Care Select* members. The CMO meets the requirements of *42 CFR 438* subpart D and the National Committee for Quality Assurance (NCQA) in developing its quality management program. In doing so:

- It includes an assessment of quality and appropriateness of care provided to members with special needs
- Completes performance improvement projects in a reasonable time to allow information about the success of performance improvement projects to be incorporated into subsequent quality improvement projects
- Produces quality of care reports at least annually

The CMO develops and maintains a physician incentive program based on clinical and service outcomes priorities as set by the FSSA and is based in pay-for-outcomes. The physician incentive program is included in the QMIP.

The CMO develops a member incentive program to encourage members to be personally accountable for their own healthcare 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. The member incentive program is included in the QMIP.

Outcome measures and targets are based on the priority areas established by the FSSA. Performance measures and targets may change on a year-to-year basis as program priorities shift and as necessary to support continuous quality improvement. The performance measures and targets applicable during subsequent years of the contract are established annually by the FSSA and reflected in an amendment to the contract.

The CMO performance is calculated based on care delivered during the calendar year. Future incentive payments for any measure will be dependent upon the CMO maintaining or improving the outcome on that individual measure from the prior year.

Incentives may be payable in the form of a withhold. Any measure identified as using Healthcare Effectiveness Data and Information Set (HEDIS) specifications is bound to the HEDIS specifications for the measurement year. Other measures will be paid based on custom specifications and performance will be determined by the FSSA or designee.

The CMO submits information to the FSSA, in the format and detail specified by the FSSA, with respect to each following performance measure. The FSSA uses the CMO's NCQA-certified HEDIS software administrative rate report for the measurement year to determine eligibility for certain incentive payments. The *Care Select* program requires only the use of HEDIS administrative rates. The NCQA-certified HEDIS software administrative rates are considered priority reports and must be received by July 31 of each year. Any data not meeting established minimum standards for sampling, or data received after required submission date, is not eligible for an incentive payment.

The contractor submits the FSSA-approved contractor's member survey CMO's final report.

Incentive payments payable in the form of a withhold are based on benchmarks established for:

- Ambulatory Care: Utilization of ambulatory services in the categories of outpatient visits and emergency department visits. HEDIS measure (HEDIS AMB) using administrative data

- Follow-up after hospitalization for mental illness: Percentage of members who received follow-up within seven days of discharge from hospitalization for mental health disorders. HEDIS measure (HEDIS FUH) using administrative data
- Adult Ambulatory and Preventive Care: HEDIS measure (HEDIS AAP) using administrative data
- Health Risk Assessments: During the measurement year, this measure is defined as the percentage of HRAs completed for members identified for *Care Select.*
- Administrative reporting for *Pharmacotherapy Management of COPD Exacerbation.*
- Participate in other quality improvement activities to be determined by the FSSA.

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 represent 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 OMPP Quality Strategy Committee meetings on a quarterly basis to update the OMPP and report on the CMO's quality management, improvement activities, and outcomes. The CMO must have other appropriate personnel attend the OMPP Quality Strategy Committee meeting monthly.

The CMO must have a structure in place (for example, other committees, subcommittees, work groups, task forces) that is incorporated into and formally supports the CMO's internal Quality Management and Improvement Committee, and its 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 must include a time line of activities and assessments of progress toward goals. The CMO must submit its Quality Management and Improvement Work Plan to the OMPP during the readiness review and annually thereafter, and provide quarterly progress updates to the OMPP. The CMO must be prepared to periodically report on its quality management activities to the *Care Select* 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 FSSA, the Indiana Medicaid Fraud Control Unit (IMFCU), the Fraud and Abuse Detection contractor (FAD) and the IHCP Program Integrity Department. The CMO must report member fraud to the FSSA, the IHCP Program Integrity Department, the FAD, the Indiana Bureau of Investigation, and the Office of the Inspector General. However, no Program Integrity Plan is necessary.

State Monitoring of Care Management Organization

Care Management Organization Reporting Manual

The State creates and updates a CMO reporting manual each year of the contract. The most up-to-date and final information regarding reporting to the State is available in the *CMO Reporting Manual*. The reporting submission requirements, data specifications, and formatting for submission is available in the reporting manual and templates.

External Quality Review

The State conducts external quality reviews (EQRs) of the CMOs to monitor the performance and outcomes of the vendors. 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, and conducting 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 Care Management Organization Monitoring Activities

The FSSA staff provides direct oversight of the CMOs to evaluate the effectiveness and efficiency of the *Care Select* care management program and its participating CMOs. The FSSA staff evaluates the readiness of newly contracted CMOs to participate in *Care Select* and assesses compliance of all CMOs with federal and state regulations and contract provisions. The FSSA staff 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), *Medicaid HEDIS National Committee for Quality Assurance (NCQA),* and Indiana's state-specific performance standards.

Readiness Reviews

At least 30 calendar days before any members are transitioned to *Care Select* and the new CMO; the CMO passes a readiness review conducted by the FSSA and/or its subcontractors. Required elements of the readiness review include at least the following:

- Administrative requirements
- Covered benefits and services
- Approved initial assessment tool and data repository
- Behavioral health services
- Quality management and improvement work plan
- Management information systems and performance reporting
- Attendance at a series of orientation sessions to assist the CMO in developing its internal operations to support the requirements of the CMO's contract with the State, for example:
  - Data submission
  - Data transmissions
  - Reporting formats
  - So forth

This list may be modified by the FSSA during contract negotiations.

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 through *Care Select*. 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 *Care Select* unless otherwise specified by the FSSA. The State publishes *Care Select*'s performance and recognizes the CMO when *Care Select* 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 FSSA. The CMO must have policies, procedures, and mechanisms in place to ensure that financial and nonfinancial performance data submitted to the FSSA and the monitoring contractor is accurate and is 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 the president, chief executive officer, and executive director) certifying the accuracy, truthfulness, and completeness of the CMO's data. The *CMO Reporting Manual* details the following reporting requirements.

The FSSA reserves the right to audit the CMO's self-reported data and change reporting requirements at any time with reasonable notice. The FSSA may require corrective actions or assess liquidated damages for CMO noncompliance with these and other subsequent reporting requirements and performance standards.

Contractor Reports and Time Frame for Processing

The contractor must submit reports and supporting documentation to the State, demonstrating to the satisfaction of the State the contractor's progress toward the achievement of the performance targets set forth in the contract. Such reports must be submitted no later than 30 calendar days following the end of each calendar quarter.

The exact format and content of the report, including the requirements for any supporting documentation, must be mutually agreed on between the State and contractor. Each report must separately identify the contractor's progress with respect to all the following time periods:

- The most recent calendar quarter
- Calendar year-to-date
- Since the start of the contract

The State has 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 the 30-day time period, the State must send a written notice to the contractor indicating that the report has been accepted or rejected. If the report has been accepted, the State's notice must indicate the amount of payment, if any recommended, based on the contractor's performance relative to the metrics and measures addressed in the report. If the report has been rejected, the State's notice must indicate that the report is incomplete or otherwise lacking adequate supporting documentation, or that the State desires to audit the contractor's records relative to its performance before accepting the report. If a report is rejected as incomplete or lacking adequate supporting documentation, the contractor has 21 calendar days from the date of its receipt of the rejection notice to furnish the State with the requested information. The State must review any additional information timely submitted and notify the contractor whether the

report has been accepted or rejected based on the information submitted. If the State requests an audit, the State must conduct its audit within a reasonable time period not to exceed 60 calendar days, provided the contractor cooperates in such an audit, and within 30 calendar days of completing its audit, notify the contractor whether the report that gave rise to the audit has been accepted or rejected.

Reviews

The contractor agrees that the State may periodically review the contractor's books and records to verify the accuracy of the contractor's performance reports and to otherwise determine the contractor's entitlement to performance-based monies. Such reviews may be conducted at any time with reasonable prior notice. The contractor must cooperate with the State with respect to any such review. The State's review rights 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:

- HEDIS *Ambulatory Care* Measure
- HEDIS *Follow-up after Hospitalization for Mental Illness* Measure
- Administrative Reporting for *Adult Ambulatory and Preventive Care*
- Administrative Reporting for *Completion of Health Risk Assessments*
- Administrative Reporting for *Pharmacotherapy Management of COPD Exacerbation*

Liquidated Damages, Administrative and Financial Reports

This section includes all performance reporting required by the FSSA 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 FSSA any vacancies of key staff and its plans for filling those positions and covering the responsibilities created by a key staff member's vacancy. Likewise, the CMO must notify the FSSA's managed care manager in writing within five business days after a candidate's acceptance to fill a key staff position or five business days before the candidate's start date, whichever occurs first. Whenever the information changes, the CMO must submit to the FSSA an updated organizational chart, including email addresses and telephone numbers for key staff.

Financial Reporting

An audited financial statement is required and assists the FSSA in monitoring the CMO's financial trends to assess its stability and continued ability to offer healthcare services to its members. If the CMO does not meet the financial reporting requirements, the State notifies the CMO of the noncompliance and designates a period of time, not fewer than 10 calendar days, during which the CMO must provide a written response to the notification. The CMO must meet Indiana Department of Insurance (IDOI) licensure and financial requirements.

Member Service Reports

Member service reports identify the methods the CMO uses to communicate to members about preventive healthcare and program services and monitor member satisfaction. The following are examples of member service reports:

- *Member Helpline Performance Report* (quarterly or as determined by the FSSA)
- *Member Grievances Report* (quarterly)
- *Member Appeal Report* (quarterly)
- *Medicaid Hearing & Appeals* (as determined by the FSSA)
- *Member Disenrollment Reports*
- *Disease Management*
- *Care Management*
- *Complex Case Management*

Network Development Reports

Network development reports assist the FSSA 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 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 FSSA 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 Work Plan* and *Annual Quality Program Evaluation*

- *HEDIS Data Submission Tool* (annually)

Utilization and Financial Reports

Utilization assists the FSSA in monitoring the CMO's utilization trend. The CMO monitors utilization by subpopulation, when appropriate.

- *Service Utilization – Physical Health* (quarterly)
- *Service Utilization – Behavioral Health* (quarterly)

Performance Monitoring and Incentives

On a quarterly basis, the CMO must submit a report to the FSSA documenting the progress towards performance targets under the contract, at a granular level, for that quarter, year, and the agreement to date.

Data submitted by the CMO, as well as claims data, are the primary sources of information the State uses in its monitoring efforts. The FSSA establishes the data submission requirements and time frames. This data comes 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

Table 13.1 lists the current performance indicators and the performance target for each measure. The FSSA may implement incentives to reward any CMO whose performance is consistently above the targets for the majority of the following measures listed. The FSSA also assesses liquidated damages or applies other remedies listed in this section for failure to meet the minimum standards listed in Table 13.1.

Table 13.1 – Performance Indicators and Performance Targets

Service Area	Service Standard for Release of Withholding	Amount of Withholding Released if Service Standard Met
Guaranteed Savings	To be determined within the CMO's contract over the course of the full contract	5% of the administrative withhold
Other measures as defined by the FSSA and the CMOs	To be determined within each calendar year's contract amendment	15% of the administrative withhold

The FSSA reserves the right to identify additional performance indicators and targets, modify the performance indicators and targets before awarding the contract, 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 90% of each invoice the CMOs provide with net 30 day payment terms. Ten percent of each invoice shall be held back, to be paid within 30 days of the end of each year, according to the CMO's demonstrated and documented performance against the targets and standards listed in

this section. The CMOs participate in a pay-for-outcomes program that focuses on rewarding the CMO's efforts to improve quality and outcomes for *Care Select* members. At least 50% of any performance-related delayed payments the CMOs receives are passed on to providers and/or members.

The FSSA's program is three-tiered:

- In the first tier, the FSSA shall provide financial and/or nonfinancial performance incentives to the CMOs based on performance targets in priority areas established by the State.
- In the second tier, the CMOs shall establish incentives for providers to improve quality and outcomes in areas consistent with the first tier.
- In the third tier, the CMOs shall establish incentives for members to actively participate in their healthcare and to improve compliance with healthcare in areas consistent with the first and second tier.

The FSSA reserves the right to revise measures on an annual basis and shall notify the CMOs of changes to incentive measures in the quarter preceding the beginning of the next contract year. The CMOs shall establish a performance-based incentive system, at minimum, for high-volume PMPs. The FSSA defines high-volume PMPs as the top 10% of the CMOs' contracted PMPs, based on member enrollment. Incentives may be financial or nonfinancial, but the incentive system shall address the priority areas identified by the FSSA. With State approval, the CMOs shall determine its own methodology for incenting providers. The State encourages creativity in designing pay-for-performance programs. The CMOs earning financial incentives shall reinvest at least 50% of the incentive amount the CMOs receives in member and provider incentives. After the FSSA announces the award, but before the FSSA distributes the award, the CMOs shall submit to the FSSA its proposal for reinvesting 50% of the incentive amount.

The CMOs may also provide nonfinancial 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 CMOs shall also be required to establish a program to encourage members' personal responsibility for health-promoting behavior in the priority areas defined by the FSSA. 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 nonfinancial. With State approval, the CMOs shall determine its own methodology for incenting members. The incentive program shall address the FSSA's priority areas and shall reward members' personal responsibility. The value of member incentives may not exceed $50 per year per individual, and shall be approved by the FSSA. The CMOs 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 CMOs shall comply with all marketing provisions in the *42 CFR 438.104*, and federal and state regulations regarding inducements.

Acceptance of Report

Each reporting period, the CMOs shall submit all reports electronically, in a format acceptable to the FSSA, and shall receive written verification that the report was received. If the report was late, the FSSA shall note it in writing, and the CMOs shall be subject to liquidated damages. Upon receipt of each report, the FSSA shall have a period of 30 calendar days to review the report's format and content. Within the 30-day window, the FSSA 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 30 days of the FSSA's receipt of the report, the CMOs may assume the report was accepted as is.

Payment of Performance Withholding

At the end of each contract year, the FSSA shall determine whether the CMOs' performance in the year was sufficient to earn all or a portion of the 10% performance-related delayed payment. The FSSA's decision to release or continue to hold some or the entire withheld amount shall be final. If the FSSA determines that payment of some or the entire withheld portion is due, the FSSA shall pay the CMO within 30 calendar days of the completion of its review of the relevant reports.

Failure to Perform or Noncompliance Remedies

Areas of Noncompliance

Noncompliance with General Contract Provisions

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 noncompliance issues. If this occurs, the State notifies the CMO in writing of the nature of the nonperformance issue. The State establishes 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 nonperformance issue within the specified time, the State may enforce any of the remedies listed in this section.

Noncompliance with Reporting Requirements

The CMO reporting manual includes sample reporting templates demonstrating the required formats and submission instructions for the reports. The FSSA may change the frequency of required reports, or may require additional reports, at the FSSA's discretion. The State may assess liquidated damages of $4,654 (per instance) for priority reports and $482 (per instance) for other reports when reports are not delivered complete, on time, and in the correct reporting formats, or are submitted incorrectly.

If the CMO's noncompliance with the reporting requirements has an impact on the State's ability to monitor the CMO's solvency, and the CMO's financial position requires the State to transfer members out of *Care Select,* the CMO must pay any costs the State incurs to accomplish the transfer of members. Further, the FSSA withholds all care management payments or require corrective action until the CMO provides satisfactory financial data.

Noncompliance 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. The CMO is responsible for any costs associated with the delay. In addition, the FSSA assesses liquidated damages in the amount of $5,438 for each business day the CMO delays in submitting readiness review responses past due dates.

Noncompliance Remedies

The CMO must ensure quality care for its members. To assess attainment of this goal, the State monitors certain quality and performance standards and holds the CMO accountable for being in compliance with contract terms. The FSSA accomplishes this by working collaboratively with the CMO to maintain and improve programs, and not to impair CMO stability.

If the CMO fails to meet performance requirements or reporting standards set forth in the CMO contract, the State provides the CMO with a written notice of noncompliance. The FSSA may require

any of the corrective actions or remedies discussed in this section The State provides written notice of noncompliance to the CMO within 60 calendar days of the State's discovery of such noncompliance.

If the FSSA 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 FSSA may require corrective actions when the CMO has failed to provide the requested services. The nature of the corrective actions depends on the nature, severity, and duration of the deficiency and repeated nature of the noncompliance. The written notice of noncompliance corrective actions may be instituted in any sequence and include, but are not limited to, the following:

- *Written Warning* – The FSSA may issue a written warning and solicit a response regarding the CMO's corrective action.
- *Formal Corrective Action Plan* – The FSSA 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 FSSA. If the corrective action plan is not acceptable, the FSSA may provide suggestions and direction to bring the CMO into compliance.
- *Withholding Care Management Payments* – The FSSA may suspend care management payments for the following month or subsequent months when the State determines that the CMO is noncompliant. The FSSA must give the CMO written notice 10 business days before suspending care management payments and must offer specific reasons for noncompliance that result in suspension of payments. The State may continue to suspend all care management payments until noncompliance issues are corrected.
- *Suspending Enrollment* – The FSSA 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 notifies the CMO in writing of its intent to suspend new enrollment at least 10 business days before the first day of the suspension period. The suspension period may be for any length of time specified by the State. The State bases the duration of the suspension on the nature and severity of the default and the CMO's ability to cure the default.
- *Assigning the CMO's Membership and Responsibilities to Another CMO* – The State may assign the CMO's membership and responsibilities to one or more other CMOs that also provide services to the Hoosier Healthwise population, subject to consent by the CMO that would gain that responsibility. The State shall notify the CMO in writing of its intent to transfer members and responsibility for those members to another CMO at least 10 business days before transferring any members.
- Appointing Temporary Management of the CMO's Plan – The State may assume management of the CMO's plan or may assign temporary management of the CMO's plan to the State's agent, if at any time the State determines that the CMO can no longer effectively manage its plan and provide services to members.
- *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 $917 (per instance) for each determination of marketing violations.
- *Contract Termination* – The State reserves the right to terminate the contract, in whole or in part, because of 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 FSSA 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.

Liquidated Damages

If the CMO fails to meet performance requirements or reporting standards established in the contract, or other standards established by the State, damages will be sustained by the State, and the CMO will pay to the State its liquidated damages according to the following subsections and subject to the limitations provided in *42 USC Chapter Seven, Subchapter XIX, Section 1396u-2 (e).*

If a CMO fails to meet specified performance or reporting requirements subject to liquidated damages, it is and shall be impractical and extremely difficult to ascertain and determine the actual damages which the State sustains 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 schedule. The State and the CMO agree that the liquidated damages set forth in the following subsections are reasonable estimates of the cost to the State to compensate for failure by the CMO to meet the corresponding requirements. No punitive intention is inherent in the following liquidated damages provisions.

The FSSA 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 are assessed based on this section. If the FSSA chooses 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 State notifies the CMO of liquidated damages due and the CMO pays the State the full amount of liquidated damages due within 10 business days of receipt of the State's notice. The State may, in its sole discretion, elect at any time to offset any amount of liquidated damages due against payments otherwise due CMO pursuant to the contract.

If liquidated damages are imposed under the contract, the CMO provides the FSSA with a formal corrective action plan, as well as monthly reports on the relevant performance metrics until such time as the deficiency is corrected, for a period of 60 consecutive days.

Section 14: Management Information Systems

Overview

The care management organization (CMO) must have a management information system (MIS) sufficient to support *Care Select* requirements. The CMO must have a plan for creating, accessing, storing, and transmitting health information data in a manner that is in keeping with *Health Insurance Portability and Accountability Act* (HIPAA) confidentiality requirements for 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's information systems (IS) shall support HIPAA Transaction and Code Set requirements for electronic health information data exchange, National Provider Identifier requirements, Privacy, and Security Rule standards. The CMO's electronic mail encryption software for HIPAA security purposes shall be the same as the State's. The CMOs shall have secure email.

The CMO must develop, implement, and maintain an MIS with capabilities to perform the data receipt, transmission, integration, management, assessment, and system analysis described in this policy. The CMO must have mechanisms in place to link data into a relational database reflecting all functional areas' data integration. The CMO must have policies and procedures to describe and support the MIS backup plans, and it must have 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 Family and Social Services Administration (FSSA) and, on 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 officer, 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 at the IOT website. All hardware, software, and services provided to or purchased by the State are compatible with the principles and goals contained in the electronic 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 up its data on tape or optical disk, and store it 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 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, the following:

- Supporting immediate restoration and recovery of lost or corrupted data or software
- Establishing and maintaining, in an electronic format, weekly and daily backups 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
- Resuming normal business functions, in the event of a catastrophic or natural disaster, at the earliest possible time, not to exceed 30 calendar days
- Resuming normal business functions, in the event of other disasters caused by criminal acts, human error, malfunctioning equipment or electrical supply, and so on, at the earliest possible time, not to exceed 10 calendar days
- Developing coordination methods for required system operational activities, 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 required to accept enrollment data in electronic format via secure file transfer protocol (FTP), as directed by the FSSA. The *Companion Guide – 834 MCE Benefit Enrollment and Maintenance Transaction*, which is available on the *Companion Guide* page at indianamedicaid.com, details the enrollment data exchange. The State's fiscal agent produces the enrollment rosters three times a month. See *Fiscal Agent Care Management Organization 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 a 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 *Care Select*, 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 before the effective date in the CMO health plan, 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.

Per Member Per Month Administrative Fee (Capitation)

CMOs are paid a per-member, per-month capitation. CMOs submit their member stratification files to the fiscal agent monthly to determine payment rates. There are six *Care Select* levels. Members who have not been stratified receive a level 1 for 120 days or until the CMO is able to assess and assign a stratification level. If a member is unable to be assessed, the member is assigned a level 0 at 121 days.

CMOs must submit files to the fiscal agent by the 5th business day of each month, and the fiscal agent generates a response file that shows the member stratification levels of care data received and processed. If a record is rejected for any reason, the corrected record should be submitted in the next month's maintenance file.

> *Note: The stratification date on the record being corrected needs to reflect the current processing month, as all retro-dated records are rejected.*

The fiscal agent generates monthly administration fee payments to the CMO account identified on the EFT statement included with the initial CMO enrollment. This transfer occurs the third Wednesday of every month. Concurrently, the fiscal agent posts the administration fee roster via the 820 MCE capitation payment transaction to the File Exchange system, by CMO and region, which details the payment by capitation category of *Care Select*. A schedule of actual administration fee payment dates is distributed to the CMOs at the beginning of each year. The schedule is located in *Fiscal Agent Care Management Organization Jobs Schedule.*

Each administration fee payment includes prospective reimbursement for members enrolled in the CMO as of the first day of the same month. For example, the payment issued on or about the 15th of the month represents payment for members enrolled with the managed care entity (MCE) on the 1st or 15th day of the current month.

Member effective dates with the CMO depend on the date the member's assignment to a CMO health plan primary medical provider (PMP) is entered in Indiana*AIM*. For members newly enrolled in *Care Select*, PMP assignments entered from the 11th through the 25th of the current month are effective on the first day of the following month. New-member PMP assignments entered from the 26th of the current month through the 10th of the following month are effective on the 15th of the following month. Incumbent *Care Select* members new to a CMO by virtue of a PMP change have effective dates with the CMO on the 1st of the month.

PMP changes entered in Indiana*AIM* on or before the 25th day of the month have effective dates on the 1st day of the following month. PMP changes entered in Indiana*AIM* on or after the 26th of the month are effective on the 1st day of the second month. A member can change PMPs within the same health plan any day of the month and capitation is not affected.

Because administration fee payment is directly related to the enrollment process, Table 14.1 assists the CMO in reconciling the administration fee payments to enrollment rosters.

Table 14.1 – Reconciling Capitation Payment to Enrollment Rosters

Enrollment Roster Effective Date	Member Status on Enrollment Roster	Member Status for Payment
15th	Add	Half capitation for current month for member enrolled with the plan 17 days or less. Full capitation for member enrolled with the plan 18 days or more.
15th	Continuing	Full capitation for current month
15th	Terminated	Half capitation for current month for member enrolled 17 days or less with the plan.
1st	Add	Full capitation for current month

Enrollment Roster Effective Date	Member Status on Enrollment Roster	Member Status for Payment
15th of previous month	Terminated (death)	Capitation recouped for previous month
1st	Deleted	No capitation payment
1st	Terminated	No capitation payment
1st	Continuing	Full capitation for current month

If a CMO identifies a discrepancy in the 820 CMO capitation payment transaction, the CMO may contact HP's Managed Care director.

Capitation Adjustments

During the term of the State/CMO contract, adjustments to negotiated administration fee rates may be appropriate. The capitation lookback period for *Care Select* is 13 months of history. Interim adjustments can be positive or negative and can be generated for all members assigned to a capitation category on a specific date. At the discretion of the FSSA, the Managed Care Unit *may* generate an adjustment to the negotiated administration fee rates.

The fiscal agent completes mass administration fee adjustments at the direction of the FSSA. These adjustments are detailed on the CMO's monthly administration fee report as positive or negative adjustments.

The following events may generate adjustments to capitation payments for individual members:

- Duplicate administration fee payments
- Payments made after a member's date of death
- Identification of multiple recipient identification numbers (RIDs) for the same member
- Adjustments to a member's eligibility

The CMO is responsible for verifying member eligibility and reconciling payments from the State for each eligible member. If the CMO discovers a discrepancy in eligibility or care management payments, the CMO must notify the FSSA and the State's fiscal agent within 30 calendar days of discovering the discrepancy; and no more than 90 calendar days after the FSSA delivers the eligibility records. The fiscal agent completes all administration fee payment adjustments at the direction of the FSSA. These adjustments are detailed on the CMO's monthly administration fee report as positive or negative adjustments. If the CMO receives enrollment information or care management payment for a member, the CMO is responsible for managing the care of that member.

Administration Fee Reconciliation

Administration fee reconciliation occurs each month after the routine payment cycle. The reconciliation process systematically compares member eligibility status to administration fee payment history to identify discrepancies, such as those for retroactive changes. Payment and recoupment adjustments then process through the following month's routine administration fee cycle. See *Fiscal Agent Care Management Organization Jobs Schedule* for capitation reconciliation reason codes.

The CMO is responsible for verifying member eligibility and reconciling payments from the State for each eligible member. If the CMO discovers a discrepancy in eligibility or care management payments, the CMO must notify the FSSA and the State's fiscal agent within 30 calendar days of discovering the

discrepancy and no more than 90 calendar days after the FSSA delivers the eligibility records. The CMO must return any per-member, per-month (PMPM) administrative fee overpayments to the FSSA. 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.

Completed Telephone Calls

To enable both CMOs to consistently report to the FSSA the number of completed member calls on a monthly and quarterly basis, the following clarifies the definition of a completed telephone call:

A completed telephone call is defined in the following ways for *Care Select*. The following criteria must be met for a telephone call to be deemed completed:

- The call applies to the Disease Management Program or care management activities engaged in by the contracted *Care Select* vendors.
- The member or the member's approved representative is engaged in a live dialogue.
- Disease or care management information is transmitted via a live dialogue or an appointment is made to discuss disease or care management information via a live dialogue with the member or the member's approved representative.

The following interactions are not considered completed calls:

- A message is left on an answering machine or voice mail.
- The CMO receives a busy signal.
- The member does not answer the telephone.
- The call is abandoned.

Receipt of Claims Data from Fiscal Agent

The State makes claims and eligibility data for members enrolled in *Care Select* available to the CMO through its fiscal agent. The fiscal intermediary enters this data into the State's MIS, Indiana*AIM*. The CMO is able to access Indiana*AIM* on a real-time basis to capture this data. The State now uses several reporting tools to generate its own financial and utilization reports based on this raw data, and encourages the CMO to use 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 allows the PA vendor to access its Indiana*AIM* system and submit prior authorization decisions in real time to the fiscal intermediary. The CMOs are able to view historical prior authorization decisions via this system. The State requires the PA vendor to receive prior authorization requests via regular mail, telephone, or fax, and to provide Web-based access for providers wishing to submit prior authorization.

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 FSSA's requirements for HIT and data sharing vary by resources available in each region. The following are examples of HIT initiatives that the CMO should consider developing:

- Electronic prescribing (e-prescribing)
- Electronic medical record (EMR)
- Inpatient computerized provider order entry (CPOE)
- Health information networks
- Benchmarking
- Telemedicine

National Provider Identifier Crosswalk File

On a weekly schedule, the fiscal agent provides the CMOs with a National Provider Identifier (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 is available on various files or reports. A copy of this file layout can be found on the *Care Select - Question and Answer* page at indianamedicaid.com. The password is *cmoquestion*.

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 is not required with the claim submission for the rendered service.

Indiana Care Select

Reset

Indiana *Care Select* Disease Management Program

Provider Referral Form

Member Name	
Member RID	
Member Contact Number	
Provider Name	
Provider ID	
Provider Contact Number	
Provider Signature	

Chronic Condition and/or Disease – Please check all that apply.

- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Failure
- ☐ Congestive Heart Failure
- ☐ Hypertensive Heart Disease
- ☐ Hypertensive Heart and Kidney Disease
- ☐ Rheumatic Heart Illness
- ☐ Severe Mental Illness
- ☐ Serious Emotional Disturbance (SED)
- ☐ Depression

Please note that a referral does not guarantee participation in the *Care Select* program. The individual must also meet other qualifying criteria in addition to one or more of the covered conditions. In addition, the *Care Select* program is voluntary and the individual may decide whether to participate. They can choose to opt in or out of the program at any time.

Questions may be directed to the *Care Select* Helpline at 1.866.963.7383.

Fax the completed form to the *Care Select* Program at 317.238.3120.

Figure A.1 – Written Referral Form

Appendix B: Primary Medical Provider Disenrollment Time Line

Submission of Primary Medical Provider Disenrollment Requests to the Fiscal Agent

Each care management organization (CMO) provides the fiscal agent Managed Care Unit with a list of representatives who are trained and authorized to submit primary medical provider (PMP) disenrollments. The list of representatives must be updated as responsibilities change.

A CMO notifies the fiscal agent PMP disenrollment coordinator of the intent to disenroll a PMP within five working days of receipt or issuance of the disenrollment request. The disenrollment form can be faxed to (317) 488-5020. The fiscal agent does not process the disenrollment until the CMO sends the disenrollment request. Advance notification allows the fiscal agent to begin the coordination of member enrollment in another health plan, if necessary.

CMOs submit fully completed requests for disenrollment to the fiscal agent PMP disenrollment coordinator at least five working days before the 24th day of the month. CMO health plan disenrollments are processed on the 24th day of the month. Table B.1 lists the last day on which the fiscal agent's Managed Care Unit must receive the request for it to be effective by the first day of the following month.

Table B.1 – PMP Disenrollment Request Deadlines

Effective Date	Received on or Before (Previous Month)
January 1	December 17
February 1	January 18
March 1	February 17
April 1	March 17
May 1	April 19
June 1	May 17
July 1	June 17
August 1	July 19
September 1	August 17
October 1	September 17
November 1	October 18
December 1	November 17

Appendix C: Care Select Inquiry, Grievance, and Appeal Process

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 complies with *42 CFR 438, Subpart F*, and includes all the following elements. The member exhausts the CMO's appeals process before filing an appeal with the FSSA.

The following tables outline the processes for member inquiries, grievances, and hearings and appeals.

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 care management organization (CMO) must resolve an inquiry by the close of the next business day. An inquiry that is not resolved by the close of the next business day becomes a grievance.
3. Notice of a resolution to the member	• Members are notified of the resolution to 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. • Inquiries resolved after the close of the next business day require a written notice of resolution to the member.
4. Reporting requirements	• Maintain a system for tracking and reporting the number and type of member calls, and inquiries it receives during business hours and non-business hours. • Monitor CMO member services help line and report CMO telephone service performance to the FSSA each month.

Table C.2 – Grievance Process

Issue	Final Policy
1. Definition of a grievance and an expedited grievance	A grievance is defined as an expression of dissatisfaction about any matter other than an "action." A grievance may be expressed by a member (or by a provider on behalf of a member) regarding the availability, delivery, appropriateness, or quality of healthcare services and matters pertaining to the contractual relationship between an enrollee and the 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. Therefore, a grievance does not include any of the following matters: • The denial or limited authorization of a requested service, including the type or level of service • The reduction, suspension, or termination of a previously authorized service • The denial, in whole or in part, of payment for a service • The failure to provide services in a timely manner • The failure to act within the required time frame • The failure to allow a resident of a rural area, with access to only one PMP, to obtain services outside the network Any others matters that pertain to the delivery of healthcare, such as dissatisfaction with the quality of care or services received, provider or provider staff conduct (such as rudeness) or the failure to respect an enrollee's rights, **should** be counted as a grievance regardless of the time frame for resolution. If the matter requires that the CMO review the situation and supply a decision, the grievance should include appeal rights if the subsequent decision is an adverse determination. An expedited grievance is 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 business days from the day of the decision or event in question to file an oral or written grievance. An inquiry that is not resolved by the close of the next business day becomes a grievance.
3. Time frame for a 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.
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 requires an expedited grievance review if adhering to the resolution time frame of 20 business days 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 when the CMO receives a review request.
5. Extension of the grievance resolution time frame	• If the CMO is unable to make a decision regarding a grievance within the period of 20 business days because of circumstances beyond its control, the CMO notifies the member in writing of the

Issue	Final Policy
	reason for delay within the period of 20 business days. • The CMO must then make a decision regarding the grievance within 10 business days after the date when the original 20 business days expire.
6. Notice of a resolution to the member	• The CMO must respond in writing to an enrollee within five business days after resolving a grievance or an 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 that the member may have to pay for pending care if an adverse appeal decision is made. • 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 a written notice within two calendar days.
7. Reporting requirement	• Report monthly using the grievance reporting form. • Report separately for children with special healthcare needs.

Table C.3 – 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 on promptly by the CMO – including 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 submitted within 30 business days of the initial action being reviewed.
3. Medicaid hearing and appeal review process. The hearing and appeal process needs to be pursued in the following order: • Hearing by an administrative law judge and agency review • Request for review by an administrative law judge	• The member may request a hearing by an administrative law judge, pursuant to the *Indiana Administrative Code* (*IAC) 405 IAC 1.1-1-5*. • After the administrative law judge's decision, the member may request an agency review of the decision within 10 days of receiving the administrative law judge's 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 reasonable times, places, and dates. • The decision made by the officer of the administrative law judge hearing is due within 90 business days of the date that the request for a hearing is first made. • Any party that is not satisfied with the decision of the administrative law judge may request an agency review within 10 business days of receiving 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 reasons 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 administrative law judge's decision is reversed, amended, or modified, the secretary or designee states the reasons in writing.

Appendix D: After Hours and 24-Hour Availability Audit Quality Improvement

Quality Improvement Activity

Activity Name

After Hours/24-Hour Availability Audit

Purpose or Description

The purpose of the After Hours/24-Hour Availability audit is to determine whether there is appropriate and easy access to the primary medical provider (PMP) outside regular business hours. *Care Select* ensures that members have the ability to obtain medical care 24 hours a day, seven days a week. PMPs are assessed on the process they have in place for the members to access a medical professional for urgent or emergent healthcare needs. The Family and Social Services Administration (FSSA) recommends that care management organizations (CMOs) 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% confidence rate with a plus or minus 5% margin of error.

Methodology

A random sample of PMPs within each region is queried annually. Calls are made to providers in the identified sample before 8 a.m. or after 5 p.m. and on Saturdays, Sundays, and holidays. A call log is kept until calls are completed. All calls are tabulated, and the results posted with noncompliance reasons stated and corrective action identified.

Analysis

The goal is to have 100% compliance. The findings are summarized as indicated in Table D.1.

Table D.1 – Sample of Summarized 24-Hour Availability Audit Results

Region	Total Number of 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.

The audit report must identify steps taken to communicate audit results to PMPs' offices and must include actions necessary to achieve future compliance.

Appendix E: FSSA 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 *Care Select* primary medical providers (PMPs) is to ensure that 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 Family and Social Services Administration (FSSA).

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% confidence rate with a plus or minus 5% margin of error.

Call Instructions

Auditors 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 themselves as representatives of the Hoosier Healthwise program and state they are conducting an access-to-care audit.
4. Request to speak with the person who schedules appointments.
5. Ask managed care entity (MCE)-scripted questions relevant to the type of provider.
6. Document the actual date given for the appointment.

> *Note: If the next available appointment is with the nurse practitioner in the PMP's office, the appointment is acceptable.*

7. Document 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. To choose a replacement PMP, identify every third PMP on the nonsample list. This process provides consistency and maintains the integrity of the randomized process. PMPs are replaced only because of issues unrelated to the access audit. Any problems encountered must be reported for follow-up.

- *Nurse practitioners*: A PMP office is considered to be in compliance with appointment standards if the available appointment dates fall within recommended time frames. If there is a nurse practitioner in the 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 noncompliant with 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 delivers babies but does not provide gynecological (GYN) services. If the question does not apply to the PMP, 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

Standard	Appointment Type	Appointment Time Frame
1	Urgent or emergent care	24 hours
2	Nonurgent symptomatic	72 hours
3	Routine physical exam	Three months
4	Initial appointment (nonpregnant adult)	Three months
5	Routine gynecological exam	Three months
6	New obstetric patient	Within one month of date of attempting to schedule an appointment
7	Initial appointment – Well child	Within one month of date of attempting to schedule an appointment
8	Children with special healthcare needs	One month
9	Average office wait time	One hour or less
10	Specialist referral: Emergency	 24 hours

Standard	Appointment Type	Appointment Time Frame
	Urgent	48 hours

The standard for children with special healthcare needs must be addressed for patients who have medical conditions that last (or that will last) more than one year, require special equipment, or have physical access concerns.

Analysis

The analysis of data is presented by specialty types of practice for each appointment type. See Table E.2 for an example. An additional summary table for compliance with all appointment types is also required (see Table E.3). Providers who participate in the study are sent their individual results and the aggregate results of their peers. Names of PMPs who fail to meet the expected standards are forwarded to the provider services department of the appropriate MCE for program education. All results are reported to the FSSA in the following table format for each appointment access standard.

The percentages reported must represent the total for whom the standard is applicable. For example, if a total of 100 OB/GYNs were surveyed, but only 80 do routine gynecological exams, the results for the routine gynecological exam standard would be divided by 80 to obtain the percentage of those who met 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 for *Care Select* activities.
2. Information about PMPs that did not meet the standards is forwarded to the fiscal agent's Member and Provider Relations Unit, and copies of letters sent to physicians are placed in the PMPs' files.

Reporting Activity

The final results are provided to the *Care Select* QIC.

Appendix F: Fiscal Agent Care Management Organization 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 on 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 fiscal agent bulletin board (BBS) midday on the 12th and 27th days of each month and on 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 on the first day of the following month.*

The dates listed in Table F.1 are approximate dates of processing and are subject to change.

Table F.1 – Production Enrollment 834 Records and Reports

Production Enrollment 834 Records and Reports	
January 12 – change	July 12 – change
January 27 – change and audit	July 27 – change and audit
January 31 – change	July 31 – change
February 12 – change	August 12 – change
February 27 – change and audit	August 27 – change and audit
February 28 – change	August 31 – change
March 12 – change	September 12 – change
March 27 – change and audit	September 27 – change and audit
March 31 – change	September 30 – change
April 12 – change	October 12 – change
April 27 – change and audit	October 27– change and audit
April 30 – change	October 31 – change
May 12 – change	November 12 – change
May 27 – change and audit	November 27 – change and audit
May 31 – change	November 30 – change
June 12 – change	December 12 – change
June 27 – change and audit	December 27 – change and audit
June 30 – change	December 31 – change

Monthly, the care management organization (CMO) accesses administration fee payment data using the *820 – MCE Capitation Payment Information Transaction*.

The following tables provide the codes applicable to the 820 transaction file.

Table F.2 lists applicable CMO administration fee rate cells.

Table F.2 – Care Management Organization Capitation Rate Cells

Description	Capitation Categories
Care Select Member Administration Fee Tier 1	Z1
Care Select Member Administration Fee Tier 2	Z2
Care Select Member Administration Fee Tier 3	Z3
Care Select Member Administration Fee Tier 4	Z4
Care Select Member Administration Fee Tier 5	Z5
Right Choices Program Administration Fee Tier 6	Z6

Table F.3 – Managed Care Capitation Payment Reason Codes

Description	Capitation Reason Codes
Payment – Half Month Normal	HN
Payment – Birth Month	PB
Payment – Half Month Retro	PH
Payment – Normal	PN
Payment – Retro	PR
Payment – Adjustment Payment	PA
Payment – Adjustment Recon Full Month	PC
Payment – Delivery Increase	PD
Payment – Adjustment Recon Half Month	PE
Payment – Adjustment Recon Birth Month	PG
Payment – Adjustment Increase	PI
Payment – Recipient Elig Adj	PJ
Payment – Retroactive Elig Between Programs	PK
Payment – Adjustment Auto-Recon Full Month	PL
Payment – Adjustment Auto-Recon Half Month	PM
Payment – Adjustment Auto-Recon Birth Month	PO
Recoupment – Delivery	RC
Recoupment – Death	RD
Recoupment – Recipient Elig Adj	RE
Recoupment – Adjustment Recovery Full	RF
Recoupment – Retroactive Elig Btwn Programs	RG

Recoupment – Adjustment Auto-Recon Half Month	RH
Recoupment – Adjustment Auto-Recon Full Month	RL
Recoupment – Adjustment Recovery Partial	RP
Recoupment – Delivery Systematic	RS
Recoupment – Normal Payment Notice of Pregnancy	NP
Recoupment – Notification of Pregnancy	RN

Schedule for Administration Fee Payment Cycle

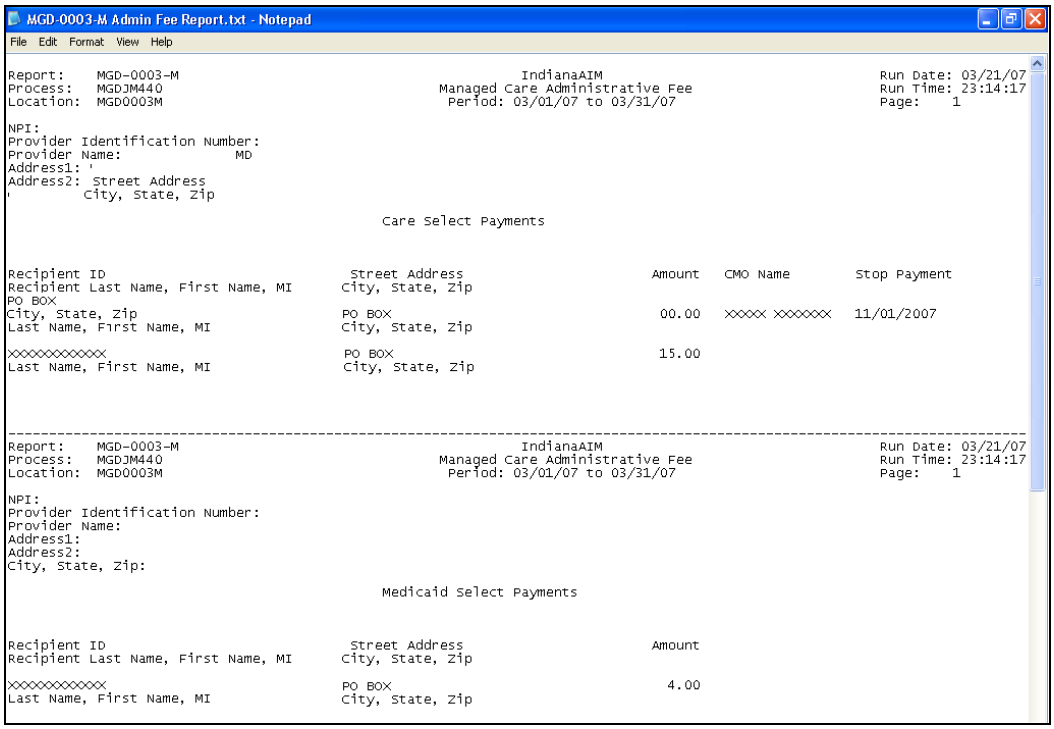
The administration fee and capitation payment cycle always runs the third Wednesday of every month, and 820 files generate the following Saturday.

Schedule for Production Administration Fee 820 Records and Reports

The 820 is produced on the Saturday after the first Wednesday that falls on or after the 15th day of the month. Barring problems with the run, the 820 rosters and summary reports are available midday the following day.

Appendix G: Administration Fee Listing Layout

The following is the primary medical provider (PMP) Administration Fee Listing layout that is mailed to the PMPs monthly.



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:              MD
Address1: '
Address2:  Street Address
'          City, State, Zip

                                        Care Select Payments


Recipient ID                          Street Address                      Amount   CMO Name        Stop Payment
Recipient Last Name, First Name, MI   City, State, Zip
PO BOX
City, State, Zip                      PO BOX                               00.00   XXXXX XXXXXXX   11/01/2007
Last Name, First Name, MI             City, State, Zip

XXXXXXXXXXX                           PO BOX                               15.00
Last Name, First Name, MI             City, State, Zip



--------------------------------------------------------------------------------------------------------------------------
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:
Address1:
Address2:
City, State, Zip:

                                        Medicaid Select Payments


Recipient ID                          Street Address                      Amount
Recipient Last Name, First Name, MI   City, State, Zip

XXXXXXXXXXX                           PO BOX                                4.00
Last Name, First Name, MI             City, State, Zip
```

Figure G.1 – PMP Administration Fee Listing

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