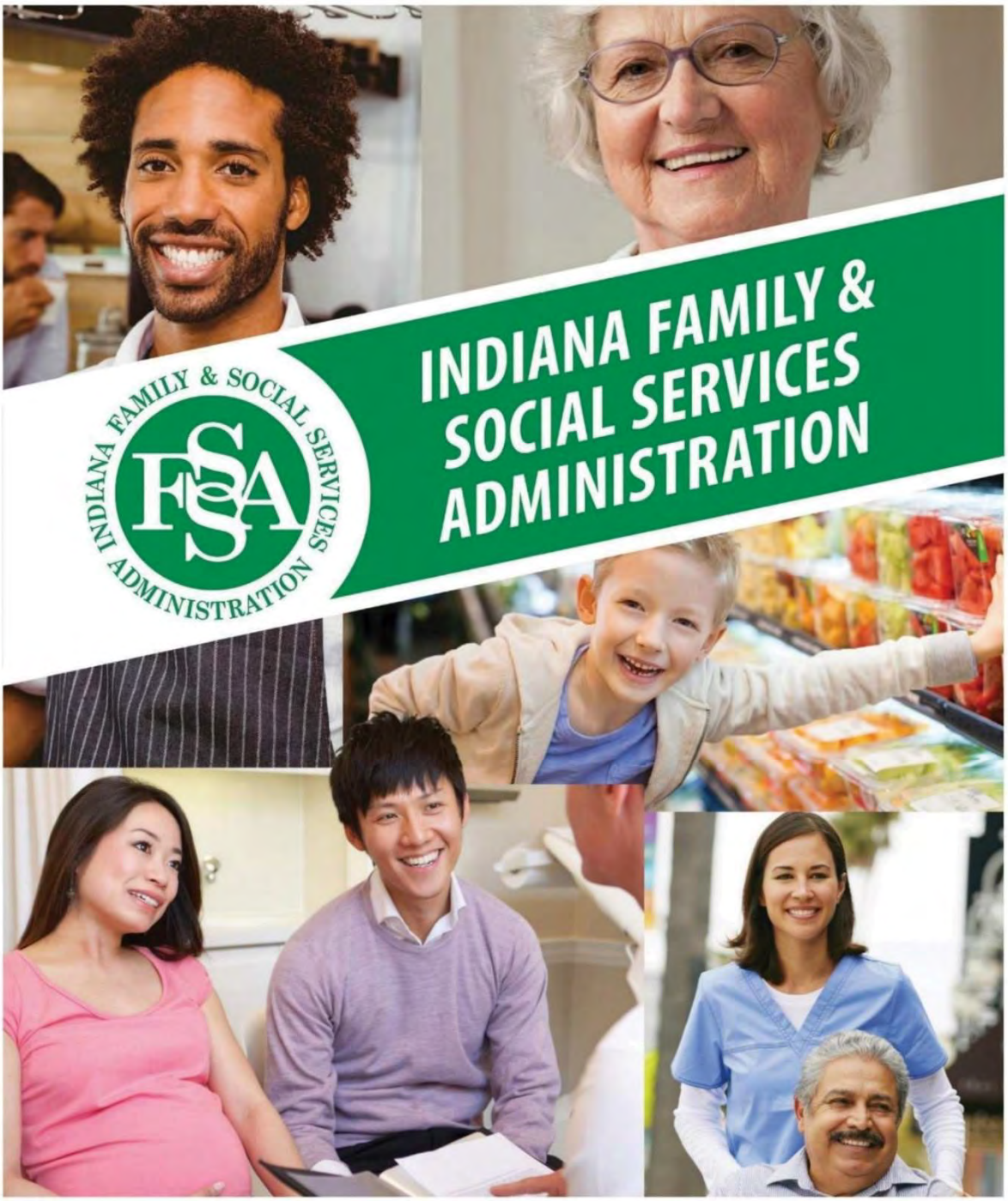
Office of Medicaid Policy & Planning

Indiana Health Coverage Programs 2022 Quality Strategy Plan



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SECTION I. Introduction

Managed care goals, objectives and overview

Overview of Indiana Health Coverage programs

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

The Indiana Family and Social Services Administration is the single state agency responsible for administering Medicaid programs. Per the U.S. Census Bureau, the population of Indiana in 2021 was 6.805 million. Per FSSA's Data and Analytics unit, the Medicaid enrollment in December 2021 was 1,971,017, of which 1,643,811 were in managed care. Thus, Medicaid provides vital health care to approximately one in four Hoosiers. In 2022, Indiana's health care coverage includes services through the Hoosier Healthwise program, Children's Health Insurance Program, Healthy Indiana Plan, Hoosier Care Connect or fee-for-service. Indiana's risk-based managed care programs include HHW, HIP and HCC. CHIP members may be served through Risk-Based Managed Care within HHW or FFS. The CHIP Quality Strategy plan is incorporated in this IHCP Quality Strategy Plan.

The FSSA Office of Medicaid Policy and Planning's Quality and Outcomes Section is charged with oversight of the managed care entities through reporting, contract compliance, and quality initiatives specific to the HHW, CHIP, HIP and HCC programs. The OMPP Quality and Outcomes staff provide oversight to the Medicaid managed care entities by monitoring data and reporting, seeks opportunities to enhance the quality of care provided to members, and contract compliance monitoring and supervision. Data collection and reporting are facilitated through the MCE's quarterly and annual self-reporting and through the Enterprise Data Warehouse program-wide reports. The MCEs must submit Quality Assessment and Performance Improvement programs to OMPP for approval and report on the quality of care at least annually. The MCE must:

- Assess the quality and appropriateness of care provided to members with special needs.
- Complete performance improvement projects in a reasonable time, to allow information about the success of the projects to be incorporated into subsequent quality improvement projects.
- Produce new information and reports on the quality of care at least annually.

OMPP Quality and Outcomes staff conducted a training for all MCEs on Quality Improvement Projects on Dec. 1, 2021. A training on QAPIs occurred during the December 2021 Quality Strategy Meeting. Both trainings informed the MCEs on the CMS QAPI requirements. The OMPP Quality and Outcomes team reviews all MCE QAPIs to ensure that priorities are aligned across all programs and populations.

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

With managed care being the delivery of health care to 83% of Indiana Medicaid members in 2021, it is Indiana's goal to ensure that the contracted MCEs not only perform the administrative functions of a typical insurer, but also be adept at addressing the unique challenges and needs of low-income populations. The plans are also expected to manage and integrate care along the continuum of health care services. OMPP expects the contracted MCEs to:

- Improve overall health outcomes
- Foster personal responsibility and healthy lifestyles
- Increase consumer knowledge of health care by increasing health care literacy as well as providing price and quality transparency
- Improve access to health care services
- Engage in provider and member outreach regarding preventive care, wellness and a holistic approach to better health
- Develop innovative utilization management techniques that incorporate member and provider education to facilitate the right care, at the right time, in the right location

To ensure that these expectations are met, Indiana oversees the allocation of care throughout multiple means—administratively, fiscally and through the delivery of member services, provider services, service utilization, care management and claims payments. Medicaid Quality and Outcomes may use corrective action(s) when a contracted MCE fails to provide the requested services or otherwise fails to meet its contractual responsibilities to the state. It is the mission of the state to ensure that members receive services efficiently and effectively.

The five MCEs contracted with the state of Indiana are Anthem Insurance Companies, Inc. (Anthem), Coordinated Care Corporation, Inc. d/b/a Managed Health Services, MDwise, Inc., CareSource and UnitedHealthcare. Two MCEs, Anthem and MHS have the HHW, HIP and HCC lines of business for risk-based managed care. Two MCEs, MDwise and CareSource, have the HHW and HIP lines of business for risk-based managed care. A fifth MCE, UnitedHealthcare, was selected and began administering the HCC program on April 1, 2021. The MCEs are expected to achieve the goals and objectives set forth by OMPP and manage the care of members enrolled in the HHW, HIP and HCC programs. Table 1 shows the different types of plans available in Indiana Medicaid.

TABLE 1 Indiana Medicaid Programs

Plan name	Populations served	Managed Care Authority	Managed Care Entity
Hoosier Healthwise	Low-income families, some pregnant members, and children – including Children's Health Insurance Program children up to age 19 within certain federal poverty level guidelines	1115(a) 1932(a)	Anthem Managed Health Services MDwise CareSource
Healthy Indiana Plan	Pregnant members and adults between the ages of 19 and 64	1115	Anthem Managed Health Services MDwise CareSource
Hoosier Care Connect	Individuals who are 65+ years of age, blind or disabled	1915(b1) (b4)	Anthem Managed Health Services

TABLE 1	Indiana Medicaid Programs		
Plan name	Populations served	Managed Care Authority	Managed Care Entity
			UnitedHealthcare
Traditional Medicaid	Dually enrolled receiving Medicare and Medicaid benefits, persons receiving Home- and Community-Based Services Waiver benefits, those receiving care in a nursing facility or other state-operated facility, individuals in a specific Medicaid aid category, such as Refugee or the Breast and Cervical Cancer aid category, and others not in risk-based managed care		None

History and overview of IHCP's risk-based managed care programs

Collectively, Hoosier Healthwise, Hoosier Care Connect, and the Healthy Indiana Plan share in ensuring members' access to primary and preventive care services by seeking to improve quality, continuity, and appropriateness of medical care. The historical timeline for Indiana's risk-based managed care program is contained in Appendix 1.

Hoosier Healthwise

Indiana established the HHW program in 1994 under the administration of OMPP. The state first introduced a primary care case management delivery system called PrimeStep. Two years later, Indiana added a risk-based managed care delivery system made up of MCE-contracted health plans, which are health maintenance organizations, authorized by the Indiana Department of Insurance, and contracted with OMPP. The historical timeline for the HHW program may be found in Appendix 2.

HHW provides health care coverage for low-income families, some pregnant members and children. The program covers medical care including, but not limited to, doctor visits, prescription medicine, mental health care, dental care, hospitalizations, surgeries and family planning at little or no cost to the member or the member's family. Based on a Feb. 1, 2018, waiver approval, all newly pregnant members with incomes at or below 138% of the federal poverty level are served in the HIP program. Pregnant members with incomes above 138% of the FPL continue to be served in HHW. HHW members are eligible for benefits either through Medicaid or through CHIP.

CHIP health care coverage is for children up to age 19 and is available to members who may earn too much money to qualify for the standard HHW coverage. A child may be covered in CHIP under the managed care HHW Package C by paying a low-cost monthly premium. The managed care entities that provide CHIP benefits as part of HHW are Anthem Insurance Companies, Inc., Coordinated Care Corporation, Inc. d/b/a Managed Health Services, MDwise, Inc. and CareSource.

Healthy Indiana Plan

Indiana established HIP in 2008 under the administration of OMPP. HIP is a health coverage program for adults between the ages of 19 and 64. HIP is a state-sponsored program and requires minimal monthly contributions from the participant. It offers health benefits including hospital services, mental health care, physician services, prescriptions, and diagnostic exams.

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

The HIP program also includes medically frail members. OMPP gathered data in 2015 regarding the members identified as medically frail and established a baseline to determine if they are receiving necessary health care and to determine if there are access to care issues. OMPP received CMS approval for what was then known as "HIP 2.0" on Jan. 27, 2015, and began accepting applications for the program. Services began just days later, as the enhanced HIP program launched on Feb. 1, 2015. In addition to processing new program applications, the launch of HIP 2.0 included the conversion of members previously enrolled in the original HIP program as well as all non-pregnant adults enrolled in HHW, Indiana's traditional Medicaid managed care program. More than 222,000 individuals were enrolled in HIP 2.0 by the end of the first quarter of operations and, to date, HIP has continued to meet its enrollment goals with 739,973 individuals fully enrolled in HIP as of December 2021. All pregnant members with incomes 138% of the federal poverty level and below were moved into the HIP program beginning in February of 2018 and are included in the enrollment numbers.

In 2022, HIP continues to emphasize personal responsibility and preventive health services. The historical timeline for the HIP program may be found in Appendix 3.

Hoosier Care Connect

In 2013, Indiana House Enrolled Act 1328 was passed by the Indiana General Assembly. This act tasked FSSA with managing care of the aged, blind, and disabled Medicaid enrollees. In response, FSSA convened the ABD Taskforce comprised of staff from across key FSSA divisions and community stakeholders who worked in 2013 and 2014 to design the HCC risk-based managed care program for individuals with significant needs. HCC covers a variety of individuals who are not eligible for Medicare, including aged, blind, and disabled; individuals receiving Supplemental Security Income; individuals enrolled through Medicaid for Employees with Disabilities (M.E.D. Works). The historical timeline for the HCC program may be found in Appendix 5.

In 2020, the state of Indiana held a procurement to choose new managed care entities to serve the HCC program. Through the Indiana Department of Administration procurement Anthem Insurance Companies, Inc., Coordinated Care Corporation, Inc. d/b/a Managed Health Services, and UnitedHealthcare Community Plan were selected to administer the new contract which went live on April 1, 2021.

Traditional Medicaid populations

The Indiana Traditional Medicaid population is comprised of those groups of members not currently enrolled in HHW, HIP or HCC. Native American populations also have access to traditional fee-for-service Medicaid should they choose not to be enrolled in a MCE.

Traditional Medicaid members do not receive managed care services as the traditional Medicaid model utilizes a fee-for-service arrangement in which physicians, hospitals and other providers contract directly with the state for services they provide.

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

- Dually enrolled receiving Medicare and Medicaid benefits
- Persons receiving home-and community-based services waiver benefits

- Persons receiving care in a nursing facility or other state-operated facility
- Individuals in a specific Medicaid aid category, such as Refugee or the Breast and Cervical Cancer aid category
- Others not in risk-based managed care

SECTION II. Development and review of quality strategy

The OMPP Quality and Outcomes Team monitors the trends in health care in the state of Indiana for all Medicaid members. Quality measures are re-evaluated and established annually in the MCE contracts as a component of statewide quality initiatives as well as pay-for-performance metrics. OMPP monitors the progress of the metrics with the goal of improving health care for Medicaid members served by the contracted MCEs. Periodically, external stakeholders identify issues or initiatives for OMPP consideration and the impact on the state. For example, in 2014 an initiative targeted at smoking cessation and pregnant members was added as an incentive measure to the MCE contracts, which remains today. As a result of input from 2020, OMPP will continue in 2022 to utilize the HEDIS Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence, seven-day and 30-day measures as pay-for-outcomes in the HIP program as part of the effort to focus on providing services to those members with alcohol dependency or substance use disorder. The Indiana Medicaid managed care programs are reviewed through a variety of forums. Input from those forums is used to review the Quality Strategy Plan and to make annual adjustments.

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

The MCE quality directors include OMPP in monthly collaboration meetings to review and discuss their ongoing Quality Improvement Projects, Quality Management and Improvement Program work plans and strategic initiatives. The contracted MCEs use the group for focused problem-solving, clarification and partnership in quality reporting. These collaboration meetings will continue in 2022.

OMPP holds OMPP Quality Committee meetings quarterly with these representatives to discuss the progress of quality improvement projects, quality subcommittee activities and reports of outcomes measures. The OMPP Quality Committee supports, advises and informs OMPP on the performance and progress toward the initiatives identified in the Quality Strategy Plan. The MCEs submit quality improvement projects for discussion at each quarterly meeting. The HHW, HIP and HCC MCEs submit quarterly clinical quality measures reports in various areas, such as the following:

- Preventive services and chronic care
- Prenatal and postpartum health outcomes
- Children and adolescents preventive care
- Behavioral health
- Utilization management
- Ambulatory care

Individual initiative reports are presented to the OMPP Quality Committee by the MCEs. The role of the committee is to assist in the development and monitoring of identified goals and strategic objectives of the written Quality Strategy and to advise and make recommendations to OMPP. The quality unit reports to the OMPP Program Evaluation manager who reports directly to the OMPP Quality and Outcomes director. The OMPP Quality and Outcomes director reports directly to the Medicaid director. The OMPP Quality and Outcomes director is the sponsor of the OMPP Quality Committee. Currently, the members of the OMPP Quality Committee include representatives from:

- Office of Medicaid Policy and Planning
- Division of Mental Health and Addiction
- Indiana Department of Health
- Providers (pediatrician, adult health and behavioral health)
- MCE quality managers
- Advocacy groups
- Consumers
- Providers
- Academia

Table 2 provides the annual schedule of OMPP Quality Committee meetings for 2022.

TABLE 2: Annual Schedule of the Quality Strategy Committee and Subcommittees

Meeting	Description	Frequency	2022 Dates
Quality Strategy Committee	Oversight of other focus groups, including neonatal and health services utilization issues and providing input for overarching Quality Strategy	Quarterly, 1-3 p.m.	3/29/2022 6/28/2022 9/27/2022 12/13/2022
Dental Advisory Panel	Focus: Improve oral health. Provide input on dental policy and provide clinical recommendations to improve oral health and the overall health of members.	Biannually, 1:30 – 3 p.m.	6/17/2022 End of 2022 (Date TBD)

In 2019, the Quality Strategy Committee, Health Services Utilization Subcommittee and Neonatal Subcommittees were combined into a single quarterly meeting. During 2021, MCE presentations focused on the development and implementation of strategies to increase the childhood immunization rates which fell dramatically due to COVID-19, increase lead screening in children, and improve COVID-19 vaccination rates among the Medicaid population. Each MCE was required to provide a plan containing baseline rates, strategies to increase rates, and interventions to be implemented including a timetable for initiation and completion. Each MCE was then required to provide an update quarterly during subsequent meetings. During the June 2021 quality meeting, the MCEs provided an overview of their efforts to identify and treat members with Sickle Cell Disease. OMPP included members of the Centers for Disease Control and Prevention and members from the Indiana Hemophilia and Thrombosis Center, who provided presentations on Sickle Cell Disease and a resource page for MCEs. Other presentations and topics discussed during the quality meetings include infant mortality reduction strategies, updates on My Healthy Baby initiative, External Quality Review recommendations and requirements, the 2021 pay-for-outcomes, and 2020 HEDIS results. Meeting topics during 2022 will include infant mortality rate reduction strategies, MCE efforts on health equity, childhood immunization rates during COVID-19 and an overview of the MCE 2022 HEDIS results (for calendar year 2021).

As a result of this shared information, the stakeholders' participation and cooperation are used to monitor, evaluate, share best practices, and improve performance. Committee members actively participate on behalf of the state of Indiana and the many Hoosiers reliant on quality health care. OMPP strives to continue raising the bar for health care and improve the quality of life for thousands of infants, children, adolescents and adult Hoosiers across the state of Indiana. OMPP maintains an ongoing review of movement within the strategic objectives through these quality committees.

The findings from the annual External Quality Review are used to monitor quality initiatives and identify areas for improvement. Initiatives may be identified for inclusion in the Quality Strategy Plan or for program modifications. The 2021 EQR for the 2020 calendar year focused on themes across multiple facets. Focus studies for the 2021 EQR were:

- Validation of performance measures
- Validation of MCE performance improvement projects
- Validation of performance measures specific to Report 0510 Institution for Mental Disease Member use
- Review of compliance with Medicaid and CHIP Managed Care Regulations
- Validation of encounter data
- Examination of MCE network adequacy specific to primary medical providers

From recent EQR findings related to the provider network adequacy and non-emergency medical transportation, OMPP identified opportunities for improvement in MCE reporting. Specific to network adequacy, OMPP provided clarity in the provider definitions for reporting including the basis and methodology for counting providers and the specifications on the categorization of providers. OMPP added NEMT reporting requirements to determine the frequency and reason for trips that were requested but could not be filled due to lack of provider availability and member no-shows. OMPP utilized the findings from the NEMT reports to conduct an onsite validation with the MCEs in January 2022.

Public comment

The state provides the quality strategy for public comment prior submitting it to CMS for review. The public comment includes obtaining input from the Medicaid Advisory Committee, members and other stakeholders. The quality strategy is also provided to the recognized Tribe in Indiana, the Pokagon band of Potawatomi, as it is provided to their tribal liaison via email by the OMPP Federal Relations Lead.

SECTION III. Goals and objectives

Quality metrics and performance targets

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

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

As part of the four global aims to support the program goals and objectives, OMPP also aligns with the Medicaid and CHIP Child and Adult Quality Core Sets. OMPP has tracked and monitored the Child Core Sets since the initiation by CMS. The Child Core Sets are created and tracked by an outside vendor, Burns and Associates. The Adult Core Sets are not yet required by CMS but OMPP voluntarily started reporting these and continues working towards quality of data. Information on OMPP reporting of the core sets can be found in the State Health Information Technology section.

The development of the HHW, HIP and HCC quality strategy initiatives is based on identified trends in health care issues within the state of Indiana, attainment of the current quality strategy goals, close monitoring by OMPP of the managed care entities' performance and unmet objectives, opportunities for improvement identified in the external quality review, and issues raised by external stakeholders and partners. OMPP has outlined initiatives for 2022 specific to each of the programs in Tables 3 through 6 below.

Hoosier Healthwise strategic objectives for quality improvements 2022

OMPP has outlined initiatives for 2022 specific to the HHW program in Table 3. Some of these objectives have been monitored and maintained from previous years, while other measures are new for the 2022 quality strategy.

TABLE 3	2022 Hoosier Healthwise Initiatives				
Objective	Methodology	MCE	2021 Baseline	2021 Results	Goal
1. Improvements in children and adolescents well-care Percentage of members with well-child visits during first 21 years of life. HEDIS measures, well-child visits in the first 30 months of life and child and adolescent well-care visits for ages 3-21 using hybrid data.	OMPP utilizes HEDIS measures for tracking the percentages of well-child services in children and adolescents	Anthem	At or above the 50th percentile	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile of adolescent well-care visits for ages 3-21.	Achieve at or above the 90th percentile of the NCQA 2022 Quality Compass improvements in children and adolescent well-child W30 and WCV HEDIS measures.
		CareSource	At or above the 50th percentile	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile for adolescent well-care visits for ages 3-21.	

TABLE 3	2022 Hoosier Healthwise Initiatives				
Objective	Methodology	MCE	2021 Baseline		Goal
		MDwise	At or above the 50th percentile	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile for adolescent well-care visits for ages 3-21.	
		MHS	At or above the 50th percentile.	Below the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile for adolescent well-care visits for ages 3-21.	
2. Improvements in childhood immunization status – Combination 10		Anthem	To be determined.	New for 2022.	Achieve at or above the 50th percentile of the NCQA Quality Compass for member childhood immunization status (Combination 10) during the measurement year.
		CareSource	To be determined.	New for 2022.	
		MDwise	To be determined.	New for 2022.	
		MHS	To be determined.	New for 2022	
3. Completion of health needs screen (>65%)	Administrative reporting.	Anthem	At or above 55%.	New for 2022.	Achieve at or above the 65% for all new members completing the health needs screening within 90 days of enrollment.
		CareSource	At or above 55%.	New for 2022.	

TABLE 3	2022 Hoosier Healthwise Initiatives				
Objective	Methodology	MCE	2021 Baseline	2021 Results	Goal
		MDwise	At or above 55%.	New for 2022.	
		MHS	At or above 55%.	New for 2022.	
4. Annual dental visit	OMPP utilizes HEDIS for tracking the percentage of members, aged 2-20 years, who had at least one dental visit during the measurement year.	Anthem	At or above 25th percentile.	At or above the 50th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for member dental visits during the measurement year.
		CareSource	At or above 25th percentile.	At or above the 25th percentile.	
		MDwise	At or above 25th percentile.	At or above the 50th percentile.	
		MHS	At or above 25th percentile.	At or above the 50th percentile.	
5. Lead screening in children	OMPP utilizes HEDIS for tracking the percentage of children 2 years of age who had one or more capillary or venous blood lead tests for lead poisoning by their second birthday.	Anthem	At or above 25th percentile.	At or above the 25th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for lead screening in children.
		CareSource	At or above 25th percentile.	At or above the 25th percentile.	
		MDwise	At or above 25th percentile.	At or above the 25th percentile.	
		MHS	At or above 25th percentile.	At or above the 25th percentile.	
6. Asthma medication ratio	OMPP utilizes HEDIS for tracking the percentage of children aged 5-11 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater.	Anthem	At or above the 50th percentile.	At or above the 50th percentile.	Achieve at or above the 90th percentile of the NCQA 2022 Quality Compass for asthma medication ratio.
		CareSource	At or above the 50th percentile.	At or above the 75th percentile.	
		MDwise	At or above the 50th percentile.	At or above the 50th percentile.	
		MHS	At or above the 50th percentile.	At or above the 75th percentile.	

TABLE 3	2022 Hoosier Healthwise Initiatives				
Objective	Methodology	MCE	2021 Baseline		Goal
7. Prenatal depression screening in pregnant members	OMPP utilizes HEDIS for tracking the percentage of members receiving prenatal depression screening in pregnant members	Anthem	NCQA in process of baselining.	Successful submission of results.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for prenatal depression screening.
		CareSource	NCQA in process of baselining.	Successful submission of results.	
		MDwise	NCQA in process of baselining.	Successful submission of results.	
		MHS	NCQA in process of baselining.	Successful submission of results.	
8. Increase in COVID-19 Vaccination rate	Administrative reporting	Anthem	To be determined.	New for 2022.	Achieve at or above 70% of eligible membership fully vaccinated.
		CareSource	To be determined.	New for 2022.	
		MDwise	To be determined.	New for 2022.	
		MHS	To be determined.	New for 2022.	

HIP Strategic Objectives for Quality Improvement 2022

Table 4 demonstrates the objectives specific to the HIP program. Some of these objectives have been monitored and maintained from previous years while other measures are new for the 2022 Quality Strategy Plan.

TABLE 4	2022 Healthy Indiana Plan Initiatives				
Objective	Methodology	MCE	2021 Baseline	2021 Results	Goal
1. POWER Account rollover (HEDIS AAP) HIP members who obtain a preventive exam during the measurement year receive power account rollover. Only codes and code combinations listed in the categories 'Preventive Care Counseling Office Visit' and 'Alternative Preventive Care Counseling Visit' apply to this measure.	OMPP utilizes HEDIS for tracking the percentage of HIP members who receive a qualifying preventive exam.	Anthem	At or above the 25th percentile.	At or above the 25th percentile.	Achieve rate at or above the 75th percentile of the NCQA 2022 Quality Compass of members who received a preventative exam.
		CareSource	At or above the 25th percentile.	Below the 25th percentile.	
		MDwise	At or above the 25th percentile.	At or above the 25th percentile.	
		MHS	At or above the 25th percentile.	At or above the 25th percentile.	
2. Prenatal depression screening in pregnant members	OMPP utilizes HEDIS for tracking the percentage of members receiving prenatal depression screening in pregnant members	Anthem	NCQA in process of baselining.	Successful submission of results.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for prenatal depression screening.
		CareSource	NCQA in process of baselining.	Successful submission of results.	
		MDwise	NCQA in process of baselining.	Successful submission of results.	
		MHS	NCQA in process of baselining.	Successful submission of results.	
3. Timeliness of ongoing prenatal care	OMPP utilizes HEDIS for tracking the percentage of	Anthem	At or above the 10th percentile.	At or above the 50th percentile.	

TABLE 4	2022 Healthy Indiana Plan Initiatives				
Objective	Methodology	MCE	2021 Baseline	2021 Results	Goal
	members receiving timeliness of ongoing prenatal care.	CareSource	At or above the 10th percentile.	At or above the 25th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for the timeliness of prenatal.
		MDwise	At or above the 10th percentile.	At or above the 50th percentile.	
		MHS	At or above the 10th percentile.	At or above the 50th percentile.	
4. Frequency of post-partum care	OMPP utilizes HEDIS for tracking the percentage of members who receive required post-partum visits.	Anthem	At or above the 25th percentile.	At or above the 75th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for required post-partum visits.
		CareSource	At or above the 25th percentile.	Below the 25th percentile.	
		MDwise	At or above the 25th percentile.	At or above the 50th percentile.	
		MHS	At or above the 25th percentile.	At or above the 50th percentile.	
5. Completion of health needs screen (>65%)	Administrative reporting.	Anthem	At or above 60%.	45.60%	Achieve at or above the 65% for all new members completing the health needs screening within 90 days of enrollment.
		CareSource	At or above 60%.	35.01%	
		MDwise	At or above 60%.	60.83%	
		MHS	At or above 60%.	70.36%	
6. Follow-up after emergency department visit for alcohol and other drug abuse dependence 7 day	HEDIS measure using administrative data	Anthem	At or above the 25th percentile.	At or above the 50th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
		CareSource	At or above the 25th percentile.	At or above the 50th percentile.	
		MDwise	At or above the 25th percentile.	At or above the 50th percentile.	

TABLE 4	2022 Healthy Indiana Plan Initiatives				
Objective	Methodology	MCE	2021 Baseline		Goal
		MHS	At or above the 25th percentile.	At or above the 50th percentile.	
7. Follow-up after emergency department visit for alcohol and other Drug Abuse Dependence 30 day	HEDIS measure using administrative data	Anthem	At or above the 25th percentile.	At or above the 75th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
		CareSource	At or above the 25th percentile.	At or above the 50th percentile.	
		MDwise	At or above the 25th percentile.	At or above the 50th percentile.	
		MHS	At or above the 25th percentile.	At or above the 25th percentile.	
8. Increase in COVID-19 Vaccination rate	Administrative reporting	Anthem	To be determined.	New for 2022.	Achieve at or above 70% of eligible membership fully vaccinated.
		CareSource	To be determined.	New for 2022.	
		MDwise	To be determined.	New for 2022.	
		MHS	To be determined.	New for 2022.	

Hoosier Care Connect strategic objectives for quality improvement 2022

Table 5 demonstrates the 2022 objectives specific to the HCC program. Some of these objectives have been monitored and maintained from previous years while other measures are new for the 2022 Quality Strategy Plan.

TABLE 5	2022 Hoosier Care Connect Initiatives				
Objective	Methodology	MCE	2021 Baseline	2021 Results	Goal
1. Adult preventative care (HEDIS)	OMPP is using the adult preventive care HEDIS measure for tracking preventive care.	Anthem	At or above the 25th percentile.	At or above the 75th percentile.	Achieve at or above the 75th percentile for NCQA 2022 Quality Compass for members 20 years and older who had a preventive care visit.
		MHS	At or above the 25th percentile.	At or above the 50th percentile.	
2. Completion of health needs screen (>65%)	Administrative reporting	Anthem	At or above 60%.	44.45%	Achieve completion of a Health Needs Screen for > 65% of all members during the first 90 days of enrollment.
		MHS	At or above 60%.	78.08%	
3. Completion of comprehensive health assessment tool	Administrative reporting	Anthem	At or above 73%.	77.60%	Achieve completion of a comprehensive health assessment for >79% for all members who are stratified into complex case management or the Right Choice Program following the initial screening, during the first 150 days of enrollment.
		MHS	At or above 73%.	87.53%	
4. Annual dental visit (HEDIS)	OMPP is utilizing the annual dental visit HEDIS measures for tracking annual dental visits.	Anthem	To be determined.	New for 2022.	Achieve at or above the 75th percentile for NCQA 2022 Quality Compass for members ages 2 to 20 years who had a dental visit.
		MHS	To be determined.	New for 2022.	
5. Follow-up after emergency department visit for alcohol	HEDIS measure using administrative data	Anthem	At or above the 25th percentile.	At or above the 50th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.

TABLE 5	2022 Hoosier Care Connect Initiatives				
Objective	Methodology	MCE	2021 Baseline	2021 Results	Goal
and other drug abuse dependence 7 day		MHS	At or above the 25th percentile.	At or above the 25th percentile.	
6. Follow-up after emergency department visit for alcohol and other drug abuse dependence 30 day	HEDIS measure using administrative data	Anthem	At or above the 25th percentile.	At or above the 25th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
		MHS	At or above the 25th percentile.	At or above the 25th percentile.	
7. Increase in COVID-19 Vaccination rate	Administrative reporting	Anthem	To be determined.	New for 2022.	Achieve at or above 70% of eligible membership fully vaccinated.
		MHS	To be determined.	New for 2022.	

Traditional Medicaid strategic objectives for quality improvement 2022

In 2022, OMPP will continue efforts to involve the traditional Medicaid population into the overall quality improvement efforts.

Table 6 demonstrates the objectives specific to OMPP's Traditional Medicaid initiatives.

TABLE 6	2022 Traditional Medicaid Initiatives			
Objective	Methodology	2021 Baseline	2021 Result	Goal
1. Breast cancer screening percentage of members who had a mammogram to screen for breast cancer.	Administrative reporting through Enterprise Data Warehouse using HEDIS specifications.	HEDIS BCS	32.31%	Increase the 2022 rate by 3%.
2. Follow-up after emergency department visit for alcohol and other drug abuse or dependence (HEDIS FUA 7-Day)	Administrative reporting through Enterprise Data Warehouse using HEDIS specifications.	HEDIS FUA 7 Day	11.11%	Increase the 2022 rate by 3%.

Public posting of quality measures and performance

OMPP Quality and Outcomes posts quality measures and performance outcomes annually to the Quality and Outcomes Reporting webpage found at: https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/.

OMPP posts annual HEDIS results for the following measures to the Quality and Outcomes Reporting webpage.

- Preventive care child measures
- Other physical health child measures
- Behavioral health child measures
- Preventive care adult measures
- Other physical health adult measures
- Behavioral health adult measures

OMPP monitors MCE compliance with contractual requirements. The MCEs submit reports to OMPP on a monthly and quarterly basis, which are reviewed by staff for compliance with the hundreds of service level agreements. Synopses of the MCE quarterly performance results can also be found on the Quality and Outcomes Reporting webpage. The synopses include data such as the following.

- Engaging in member and provider outreach
- Provider service authorization requests
- Processing provider service claims
- MCE provider network adequacy
- Measuring member satisfaction with the MCEs

LTSS performance measures

The state is in the process of implementing managed LTSS with a focus on improving service coordination to make it easier for members to navigate long-term services. The state will partner with an experienced MCE to coordinate LTSS benefits and an individual's other benefits such as Medicare. The state released a request for information in July 2021 and anticipates releasing a request for proposals for the prospective MCE in 2022. The tentative implementation date for the LTSS program is early 2024.

The LTSS program will include program-specific performance measures and the state's goal is to integrate LTSS data for the purpose of continuous outcomes measurement and improvement.

SECTION IV. Quality of care

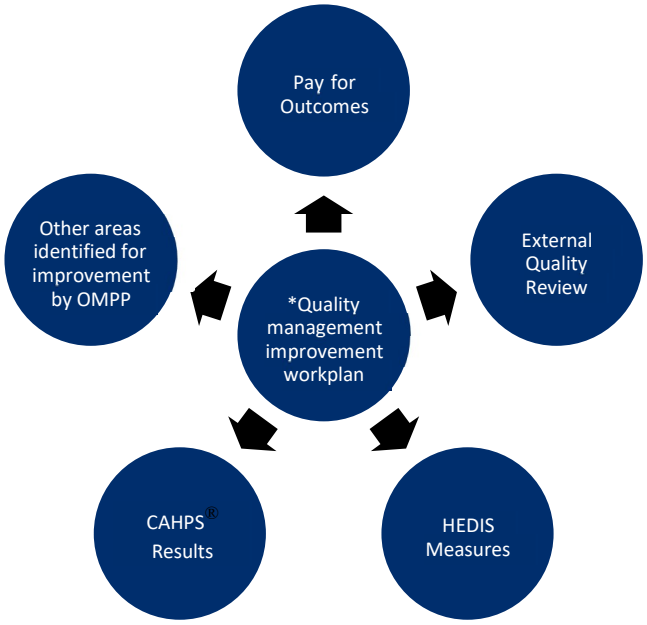
Measurement and improvement standards

The state places great emphasis on the delivery of quality health care to HHW, HIP and HCC members. Performance monitoring and data analysis are critical components in assessing how the MCEs maintain and improve the quality of care delivered across Indiana. Each reportable measure monitored by OMPP is either a HEDIS specification or is a state initiative. OMPP works with the MCEs to establish common definitions and understanding across plans for consistency in meeting HEDIS specifications and/or meeting state needs. MCE reporting is monitored monthly, quarterly and annually. Data is compared to contract specifications, HEDIS measures and between plans. During quarterly Quality Strategy Committee meetings, MCE performance data is shared. Specific priorities of each health care program

have been identified and are presented in a dashboard format comparing the MCEs' performance. OMPP uses a confirmation report process to provide feedback periodically to the MCEs on individual values.

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

OMPP identifies pay-for-outcomes measures by program. As illustrated in Table 8, a performance measure may apply to one or more health care programs. Annually, drafts of the next year's Quality Management and Improvement Work Plans and Quality Improvement Project plans are submitted to OMPP for review and approval. The QIPs are the equivalent of the CMS-required Performance Improvement Plan. OMPP continues to work with the MCEs to identify sources of input to the QMIP. The diagram below illustrates a minimum of six sources: the External Quality Review, HEDIS outcomes, CAHPS® outcomes, pay-for-outcomes results and other identified areas for improvement. Gaps in any of these sources should be addressed in the MCE's QMIP as well as any additional areas identified by OMPP.



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

The MCEs are required to develop an individualized QMIP for each of their Medicaid lines of business, although a specific Performance Improvement Plan may be utilized across multiple programs. The MCEs develop and submit draft QMIPS and PIPs by Oct. 31 for the prospective year. OMPP provides feedback to the MCEs as needed before the implementation of the QMIP on Jan. 1. Since 2016, OMPP has increased the focus on the measurement and effectiveness of the QIP interventions identified by the plans to achieve the desired improvement. OMPP provided technical assistance as needed and feedback to the plans specific to whether the identified interventions were measurable. Technical assistance and guidance were provided to the MCEs in the form of review and recommendations for their 2020, 2021 and 2022 QIPs.

To assess quality strategy effectiveness and to determine strategies for the following year, the MCEs review and monitor current member service utilization. Monitoring is conducted through data mining at the MCE level, reviewing data reports from the state fiscal agent Gainwell and referrals from providers.

Individuals with extensive utilization are further assessed for appropriateness in Indiana's restricted card program, the Right Choices Program, or disease management, care management, or complex case management programs. Individuals who underutilize appropriate health care services are encouraged to participate in preventive care services, and their PMPs are provided gaps in care reports to increase the utilization of preventive care.

Health need screens are used to identify individuals with special health care needs. HHW, HCC and HIP MCEs provide disease management, care management and complex case management programs targeting individuals with special health care needs.

OMPP has outlined 24 quality-related incentives measures in 2022. The outcome measures are composed of withholding measures and bonus measures. Targets for HEDIS measures are reviewed annually and updated when new NCQA benchmarks become available. The state recognizes that performance improvement is an ongoing process and intends to retain targets for at least two years. This allows for a longer timeframe for initiatives to take shape. At the end of 2021, performance measures were reviewed and revised, dropped or added to create targets more appropriate for meeting the needs of the Medicaid population and current state initiatives. Contract amendments occur on an annual basis or more frequently as needed if program changes occur. The Pay-for-Outcomes program is reviewed and updated as needed during the annual contract process.

The contracted MCEs may receive additional compensation for achieving or exceeding established metrics for pay-for-outcomes measures. Such additional compensation is subject to the MCEs' complete and timely satisfaction of its obligations under the state fiscal year 2022 contract. This includes timely submission of the contracted MCEs' HEDIS Report for the measurement year, the Certified HEDIS Compliance Auditor's attestation, the Consumer Assessment of Healthcare Providers and Systems report as well as timely submission of other reports detailed in the MCE Reporting Manual.

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

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

- OMPP has suspended capitation payments or enrollment to the contracted MCE
- OMPP has assigned the membership and responsibilities of the contracted MCE to another participating managed care organization
- OMPP has assumed or appointed temporary management with respect to the contracted MCE
- The contracted MCE's contract has been terminated
- The contracted MCE has, in the determination of the OMPP director, failed to execute a smooth transition at the end of the contract term, including failure to comply with the contracted MCE's responsibilities outlined in the scope of work
- Pursuant to the contract, OMPP has required a corrective action plan or assessed liquidated damages against a contracted MCE in relation to its performance under the contract during the measurement year

OMPP may, at its option, reinstate a MCE's eligibility for participation in the Pay-for-Outcomes program once the contracted MCE has properly remediated all prior instances of non-compliance and OMPP has satisfactory assurances of acceptable future performance.

OMPP works diligently to organize monitoring and reporting systems. One aspect of the OMPP quality improvement program is the monthly onsite monitoring visit with each contracted MCE. OMPP completes an in-depth review of various operational, reporting and quality topics at the onsite visit. A monthly onsite monitoring tool is prepared by OMPP Quality and Outcomes staff based on a selected topic of focus and sent to each MCE at the first of the month. The purpose of the monthly onsite monitoring tool is to gain practical insight into the current daily operational practices, reporting results, and internal quality assurance programs relative to the current month's chosen topic. The MCE returns the monthly onsite monitoring tool to OMPP with written responses to topic inquiries and other detailed quality and operational documentation for review by OMPP Quality and Outcomes. Requested data for review often consists of policies and procedures, trending and collection data, member/topic examples, and other specific information. OMPP Quality and Outcomes complete a detailed review of the supporting documentation submitted by the contracted MCE. Based on this detailed review, OMPP Quality and Outcomes prepares the agenda and a set of drill-down questions that are sent to the MCE in advance of the on-site visit. At the onsite visit, OMPP Quality and Outcomes staff discusses the MCE's performance as it relates to the operational, reporting and quality expectations. The MCEs have an opportunity to provide additional topic information and ask questions to gain a better understanding of the state's expectations and suggestions for improvement. The onsite visit offers an opportunity for the MCEs and OMPP Quality and Outcomes staff to discuss other issues not included on the agenda. Upon conclusion of the monthly onsite monitoring visits, OMPP Quality and Outcomes staff prepares and sends a feedback tool to each MCE that summarizes specific onsite visit information, action items and discussion of other high-level issues.

The on-site visit is an integral part of the process to ensure that the contracted MCEs are operating according to their contractual obligations. During the COVID-19 public health emergency, the Quality team has met virtually with the MCEs as part of the onsite requirement. The MCEs are asked to complete systems demonstrations and provide individual case reviews for members during these virtual meetings.

State-defined performance/quality improvement projects

OMPP requires standard processes for submission of QMIP Work Plans and Performance/Quality Improvement Projects from the contracted MCEs.

- QMIP Work Plan template: contracted MCEs are required to use a standard template for submission of QMIP Work Plans. This standardized template is a helpful tool for reviewing the draft work plans as well as the quarterly progress updates submitted by the contracted MCEs.
- QIPs: Contracted MCEs may use either the OMPP developed standard template or their own formatted document for submission of their QIPs. This allows for greater transparency into the development, implementation, review, and quarterly update of each MCE's QIPs.

For 2022, OMPP required all MCEs to develop a QIP specific to increasing the rates of completion for the Health Needs Screen. All MCEs were also required to create a QIP with interventions related to increasing the speed of engagement with care or case management for members with a recent ER visit related to substance abuse; increasing the number of individuals with a substance use disorder diagnosis who are engaged in care or case management; and increase the percentage of individuals who have an ER visit with a principal diagnosis of alcohol or other drug abuse or dependence who have a follow-up visit within seven or 30 days (HEDIS FUA measure).

Table 7 exhibits identified Performance/Quality Improvement Project topics of focus for 2022 for HHW, HIP and HCC.

TABLE 7	2022 Quality Improvement Projects				
QIP Topic	QIP Aim	QIP Intervention	Applicable	2022	2022 Goal
Anthem					
Health needs screen	Interventions and activities to increase completion rate for the OMPP approved health needs screen	• Expand call center hours and incentivize outreach specialists • Evaluate effectiveness of text outreach • Implement weekly email reminders • Implement social media campaign • Update marketing materials to emphasize the importance of HNS • Emphasize member and provider incentives Provider education on importance of completion of HNS	HHW	27.39%	40.00%
			HIP	46.59%	55.00%
			HCC	43.34%	55.00%
Follow-up and care coordination after emergency department visit for SUD	Interventions and activities to increase follow-up and care coordination engagement after an emergency department visit for substance use disorder	• Expand amount of member outreach by increasing call days and times • Increase provider engagement to assist in updating member contact information • Increasing engagement with the comprehensive mental health centers to coordinate members' behavioral and physical health • Utilize community health workers more frequently and effectively to outreach to members • Increase relationships with hospital discharge staff • Daily identification of members who visit the ED for SUD or alcohol abuse • Increased case management contact with members who have three or more ED visits in a month	HHW CM engagement	8.00%	15.00%
			HIP CM engagement	8.00%	15.00%
			HCC CM engagement	8.00%	15.00%
Managed Health Services					
Health needs screen	Interventions and activities to increase	• Increase completion of HNS via telephonic outreach and digital image via email	HHW	60.85%	70.00%

TABLE 7	2022 Quality Improvement Projects				
QIP Topic	QIP Aim	QIP Intervention	Applicable Program	2022 Baseline	2022 Goal
	completion rate for the OMPP approved health needs screen	• Increase use of Pursuant Health Kiosks at Walmart and CVS stores utilizing geo-fence technology • Include paper copy of HNS in each new member welcome packet • Promote member use of web portal for completion • Use of weekly email reminders • Member incentives	HIP	70.37%	75.00%
			HCC	79.03%	80.00%
Follow-up and care coordination after emergency department visit for SUD	Interventions and activities to increase follow-up and care coordination engagement after an emergency department visit for substance use disorder	• Provide member outreach via the ED Diversion Team • Use of member incentive	HHW FUA 7-Day	5.15%	7.09%
			HHW FUA 30-Day	6.19%	10/81%
			HIP FUA 7-Day	13.89%	15.47%
			HIP FUA 30-Day	20.10%	23.33%
			HCC FUA 7-Day	11.78%	12.72%
			HCC FUA 30-Day	16.92%	19.25%
MDwise					
Health needs screen	Interventions and activities to increase completion rate for the OMPP approved health needs screen	• Increase telephonic outreach to members with a valid phone number • Increase email outreach to members • Develop and implement interactive text outreach • Include paper copy of HNS in each new member welcome packet • Pilot use of community health workers in Allen County to complete the HNS	HHW	33.37%	55.00%
			HIP	60.85%	65.00%

TABLE 7	2022 Quality Improvement Projects				
QIP Topic	QIP Aim	QIP Intervention	Applicable Program	2022 Baseline	2022 Goal
Follow-up and care coordination after emergency department visit for SUD	Interventions and activities to increase follow-up and care coordination engagement after an emergency department visit for substance use disorder	• Outreach to members identified via pharmacy data specific to new fills for Benzodiazepines and Suboxone • Outreach to members identified via pharmacy data specific to new fills for antidepressant, antipsychotic, and antianxiety drug classes • Increase care and case management outreach based upon prior authorization requests for SUD services • Develop and implement a pilot program with two EDs experiencing a high volume of members with substance abuse to provide education on their follow-up needs	HHW CM Engagement	3.17%	5.00%
			HHW FUA 7-Day	HEDIS 25th Percentile	HEDIS 33rd Percentile
			HHW FUA 30-Day	HEDIS 10th Percentile	HEDIS 25th Percentile
			HIP CM Engagement	43.65%	50.00%
			HIP FUA 7-Day	HEDIS 50th Percentile	HEDIS 66th Percentile
			HIP FUA 30-Day	HEDIS 50th Percentile	HEDIS 66th Percentile
CareSource					
Health needs screen	Interventions and activities to increase completion rate for the OMPP approved health needs screen	• Increase telephonic outreach attempts to members • Utilize a standardized member locate strategy for new members identified as "unreachable" during initial telephonic attempts • Use of Pursuant Health Kiosks at Walmart stores • Promote member use of web portal for completion • Implement interactive texting option	HHW	56.72%	65.00%
			HIP	54.76%	65.00%
Follow-up and care coordination after emergency department visit for SUD	Interventions and activities to increase follow-up and care coordination engagement after an emergency	• Use of community health workers to increase engagement and participation in care coordination • Use of peer recovery specialist in Marion and Allen Counties to engage members within 30 days of ED visits • Use of peer comparison reports to impact transitions of care at high volume ED facilities	HHW CM Engagement	0.89%	3.00%
			HHW FUA 7-Day	HEDIS 33rd Percentile	HEDIS 50th Percentile
			HHW FUA 30-Day	HEDIS 25th Percentile	HEDIS 50th Percentile

TABLE 7	2022 Quality Improvement Projects				
QIP Topic	QIP Aim	QIP Intervention	Applicable Program	2022 Baseline	2022 Goal
	department visit for substance use disorder	• Value-based reimbursement for two high volume ED facilities in Marion County providing services to African American members with substance use disorder	HIP CM Engagement	0.58%	3.00%
			HIP FUA 7-Day	HEDIS 50th Percentile	HEDIS 75th Percentile
			HIP FUA 30-Day	HEDIS 25th Percentile	HEDIS 50th Percentile
UnitedHealthcare					
Health needs screen	Interventions and activities to increase completion rate for the OMPP approved health needs screen	• Assess member method preference for completion of the HNS • Modify outreach strategies to target completion for members who are in foster care • Increase processes utilized in obtaining member contract information • Increase use of community health workers and additional staff	HCC	59.60%	65.00%
Follow-up and care coordination after emergency department visit for SUD	Interventions and activities to increase follow-up and care coordination engagement after an emergency department visit for substance use disorder	• Increase identification of members with SUD utilizing the ED through utilization of health information exchange reports • Case management evaluation of barriers and issues to engaging with members • Develop and implement targeted provider interventions	HCC	Data collection in process due to a low denominator of 8 and inability to identify trends	To be developed upon calculation of a baseline

TABLE 7	2022 Quality Improvement Projects				
QIP Topic	QIP Aim	QIP Intervention	Applicable Program	2022 Baseline	2022 Goal
Anthem					

TABLE 7	2022 Quality Improvement Projects				
QIP Topic	QIP Aim	QIP Intervention	Applicable Program	2022 Baseline	2022 Goal
Health needs screen	Interventions and activities to increase completion rate for the OMPP approved health needs screen	• Expand call center hours and incentivize outreach specialists • Evaluate effectiveness of text outreach • Implement weekly email reminders • Implement social media campaign • Update marketing materials to emphasize the importance of HNS • Emphasize member and provider incentives Provider education on importance of completion of HNS	HHW	27.39%	40.00%
			HIP	46.59%	55.00%
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Follow-up and care coordination after emergency department visit for SUD	Interventions and activities to increase follow-up and care coordination engagement after an emergency department visit for substance use disorder	• Expand amount of member outreach by increasing call days and times • Increase provider engagement to assist in updating member contact information • Increasing engagement with the comprehensive mental health centers to coordinate members' behavioral and physical health • Utilize community health workers more frequently and effectively to outreach to members • Increase relationships with hospital discharge staff • Daily identification of members who visit the ED for SUD or alcohol abuse • Increased case management contact with members who have three or more ED visits in a month	HHW CM Engagement	8.00%	15.00%
			HIP CM Engagement	8.00%	15.00%
			HCC CM Engagement	8.00%	15.00%
Managed Health Services					
Health needs screen	Interventions and activities to increase completion rate for the OMPP approved health needs screen	• Increase completion of HNS via telephonic outreach and digital image via email • Increase use of Pursuant Health Kiosks at Walmart and CVS stores utilizing geo-fence technology	HHW	60.85%	70.00%
			HIP	70.37%	75.00%

TABLE 7	2022 Quality Improvement Projects				
QIP Topic	QIP Aim	QIP Intervention	Applicable Program	2022 Baseline	2022 Goal
		• Include paper copy of HNS in each new member welcome packet • Promote member use of web portal for completion • Use of weekly email reminders • Member incentives	HCC	79.03%	80.00%
Follow-up and care coordination after emergency department visit for SUD	Interventions and activities to increase follow-up and care coordination engagement after an emergency department visit for substance use disorder	• Provide member outreach via the ED Diversion Team • Use of member incentive	HHW FUA 7-Day	5.15%	7.09%
			HHW FUA 30-Day	6.19%	10/81%
			HIP FUA 7-Day	13.89%	15.47%
			HIP FUA 30-Day	20.10%	23.33%
			HCC FUA 7-Day	11.78%	12.72%
			HCC FUA 30-Day	16.92%	19.25%
MDwise					
Health needs screen	Interventions and activities to increase completion rate for the OMPP approved health needs screen	• Increase telephonic outreach to members with a valid phone number • Increase email outreach to members • Develop and implement interactive text outreach • Include paper copy of HNS in each new member welcome packet • Pilot use of community health workers in Allen County to complete the HNS	HHW	33.37%	55.00%
			HIP	60.85%	65.00%

TABLE 7	2022 Quality Improvement Projects				
QIP Topic	QIP Aim	QIP Intervention	Applicable Program	2022 Baseline	2022 Goal
Follow-up and are coordination after emergency department visit for SUD	Interventions and activities to increase follow-up and care coordination engagement after an emergency department visit for substance use disorder	• Outreach to members identified via pharmacy data specific to new fills for Benzodiazepines and Suboxone • Outreach to members identified via pharmacy data specific to new fills for antidepressant, antipsychotic, and antianxiety drug classes • Increase care and case management outreach based upon prior authorization requests for SUD services • Develop and implement a pilot program with two EDs experiencing a high volume of members with substance abuse to provide education on their follow-up needs	HHW CM Engagement	3.17%	5.00%
			HHW FUA 7-Day	HEDIS 25th Percentile	HEDIS 33rd Percentile
			HHW FUA 30-Day	HEDIS 10th Percentile	HEDIS 25th Percentile
			HIP CM Engagement	43.65%	50.00%
			HIP FUA 7-Day	HEDIS 50th Percentile	HEDIS 66th Percentile
			HIP FUA 30-Day	HEDIS 50th Percentile	HEDIS 66th Percentile
CareSource					
Health needs screen	Interventions and activities to increase completion rate for the OMPP approved health needs screen	• Increase telephonic outreach attempts to members • Utilize a standardized member locate strategy for new members identified as "unreachable" during initial telephonic attempts • Use of Pursuant Health Kiosks at Walmart stores • Promote member use of web portal for completion • Implement interactive texting option	HHW	56.72%	65.00%
			HIP	54.76%	65.00%
Follow-up and care coordination after emergency department visit for SUD	Interventions and activities to increase follow-up and care coordination engagement after an emergency	• Use of community health workers to increase engagement and participation in care coordination • Use of peer recovery specialist in Marion and Allen Counties to engage members within 30 days of ED visits • Use of peer comparison reports to impact transitions of care at high volume ED facilities	HHW CM Engagement	0.89%	3.00%
			HHW FUA 7-Day	HEDIS 33rd Percentile	HEDIS 50th Percentile
			HHW FUA 30-Day	HEDIS 25th Percentile	HEDIS 50th Percentile

TABLE 7	2022 Quality Improvement Projects				
QIP Topic	QIP Aim	QIP Intervention	Applicable Program	2022 Baseline	2022 Goal
	department visit for substance use disorder	• Value-based reimbursement for two high volume ED facilities in Marion County providing services to African American members with substance use disorder	HIP CM Engagement	0.58%	3.00%
			HIP FUA 7-Day	HEDIS 50th Percentile	HEDIS 75th Percentile
			HIP FUA 30-Day	HEDIS 25th Percentile	HEDIS 50th Percentile
UnitedHealthcare					
Health needs screen	Interventions and activities to increase completion rate for the OMPP approved health needs screen	• Assess member method preference for completion of the HNS • Modify outreach strategies to target completion for members who are in foster care • Increase processes utilized in obtaining member contract information • Increase use of community health workers and additional staff	HCC	59.60%	65.00%
Follow-up and care coordination after emergency department visit for SUD	Interventions and activities to increase follow-up and care coordination engagement after an emergency department visit for substance use disorder	• Increase identification of members with SUD utilizing the ED through utilization of health information exchange reports • Case management evaluation of barriers and issues to engaging with members • Develop and implement targeted provider interventions	HCC	Data collection in process due to a low denominator of 8 and inability to identify trends	To be developed upon calculation of a baseline

Pay-for-outcomes performance measures

Table 8 indicates the 2022 OMPP Quality and Outcomes Quality Measures which apply to the HHW, HIP and HCC programs. These pay-for-outcomes goals are listed by managed care program. OMPP continues a commitment to quality improvement and closely monitors the health care program goals working closely with the contracted MCEs to ensure quality improvement.

TABLE 8	2022 P4O Goals by Program	
HEDIS	State Reports	Description
Hoosier Healthwise Plan P4O Goals		
	Report 0512	Health Needs Screen
W30	Report 0401	Well-Child Visits in the First 30 Months—Six or More Visits
WCV	Report 0401	Child and Adolescent Well-Care Visits—3 to 21-years of age
CIS	Report 0401	Childhood Immunization Status
LSC	Report 0508	Lead Screening for Children
AMR	Report 0402	Asthma Medication Ratio
ADV	Report 0402	Annual Dental Visit
PND-E	Administrative data	Prenatal Depression Screening
	Administrative data	COVID-19 Vaccination Rate
Healthy Indiana Plan P4O Goals		
AAP	Report 0402	Adult Ambulatory and Preventative Care
	Report 0512	Health Needs Screen
PPC	Report 0402	Timeliness of Ongoing Prenatal Care
PPC	Report 0402	Postpartum Care: Percentage of Deliveries with Post-Partum Visit
PND-E	Administrative Data	Prenatal Depression Screening
FUA	Report 0402	Follow-up after Emergency Department Visit for Alcohol and other Drug Dependence 7-Day Follow-Up
FUA	Report 0402	Follow-up after Emergency Department Visit for Alcohol and other Drug Dependence 30-Day Follow-Up
	Administrative data	COVID-19 Vaccination Rate
Hoosier Care Connect Plan P4O Goals		
AAP	Report 0402	Adult Ambulatory and Preventative Care
ADV	Report 0402	Annual Dental Visits
	Report 0512	Health Needs Screen
	Report 0513	Comprehensive Health Assessment Tool
FUA	Report 0402	Follow-Up After Emergency Department Visit for Alcohol or other Drug Dependence 7-Day Follow-Up
FUA	Report 0402	Follow-Up After Emergency Department Visit for Alcohol or other Drug Dependence 30-Day Follow-Up

TABLE 8	2022 P4O Goals by Program	
HEDIS	State Reports	Description
	Administrative data	COVID-19 Vaccination Rate

For contract year 2020, Table 9 describes MCE performance results for HHW upon which payout percentages are based.

TABLE 9 Hoosier Healthwise "Pay for Outcomes" Measure Overview											
Anthem			MHS			MDwise			CareSource		
2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020
Utilization of Ambulatory Services in ED (AMB); Target threshold: <HEDIS 50th %											
43.25	42.28	28.48	43.10	43.69	28.3	46.49	45.87	29.2	48.69	49.94	30.82
<HEDIS 25th percentile	<HEDIS 25th percentile	<HEDIS 25th percentile	<HEDIS 25th percentile	<HEDIS 25th percentile	<HEDIS 25th percentile	<HEDIS 25th percentile	<HEDIS 25th percentile	<HEDIS 25th percentile	<HEDIS 25th percentile	<HEDIS 50th percentile	<HEDIS 25th percentile
Well Child Visits (0 15 months) with ≥6 visits HEDIS measure (HEDIS W30) using hybrid data; Target threshold: >HEDIS 50th %											
N/A	N/A	59.95%	N/A	N/A	54.88%	N/A	N/A	45.40%	N/A	N/A	56.41%
		>HEDIS 50th percentile			Not eligible for withhold			<HEDIS 50th percentile			>HEDIS 50th percentile
Child and Adolescent well care Visits (3 21 years). HEDIS measure (HEDIS WCV) using hybrid data; Target threshold: >HEDIS 50th %											
N/A	N/A	50.27%	N/A	N/A	48.51%	N/A	N/A	46.36%	N/A	N/A	46.46%
		>HEDIS 50th percentile			>HEDIS 50th percentile			<HEDIS 50th percentile			>HEDIS 50th percentile
Follow up after Hospitalization for Mental Illness. HEDIS measure (HEDIS 7 Day FUH); Target threshold: >HEDIS 50th %											
44.48%	53.55%	52.68%	49.18%	47.46%	50.59%	46.47%	48.20%	52.66%	39.94%	53.75%	53.11%
<HEDIS 50th percentile	>HEDIS 90th percentile	>HEDIS 75th percentile	>HEDIS 75th percentile	>HEDIS 75th percentile	>HEDIS 75th percentile	>HEDIS 75th percentile	>HEDIS 75th percentile	>HEDIS 75th percentile	>HEDIS 50th percentile	>HEDIS 90th percentile	>HEDIS 75th percentile
Lead Screening in Children HEDIS measure (HEDIS LSC); Target threshold: >HEDIS 25th %											
60.10%	63.05%	65.45%	64.72%	64.72%	66.84%	57.91%	63.50%	65.36%	39.42%	62.77%	67.64%

TABLE 9 Hoosier Healthwise "Pay for Outcomes" Measure Overview											
Anthem			MHS			MDwise			CareSource		
2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020
Not eligible for withhold	>HEDIS 25th percentile	>HEDIS 25th percentile	>HEDIS 50th percentile	>HEDIS 25th percentile	>HEDIS 25th percentile	Not eligible for withhold	>HEDIS 25th percentile	>HEDIS 25th percentile	Not eligible for withhold	Not eligible for withhold	>HEDIS 25th percentile
Annual Dental Visits HEDIS measure (HEDIS ADV); Target threshold: >HEDIS 25th %											
No data available	60.35% >HEDIS 50th percentile	48.62% >HEDIS 50th percentile	No data available	62.14% >HEDIS 50th percentile	49.78% >HEDIS 50th percentile	No data available	60.53% >HEDIS 50th percentile	48.28% >HEDIS 50th percentile	No data available	49.79% >HEDIS 25th percentile	40.63% >HEDIS 25th percentile
Asthma Medication Ratio (HEDIS AMR); Target threshold: >HEDIS 50th %											
No data available	No data available	82.27% >HEDIS 50th percentile	No data available	No data available	82.93% >HEDIS 75th percentile	No data available	No data available	82.10% >HEDIS 50th percentile	No data available	No data available	84.47% >HEDIS 75th percentile

For the contract year 2020, Table 10 describes MCE performance results for HIP upon which payout percentages are based.

TABLE 10 Healthy Indiana Plan "Pay for Outcomes" Measure Overview												
Anthem			MHS			MDwise			CareSource			
2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	
Rate of ER admission per 1,000 member months (HEDIS AMB measure for ED visits); Target threshold: 90 visits per 1000 member months												
79.23	77.39	65.63	88.82	79.59	67.01	92.27	80.77	67.95	80.94	74.71	67.71	
Eligible for 100% of withhold	Eligible for 100% of withhold	Eligible for 100% of withhold	Eligible for 50% of withhold	Eligible for 100% of withhold	Eligible for 100% of withhold	Not eligible for withhold	Eligible for 75% of withhold	Eligible for 100% of withhold	Eligible for 75% of withhold	Eligible for 100% of withhold	Eligible for 100% of withhold	
Rate of members 19+ who had Preventive care Visit (HEDIS AAP using administrative data); Target threshold: >HEDIS 25th %												
84.20%	85.05%	80.24%	81.78%	82.13%	78.19%	81.80%	81.73%	76.80%	73.22%	75.11%	72.26%	
>HEDIS 50th percentile	>HEDIS 50th percentile	>HEDIS 50th percentile	>HEDIS 50th percentile	>HEDIS 50th percentile	>HEDIS 25th percentile	>HEDIS 50th percentile	>HEDIS 50th percentile	>HEDIS 25th percentile	Not eligible for withhold	Not eligible for withhold	Not eligible for withhold	
Health Needs Screener Completion; Target threshold: >60% completion												
21.95%	27.73%	46.60%	54.37%	63.31%	70.36%	50.38%	58.24%	60.83%	20.81%	18.55%	35.01%	
Not eligible for withhold	Not eligible for withhold	Not eligible for withhold	Not eligible for withhold	Eligible for 25% of the withhold	Eligible for 100% of the withhold.	Not eligible for withhold	Not eligible for withhold	Eligible for 25% of the withhold	Not eligible for withhold	Not eligible for withhold	Not eligible for withhold	
Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse, seven days (HEDIS FUA)												
		17.63%			14.63%			15.10%			16.82%	
		>HEDIS 50th			>HEDIS 50th			>HEDIS 50th			>HEDIS 50th	
Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse, 30 days (HEDIS FUA)												
No data available	No data available	26.23%	No data available	No data available	19.99%	No data available	No data available	23.21%	No data available	No data available	21.74%	
		>HEDIS 75th			>HEDIS 25th percentile			>HEDIS 50th			>HEDIS 50th	

TABLE 10 Healthy Indiana Plan "Pay for Outcomes" Measure Overview											
Anthem			MHS			MDwise			CareSource		
2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020
Postpartum Care Visits: Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery (HEDIS PPC using hybrid data); Target threshold: >HEDIS 25th %											
72.34%	77.37%	82.97%	63.02%	77.86%	77.37%	66.91%	77.13%	78.42%	67.15%	79.08%	71.05%
>HEDIS 75th percentile	>HEDIS 50th percentile	>HEDIS 75th percentile	>HEDIS 25th percentile	>HEDIS 75th percentile	>HEDIS 50th percentile	>HEDIS 50th percentile	>HEDIS 25th percentile	>HEDIS 50th percentile	>HEDIS 50th percentile	>HEDIS 50th percentile	Not eligible for withhold
Timeliness of Ongoing Prenatal Care (HEDIS PPC)											
88.52%	91.97%	92.46%	81.27%	95.86%	87.83%	84.18%	91.24%	87.63%	75.21%	79.81%	85.16%
>HEDIS 75th percentile	>HEDIS 50thh percentile	>HEDIS 75th percentile	Not eligible for withhold	>HEDIS 50th percentile	>HEDIS 50th percentile	Not eligible for withhold	>HEDIS 50th percentile	>HEDIS 50th percentile	Not eligible for withhold	>HEDIS 10th percentile	>HEDIS 25th percentile
Percent of maternity discharges who made a connection with the quit line											
0.97%	0.73%	0.76%	1.84%	1.58%	1.43%	0.89%	0.56%	0.39%	0.89%	0.81%	0.60%
Not eligible for withhold	Not eligible for withhold	Not eligible for withhold	Eligible for 50% of withhold	Eligible for 50% of withhold	Not eligible for withhold	Not eligible for withhold	Not eligible for withhold	Not eligible for withhold	Not eligible for withhold	Not eligible for withhold	Not eligible for withhold

Table 11 describes MCE performance results for HCC upon which payout percentages are based.

TABLE 11 Hoosier Care Connect "Pay for Outcomes" Measure Overview					
Anthem			MHS		
2018	2019	2020	2018	2019	2020
Rate of ER admission per 1,000 member months (HEDIS AMB measure for ED visits)					
95.39	95.36	76.02	97.37	90.79	72.37
Not eligible for withhold	Not eligible for withhold	Eligible for 100% of withhold	Not eligible for withhold	Not eligible for withhold	Eligible for 100% of withhold
Adult Preventative Care (HEDIS AAP)					
85.67%	86.65%	84.32%	81.89%	81.69%	79.43%
>HEDIS 75th percentile	>HEDIS 75th percentile	>HEDIS 75th percentile	>HEDIS 50th percentile	>HEDIS 50th percentile	>HEDIS 50th percentile
Follow up after Hospitalization for Mental Illness 7 day with Medicaid Rehabilitation Option (MRO)					
59.35%	48.05%	44.73%	62.90%	41.52%	36.54%
Not eligible for withhold	>HEDIS 75th percentile	>HEDIS 50th percentile	Not eligible for withhold	>HEDIS 50th percentile	>HEDIS 25th percentile
Follow Up after Emergency Department Visit for Alcohol and Other Drug Abuse 7 days (HEDIS FUA)					
No data available	No data available	13.92% >HEDIS 50th percentile	No data available	No data available	12.38% >HEDIS 25th percentile
Follow Up after Emergency Department Visit for Alcohol and Other Drug Abuse 30 days (HEDIS FUA)					
No data available	No data available	19.61% >HEDIS 50th percentile	No data available	No data available	16.59% >HEDIS 25th percentile
Completion of Comprehensive Health Assessment (CHAT)					
84.67%	79.80%	77.60%	78.12%	76.13%	87.53%
Eligible for 100% of withhold	Eligible for 100% of withhold	Eligible for 50% of withhold	Eligible for 50% of withhold	Eligible for 50% of withhold	Eligible for 100% of withhold.

TABLE 11 Hoosier Care Connect "Pay for Outcomes" Measure Overview					
Anthem			MHS		
2018	2019	2020	2018	2019	2020
Completion of Health Needs Screening (HNS)					
19.90%	31.32%	44.45%	34.09%	62.43%	78.08%
Not eligible for withhold	Not eligible for withhold	Not eligible for withhold	Not eligible for withhold	Eligible for 25% of withhold	Eligible for 100% of withhold.

Transition of care policy

OMPP is committed to providing continuity of medical care during a member's transition period among the various Indiana Medicaid programs and the MCEs. The MCE must have mechanisms in place to ensure the continuity of care and coordination of medically necessary health care services for its members. The MCE is financially responsible for providing medically necessary care during the transition. Some examples of the need for special consideration include, but are not limited to, the following:

- Transitions for members receiving HIV, Hepatitis C, and/or behavioral health services, especially for those members who have received prior authorization from their previous MCE or through fee-for-service.
- Members transitioning into a managed care program from traditional fee-for-service.
- Members transitioning between MCEs, particularly during an inpatient stay.
- Members transitioning between Indiana Medicaid programs, particularly when a member becomes pregnant or disabled, or meets the annual or lifetime benefit maximum.
- Members exiting a managed care program to receive excluded services.
- Members transitioning to a new PMP.
- Members transitioning to private insurance or Marketplace coverage.
- Members transitioning to no coverage.
- Members transition between benefit packages.

In situations such as a member or PMP disenrollment, the MCE must facilitate care coordination with other MCEs or other PMPs. When receiving members from another MCE or fee-for-service, the MCE must honor previous authorizations for a minimum of 30 calendar days from the member's date of enrollment with the MCE. The MCE must establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member's enrollment in their plan.

Additionally, when a member transitions to another source of coverage, the MCE must be responsible for providing the receiving entity with information on any current service authorizations, utilization data and other applicable clinical information such as disease management, case management or care management notes. This process is overseen by the MCE Transition Coordination Manager.

The MCE will be responsible for care coordination after the member has disenrolled from the MCE whenever the member disenrollment occurs during an inpatient stay. In these cases, the MCE will remain financially responsible for the hospital DRG payment and any outlier payments (without a capitation payment) until the member is discharged from the hospital or the member's eligibility in Medicaid terminates. The MCE must coordinate discharge plans with the member's new MCE.

OMPP monitors the transition of care through member and provider grievance and appeals.

Disparities plan

In 2021, FSSA continued developing a comprehensive effort to identify the causes of health disparities in Indiana and to create targeted strategies for reform. FSSA's Office of Healthy Opportunities prioritizes identifying and reducing the impact of social determinants of health on the clients we serve, recognizing that factors like access to food, stable housing and education may limit someone from reaching their full human potential. By serving our clients holistically, FSSA can begin to remove barriers and positively impact health outcomes for vulnerable populations. The Office of Healthy Opportunities will be led in 2021 by the newly hired Chief Health Equity and ADA Officer, charged with addressing issues of social equity, with an emphasis on supporting communities of color and persons with disabilities. She will work

with the Office of Healthy Opportunities and incorporate FSSA divisions to expand the scope of that work to include policy evaluation, metrics development and community engagement.

Sickle cell initiative

In the spring of 2021, OMPP began work with the Indiana Hemophilia and Thrombosis Center and a representative from the CDC to develop strategies to increase awareness of, provide training to and share current best practices specific to sickle cell disease with the Indiana MCEs. The IHTC and CDC provided an in-depth presentation on sickle cell disease to a large number of MCE care coordination, clinical and medical director staff during the June 2021 OMPP Quality Meeting. The MCEs also presented their current efforts specific to sickle cell disease during this meeting. OMPP Quality staff completed monthly onsite meetings in June 2021 with all MCEs to review and evaluate their current efforts to identify and provide quality care to members diagnosed with sickle cell disease. OMPP continues to meet regularly with the IHTC to develop educational materials for the MCEs that will increase their awareness of sickle cell disease with the goal of increased care coordination and better quality health outcomes for those members. The sickle cell initiative is inclusive of all genders, ages, ethnicities and races. OMPP also prioritized sickle cell disease as a condition of interest for inclusion in the 2023 HIP and HHW contracts. OMPP views these efforts as important in acknowledging health inequity and working to ensure health care is equitable to all.

Blood lead efforts

In an effort to improve care for Medicaid members, MCE and OMPP representatives met monthly during 2021 with immunization and blood lead staff from the Indiana Department of Health. During the March 2021 OMPP Quality Meeting, IDOH blood lead staff provided an overview of their program and efforts to increase the lead testing rate in Indiana. The MCEs also provided information on their individual strategies currently in place to comply with the blood lead requirements documented in their managed care contracts. Meetings between OMPP and the MCEs as well as IDOH continued from March through September of 2021 with a focus on identifying tools and supports needed by the MCEs to increase blood lead testing efforts for Medicaid members. At OMPP's request, the MCEs worked to identify specific barriers and needs to increase their testing rates. OMPP required the MCEs to provide formal feedback on the effectiveness of the monthly blood lead data provided to them by IDOH. The MCEs provided this information during the September 2021 OMPP Quality Meeting. A follow-up meeting with IDOH resulted in the development of an IDOH blood lead informational flyer distributed to providers in November of 2021. IDOH met with each of the MCEs to discuss and determine how to most effectively provide blood lead data to them moving forward.

OMPP further includes blood lead testing as a pay-for-outcomes measure in the HHW program. Indiana zip codes identified as being areas with high blood lead exposure and containing a large population of Medicaid recipients are also identified as being home to higher percentages of residents who are Hispanic or Black. The blood lead efforts are inclusive of all genders, ages, ethnicities and races.

MCE health equity monitoring

As part of the December 9, 2020, OMPP Quality Meeting, OMPP required the MCEs to provide presentations outlining their current health equity efforts. OMPP encouraged the MCEs to develop data collection methods that would guide future health equity efforts by including information specific to gender, ethnicity, race, region, primary language and disability.

The MCEs are required to participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural, and ethnic backgrounds. Per 42 CFR 438.204, at the time of enrollment with the MCE, the State shall provide the race, ethnicity and primary language of each member. This information is utilized by the MCE to ensure the delivery of culturally competent services. The MCE must ensure all services are delivered through a health equity lens. The MCE maintains health equity representatives who are actively

involved in improvement initiatives to reduce disparities by: obtaining input from Medicaid-insured individuals and from providers of direct services which are intended to reduce adverse health outcomes among Medicaid insured individuals, determining the root cause of inequities, developing targeted interventions and measures and collecting and analyzing data to track progress in disparity reduction efforts. The MCEs will utilize Community Health Workers as part of broader community health integration initiatives and promotion of culturally competent care. The MCE will submit an annual health equity plan for OMPP approval which incorporates the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services. The CLAS standards are available at https://www.thinkculturalhealth.hhs.gov/clas/standards.

The MCEs are also required to conduct a health needs screening for new members who enroll in their plan. The health needs screening helps identify the member's physical and behavioral healthcare needs, and special healthcare needs such as health disparities and identifies members who might need additional services and supports regardless of gender, age, ethnicity and race.

The MCEs will be required to have a Health Equity Officer as key staff by Jan. 1, 2023, if this key staff is not already in place by that time.

Cultural competency

The MCEs must provide services in a culturally competent manner. The MCEs must incorporate the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services into the provision of healthcare services for its members.

Data on race and ethnicity is sent to the MCEs via the 834-eligibility file. This information is to be utilized by the MCEs to ensure the delivery of culturally competent services. The MCEs must make all information available in English and Spanish and other prevalent languages, including American Sign Language, identified by OMPP, upon the member's request. Each MCE must identify additional languages that are prevalent among its membership. The MCE must also inform members that information is available upon request in alternative formats and how to obtain them. OMPP defines alternative formats as Braille, large-font letters, audio, prevalent languages, and verbal explanation of written materials. All materials must be approved by OMPP and be culturally appropriate. Verbal interpretation services must also be available and provided by the MCEs upon request. The MCEs must also ensure that all its contracted providers can respond to the cultural, racial and linguistic needs of the populations that they serve.

Identification of persons who need LTSS or persons with special health care needs

LTSS

The state is in the process of implementing managed LTSS with a focus on improving service coordination to make it easier for members to navigate long-term services. The state will partner with an experienced MCE to coordinate LTSS benefits and an individual's other benefits such as Medicare. The state released a Request for Information in July 2021 and anticipates releasing a Request for Proposals for the prospective MCE in 2022. The tentative implementation date for the LTSS program is early 2024.

The LTSS program will include program-specific performance measures and the state's goal is to integrate LTSS data for the purpose of continuous outcomes measurement and improvement.

Special needs

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

In accordance with 42 CFR 438.208(c)(2), which specifies allowable staff, OMPP requires each MCE to have a health care professional assess the member through a comprehensive health assessment tool if the health screening identifies the member as potentially having a special health care need. When the further assessment confirms the special health care need, the member must be placed in the appropriate level of care coordination, either care management or complex case management. Each MCE must offer continued coordinated care services to members with special health care needs transferring into the MCE from another MCE. MCE activities supporting the special health care needs population must include, but are not limited to:

- Conducting the initial screening and a comprehensive health assessment to identify members who may have special needs
- Scoring the initial screening and comprehensive health assessment results
- Distributing findings from the health assessment to the member's PMP, OMPP and other appropriate parties in accordance with state and federal confidentiality regulations
- Coordinating care through a special needs unit or comparable program services in accordance with the member's care plan
- Analyzing, tracking, and reporting to OMPP the issues related to children with special health care needs, including grievances and appeals data
- Participating in clinical studies of special health care needs as directed by the state

SECTION V. Assessment

Monitoring and compliance

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

- Quality management and improvement program work plans
- Data analysis
- Enrollee hotlines operated by the state's enrollment broker
- Geographic mapping for provider network
- External quality review
- Network adequacy assurance submitted by plan
- Onsite monitoring reviews
- Recognized performance measures reports

OMPP Quality and Outcomes staff oversees contract compliance by enforcing reporting requirements mandated within the MCEs' contracts. Each contracted MCE is required to document outcomes and performance results, as instructed within each program reporting manual, to demonstrate data reliability, accuracy and validity. The MCE Reporting Manual provides guidance from OMPP on required performance reporting for the MCEs contracted to deliver services for HHW, HIP and HCC. The MCE Reporting Manual is tailored to the goals of each program and describes the reporting process, submission requirements, report descriptions, definitions, and templates of all reports with an OMPP required format. The reports submitted in compliance with MCE Reporting Manual specifications are generally referred to as "periodic MCE reports."

In general, reports are submitted quarterly to monitor and compare clinical outcomes against targets, standards, and benchmarks as established by OMPP. The OMPP Quality and Outcomes staff directly manages all contracted MCE reporting to ensure timely submissions. This management supports OMPP's capacity to align and increase oversight processes across the MCEs and the programs. OMPP Quality and Outcomes staff conducts a comparative review of the report submissions by the MCEs to ensure that key performance indicators, both operational and clinical, are effectively being identified, collected, validated and analyzed. Quality and Outcomes conducts quarterly Reporting Meetings to discuss the MCEs' data submissions. Representatives from OMPP pharmacy, program integrity, contract compliance and operations meet to discuss the various reports submitted, analyze the data, identify discrepancies and develop feedback for the MCEs. Anomalies that are identified may also be targeted for discussion at the Quality Strategy Committee and/or the monthly onsite visit.

OMPP Quality and Outcomes sends a confirmation report to the plans confirming the receipt of required data along with any inquiries related to questionable data points. An analysis memo that reviews the finalized performance results, as well as the metrics which fail to meet specified targets, is returned to the plans. Processes have been developed and implemented to improve accountability, compliance and reliance on the operations and health outcome achievements of the state's contracted MCEs.

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

Typically, OMPP Quality and Outcomes staff review and update the reporting manuals annually based on the current needs of the programs and in conjunction with the contracted MCEs. In 2019, the HHW, HIP and HCC reporting manuals experienced a major overhaul with the implementation of streamlined

reporting processes and increased consistency in reporting for both the MCEs and OMPP. All reports were reviewed to determine whether they were needed for all programs, required alignment in terms of reporting periods and submission and, if reports should be deleted, revised or created to capture more meaningful data.

OMPP incorporated multiple steps within the HHW, HIP and HCC report review processes to reinforce OMPP's commitment to receive quality data in a complete, timely, and accurate manner. Validation of submitted data is crucial to ensure that performance analysis is based on sound information. OMPP Quality and Outcomes staff reviews data for contract compliance, adherence to established standards and comparisons between MCEs as well as data for progress toward pay-for-outcomes measures and quality initiatives.

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

Quality and appropriateness of care

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

National performance measure

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

Network adequacy and availability of services

Availability of services

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

The MCEs' contractual obligations with OMPP are aimed at ensuring that covered services are available to Indiana Medicaid members and delivered in a culturally competent manner. The MCEs must have written provider agreements with providers in the networks. The MCEs are responsible for ensuring covered services are available and geographically accessible. The networks must provide adequate numbers of facilities, physicians, ancillary providers, service locations, and personnel for the provision of high-quality covered services for all Indiana Medicaid members. The MCEs must ensure that all their contracted providers are registered IHCP providers and can respond to the cultural, racial and linguistic needs of its member populations. Each MCE is contractually obligated to meet the unique needs of its members, particularly those with special health care needs, within their networks. For members who may require out-of-network services, the out-of-network providers must be IHCP providers to receive reimbursement from the MCEs.

The contracted MCEs encourage out-of-network providers, particularly emergency services providers, to enroll in the IHCP. Tribal Health providers are not required to participate with the MCE, and Native Americans enrolled in MCEs can choose their Tribal Health provider whether in or out of network and those providers should be reimbursed the same as if they were in-network, under the same prior authorization requirements and at the same rate as in-network providers. The MCEs must offer Tribal Health providers contracts with their network that consider the Indian Health Addendum, but Tribal providers are not required to contract with MCEs for their Native American patients to be served.

Each MCE must develop and have under contract its specialist and ancillary provider network before receiving enrollment. HCC access requirements were changed as a part of the re-implementation of the program in 2021. New requirements for substance use disorder treatment and pediatric dentistry access were added as a result of community partner feedback.

Maintain and monitor network of appropriate providers

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

- Anticipated enrollment
- Expected utilization of services, taking into consideration the characteristics and health care needs of HHW, HIP and HCC members
- Numbers and types of providers required, including training, experience and specialization, to furnish the contracted services
- Numbers of network providers who are not accepting new members
- Geographic location of providers and members, considering the distance, travel time, the means of transportation ordinarily used by members and whether the location provides physical access for members with disabilities

OMPP Quality and Outcomes reserves the right to implement corrective actions and will assess liquidated damages if the contracted MCE fails to meet and maintain the specialist and ancillary provider network access standards. OMPP monitors the MCEs' specialist and ancillary provider network to confirm that the MCE is maintaining the required level of access to specialty care. OMPP reserves the right to increase the number or types of required specialty providers at any time.

Female member direct access to women's health specialist

The MCEs are contractually required to provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the female member's designated PMP if that provider is not a women's health specialist. The MCEs may also establish claims processing procedures that allow payment for certain women's health codes without prior authorization or referral.

Second opinions

The managed care MCEs must comply with all member requests for a second opinion from a qualified professional. If the provider network does not include a qualified provider for a second opinion, the MCE must arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.

Adequate and timely coverage of services not available in-network

With the exception of certain self-referral service providers and emergency medical care, the MCE may limit its coverage to services provided by in-network providers once the contracted MCE has met the network access standards and has received state approval to close the network. The MCE must authorize and pay for out-of-network care if the MCE is unable to provide necessary covered medical services

within contractually required mileage standards. The MCE must authorize these out-of-network services in the timeframes established in the MCE contract and must adequately cover the services for as long as the MCE is unable to provide the covered services in-network. The MCE must require out-of-network providers to coordinate with the MCE on payment and reimbursement to ensure that any cost to the member is no greater than it would be if the services were furnished in-network.

The MCE may require out-of-network providers to obtain prior authorization from the contracted MCE before rendering any non-self-referral or non-emergent services to members. If the out-of-network provider has not obtained such prior authorization, the MCE may deny payment to that out-of-network provider. The MCE must cover and reimburse for all authorized, routine care provided to its members by out-of-network providers.

To ensure adequate and timely services are available to members, the MCE must make nurse practitioner services available to members. If nurse practitioner services are available through the contracted MCE, the contracted MCE must inform the member that nurse practitioner services are available. Members can use the services of out-of-network nurse practitioners if no nurse practitioner is available in the member's service area and within the MCE's network.

MCEs must make covered services provided by federally qualified health centers and rural health clinics available to members who are out-of-network. If an FQHC or RHC is not available in the member's service area within the contracted MCE's network.

Out-of-network provider coordination with MCEs for payment

Payment of out-of-network providers for coordination varies by program. In HHW and HCC, the contracted MCE must reimburse any out-of-network provider's claim for authorized services provided to HHW and HCC members at a rate it negotiates with the out-of-network provider or the lesser of the following: the usual and customary charge made to the general public by the provider or the established Indiana Health Coverage Programs amount equal to 98% of the Medicaid fee-for-service reimbursement rates that exist for participating IHCP providers at the time the service was rendered.

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

Provider credentialing

Providers must first be enrolled as an IHCP provider before initiating credentialing with an MCE (42 CFR 455). All managed care MCEs must have written credentialing and re-credentialing policies and procedures to ensure the quality of care is maintained or improved and to assure that all contracted providers hold current state licensure and enrollment in the IHCP. The MCEs' credentialing and recredentialing process for all contracted providers must meet the National Committee for Quality Assurance guidelines.

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

The contracted MCEs must ensure that providers agree to meet all OMPP's and the MCEs' standards for credentialing PMPs and specialists and maintain IHCP manual standards, including:

- Compliance with state record-keeping requirements
- OMPP's access and availability standards Quality improvement program standards

The MCEs' provider credentialing and selection policies must not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. The MCEs must not

employ or contract with providers that have been excluded from participating in federal health care programs under Section 1128 or Section 1128A of the Social Security Act.

MCEs must ensure that the network providers offer hours of operation that are no less than the hours of operation offered to their commercial members if the MCE also serves commercial members. The MCE must also make covered services available 24/7 when medically necessary. In meeting these requirements, the MCE must:

- Establish mechanisms to ensure compliance by providers
- Monitor providers regularly to determine compliance
- Take corrective action if there is a failure to comply

Each MCE must provide OMPP written notice at least 90 calendar days in advance of the contracted MCE's inability to maintain a sufficient network in any county.

Provider incentive program

MCEs are contractually required to comply with Section 1876(i)(8) of the Social Security Act and federal regulations, including: 42 CFR 438. (3)(i); 42 CFR 422.208; and, 42 CFR 422.210. The MCEs must supply to OMPP information on its plan as required in the regulations and with sufficient detail for OMPP to determine whether incentive plans comply with federal requirements regarding physician incentive plans. The MCEs must provide information concerning its physician incentive plan upon request to its members and in any marketing materials in accordance with the disclosure requirements stipulated in the federal regulations. Similar requirements apply to subcontracting arrangements with physician groups and intermediate entities. Physician incentive plans must comply with the federal requirement to refrain from making any specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member. The MCEs must also meet requirements for stop-loss protection, member survey and disclosure requirements under 42 CFR 438.6(b).

Assurances of adequate capacity and services

All MCEs are contractually obligated to:

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

OMPP requires each of the contracted MCEs to submit network access reports. In 2019, OMPP revised and substantially enhanced the network access reporting by aligning the requirements to ensure consistency by all MCEs in reporting the number of providers and member access. The reporting requires each MCE to provide the unique count of providers under contract by provider specialty and county location. The reports now require the MCEs to utilize the IHCP provider type and specialty that is assigned to the provider. For those specialties without a pre-defined IHCP provider type or specialty, the MCEs are required to use the nationally recognized taxonomy code for the provider in assigning them to a specialty category. Each provider is to be counted once based on the county in which the rendering provider is located. The unique providers by county are then compared to the MCE's capitation payment file containing the total members enrolled with them in each line of business in September. Enrollees are then segmented into one of the state's 92 counties. Each member is then tested to determine the distance that the member would need to travel to seek the services of each provider category listed on the report.

OMPP believes that enhanced reporting will provide a more accurate accounting of member access to the services they need. The MCEs will submit network access reports on an annual basis in October of each

year and at any time there is a significant change to the provider network. OMPP reserves the right to expand or revise the network requirements due to changing provider or member enrollment, as it deems appropriate. OMPP stipulates that an MCE may not discriminate concerning participation, reimbursement, or indemnification of any provider, solely based on such license or certification, who is acting within the scope of the provider's license or certification under applicable state law. However, the MCEs may include providers only to the extent necessary to meet the needs of the MCE's members. The MCEs may also manage provider enrollment to establish and maintain quality measures and control costs consistent with the MCE's responsibilities.

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

Acute care hospital facilities

OMPP requires that all MCEs provide a sufficient number and geographic distribution of acute care hospital facilities to serve the expected enrollment. The transport distance to a hospital from the member's home shall be usual and customary, not to exceed 30 miles in urban areas and 60 miles in rural areas. Inpatient services are covered when such services are prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.

Primary medical provider requirements

To assure the availability of PMPs for members around the state, OMPP's managed care contracts include provisions on PMPs:

- PMPs are allowed to contract with one or multiple MCEs. A PMP may also participate as a specialist in another MCE. The PMP may maintain a patient base of individuals who are not members of HHW, HIP and/or HCC (e.g., commercial or traditional Medicaid members).
- The MCEs may not prevent the PMP from contracting with other MCEs.
- The MCEs must ensure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. PMPs must coordinate each member's physical and behavioral health care and make any referrals necessary. In HHW a referral from the member's PMP is required when the member receives physician services from any provider other than his or her PMP unless the service is a self-referral service.
- The MCEs must provide access to PMPs within at least 30 miles of the member's residence. Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians, gynecologists and endocrinologists (if primarily engaged in internal medicine). Due to the characteristics of needs for members who are aged, blind or disabled, in HCC any physician may be an individual's PMP.
- The MCE's PMP contract must state the PMP panel size limits and the MCE must assess the PMP's non-HHW, HIP and HCC practice size when assessing the PMP's capacity to serve the MCE's Medicaid members. Gainwell, OMPP's fiscal agent, maintains a separate panel for those PMPs contracted with more than one MCE.
- The MCEs 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 MCEs must also ensure that members have telephone

access to their PMP (or appropriate designee such as a covering physician) in English and Spanish 24/7.

- Each PMP shall be available to see members at least three days per week for a minimum of 20 hours per week at any combination of no more than two locations.
- The MCEs must ensure that PMPs are maintaining the PMP medical care standards and practice guidelines detailed in the IHCP Provider Manual. The MCEs must monitor medical care standards to evaluate access to care and quality of services provided to members and to evaluate providers regarding their practice patterns.

Specialist and ancillary provider network requirements

In addition to maintaining a network of PMPs, the MCEs must provide and maintain a comprehensive network of IHCP provider specialists and ancillary providers.

As with PMPs, specialist and ancillary providers may serve in all MCE networks. In addition, physicians contracted as a PMP with one MCE may contract as a specialist with other MCEs.

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

OMPP requires the MCEs to develop and maintain a comprehensive network of specialty providers listed in Table 12 below. For providers identified with an asterisk (*), the contracted MCEs must provide, at a minimum, two specialty providers within 60 miles of the member's residence. For providers identified with two asterisks (**), the contracted MCEs must provide, at a minimum, one specialty provider within 90 miles of the member's residence.

TABLE 12 Network Provider Specialties	
Specialties	Ancillary Providers
Anesthesiologists* Cardiologists* Cardiothoracic surgeons** Dentists/Oral Surgeons * Dermatologists** Endocrinologists* Gastroenterologists* General surgeons* Hematologists Infectious disease specialists** Interventional radiologists** Nephrologists* Neurologists* Neurosurgeons** Non-hospital-based anesthesiologist (e.g., pain medicine)** OB/GYNs Occupational therapists* Oncologists* Ophthalmologists* Optometrists* Orthodontists* Orthopedic surgeons* Orthopedists Otolaryngologists Pathologists** Physical therapists* Psychiatrists* Pulmonologists* Radiation oncologists** Rheumatologists** Speech therapists* Urologists*	Diagnostic testing* Durable Medical Equipment Home Health Prosthetic suppliers**

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

- Two durable medical equipment providers must be available to provide services to the MCE's members in each county or a contiguous county.

- Two home health providers must be available to provide services to each MCE's members in each county or a contiguous county.

Effective April 1, 2021, OMPP requires additional network access specific to the HCC program. MCEs must ensure the availability of an adult general dentistry provider and pediatric dentistry provider within 30 miles of the member's residence. MCEs must also ensure the availability of a medication-assisted treatment provider within 30 miles of the member's residence as part of their network of substance use disorder treatment providers.

In addition, the MCEs must demonstrate the availability of certain specialty providers. The MCEs must also contract with the Indiana Hemophilia and Thrombosis Center or a similar OMPP approved federally recognized treatment center. This requirement is based on the findings of the Centers for Disease Control and Prevention 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. The MCEs must also arrange for laboratory services only through those IHCP-enrolled laboratories with Clinical Laboratory Improvement Amendments certificates.

Physician faculty access to care

For 2022, OMPP's PFAC reimbursement is intended to generally mirror the fee-for-service required payment arrangement for Medical School Faculty under the state plan. Eligible medical school physicians and practitioners are paid an enhanced rate for utilization and delivery of services to Medicaid members for the purpose of increasing the overall access to services by ensuring Medicaid members have access to care via physicians in academic medical centers. It is anticipated that this payment arrangement will enhance the quality strategy goals previously stated for HHW, HIP and HCC including increasing adult and child preventive care HEDIS measures to the 50th percentile, reducing emergency department use to below 80 visits per 1,000 members and increase the timeliness of prenatal care PPC-AD Core Measure to 60% for pregnant members. The enhanced payment differential may be reduced, based on performance metrics listed in the state plan. OMPP will tie its provider performance under this payment arrangement to the following measures: percent of patients seen in clinics in less than seven days; median lag times for clinic visits for all specialties; median time for patients to see a provider within the emergency department; and percentage of patients who report they would recommend hospital or clinic. The performance targets were developed following a review of baseline historical data and national benchmarks. The state intends to re-evaluate performance targets annually during the duration of this arrangement.

TABLE 13 Additional 2022 Physician Faculty Access to Care Measures

Measure	Methodology	Goal
1. Percent of patients seen in clinics within seven days of requesting an appointment.	Administrative reporting	More than 35% of patients are seen in clinics in fewer than seven days from the time the patient requests the appointment.
2. Median lag time for clinic visits for all specialties.	Administrative reporting	More than 55% of all new patients are seen within three weeks for specialty care visits.
3. Median time for patients to see a provider within the emergency department.	Administrative reporting	Emergency department wait times are under 40 minutes
4. Percentage of patients who report they would recommend a hospital or clinic.	Administrative reporting	More than 70% of patients would recommend the hospital or clinic

Institutions for mental disease

In 2016, OMPP, in accordance with 42 CFR 438.3(e)(2), began to reimburse the MCEs for services provided to Members ages 21 to 64 years who experienced short-term stays of no more than 15 days in a calendar month in facilities designated as Institutions for Mental Disease. Member access to mental health and substance use disorder services was therefore expanded by OMPP's formal designation of 12 facilities as IMDs.

In December 2019, the Indiana Family and Social Services Administration received federal approval from the Centers for Medicare and Medicaid Services of a Medicaid waiver, to take effect on Jan. 1, 2020, that gives Indiana Medicaid the authority to pay for acute inpatient stays in institutions for mental disease for individuals diagnosed with a serious mental illness. This waiver was extended on Oct. 26, 2020, and remains in effect through Dec. 31, 2025. Prior to this waiver, Medicaid law prevented funding from being used for inpatient SMI treatment at any hospital, nursing facility or other institution with more than 16 beds. Through this new waiver, Indiana will be able to cover acute inpatient stays in IMDs for individuals whose primary diagnosis is a serious mental illness. Because approximately 25% of individuals with a serious mental illness also have a substance use disorder, this waiver will allow for consistency in their treatment. Currently, there are 18 facilities across Indiana that meet the IMD designation criteria.

According to Indiana Medicaid records, in state fiscal year 2019, only about half of Indiana's traditional Medicaid members receiving inpatient psychiatric services accessed those services through an institution for mental disease. Approval of the waiver amendment will mitigate these barriers to access and will shift services from less appropriate settings to facilities like hospitals and larger mental health treatment facilities. Under this waiver, patients receive longer, more appropriate inpatient stays, aiding in achieving stabilization and more successful transitions back into their homes and communities. The change is expected to ultimately drive down the costs associated with overuse of the emergency department for mental health problems and psychiatric crises as well as other costs caused by lack of access to appropriate care settings.

Non-psychiatrist behavioral health providers

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

The MCEs must meet specific network composition requirements for non-psychiatrist behavioral health providers:

- In urban areas, the MCEs must provide at least one behavioral health provider within 30 minutes or 30 miles. Due to the availability of professionals, access problems may be especially acute in rural areas. In rural areas, the MCE must provide at least one behavioral health provider within 45 minutes or 45 miles. The MCE must provide assertive outreach to members in rural areas where behavioral health services may be less available than in urban areas.
- The MCEs also must monitor utilization in rural and urban areas to assure equality of service access and availability. The following list represents behavioral health providers that should be available in each MCE's network:
    - Outpatient mental health clinics
    - Community mental health centers
    - Psychologists
    - Certified psychologists

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

Coordination of benefits and continuity of care

If a member is also enrolled in or covered by another insurer, the MCE is responsible for coordinating benefits to maximize the utilization of third-party coverage. The MCE must share information regarding its members, especially those with special health care needs, with other payers as specified by OMPP and in accordance with 42 CFR 438.208(b) regarding coordination of care. In the process of coordinating care, the MCE must protect each member's privacy in accordance with the confidentiality requirements stated in 45 CFR 160 and 164, which address the security and privacy of individually identifiable health information. The MCE is responsible for payment of the member's coinsurance, deductibles, co-payments and other cost-sharing expenses. However, the MCE's total liability must not exceed what the contracted MCE would have paid in the absence of third-party liability, after subtracting the amount paid by the primary payer.

OMPP requires that each MCE coordinates benefits and payments with the other insurer for services authorized by the MCE that were provided outside the MCE's plan. Such authorization may occur prior to provision of service, but any authorization requirements imposed on the member or provider of service by the contracted MCE must not prevent or unduly delay a member from receiving medically necessary services. Each MCE remains responsible for the costs incurred by the member concerning care and services which are included in the MCE's capitation rate and not covered or payable under the other insurer's plan.

In accordance with IC 12-15-8 and 405 IAC 1-1-15, OMPP has a lien upon any money payable by any third party who is or may be liable for the medical expenses of a Medicaid recipient when Medicaid provides medical assistance. An MCE may exercise independent subrogation rights it may have under Indiana law in pursuit or collection of payments it has made when a legal cause of action for damages is instituted by the member or on behalf of the member.

Coordination of benefits: Hoosier Healthwise, Package A

If an HHW member is enrolled in or covered by another insurer, the MCE is fully responsible for coordinating benefits. If an HHW Package A member's primary insurer is a commercial HMO and the contracted MCE cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the contracted MCE's rules, the MCE may submit to the enrollment broker a written request for disenrollment. The request must provide a specific description of the conflicts and explain why benefits cannot be coordinated. The enrollment broker will consult with OMPP and the request for disenrollment will be considered and acted upon accordingly.

Coordination of benefits: Hoosier Healthwise, Package C

An individual is not eligible for HHW Package C if they have other health insurance coverage. If the MCE discovers that a HHW Package C member has other health insurance coverage, they must report

the member's coverage to the state. OMPP requires the MCE to assist the state in its efforts to terminate the member from HHW Package C due to the existence of other health insurance.

The MCEs should coordinate with other insurance types such as worker's compensation insurance and automobile insurance.

Coordination of benefits: HIP

An individual is not eligible for HIP if they have other health insurance coverage. If the MCE discovers that a HIP member has other health insurance coverage, they are required to coordinate benefits and must report the member's coverage to the state. OMPP requires each MCE to assist the state in its efforts to terminate the member from HIP due to the existence of other health insurance.

Coordination of benefits: HCC

If an HCC member is enrolled in or covered by another insurer, the MCE is fully responsible for coordinating benefits. If an HCC member's primary insurer is a commercial HMO and the contracted MCE cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the contracted MCE's rules, the MCE may submit to the enrollment broker a written request for disenrollment. The request must provide a specific description of the conflicts and explain why benefits cannot be coordinated. The enrollment broker will consult with OMPP and the request for disenrollment will be considered and acted upon accordingly.

Clinical practice guidelines

MCEs develop or adopt practice guidelines based on valid and reliable clinical evidence and/or through the consensus of health care professionals in the field. The MCE must utilize a nationally recognized set of guidelines, including but not limited to non-company customized Milliman Care Guidelines or InterQual, which must be approved by the state. These practice guidelines are evaluated according to the needs of Indiana Medicaid members and are periodically reviewed and updated. Periodically, the MCEs meet to consult on best practices and effective interventions. Practice guidelines are distributed to providers through the plans' provider relations representative visits and/or mailings and may be available on plans' websites.

Coverage and authorization of services

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

The MCEs must establish and maintain medical management criteria and practice guidelines in accordance with state and federal regulations that are based on valid and reliable clinical evidence or consensus among clinical professionals and consider the needs of the contracted MCEs' members. Pursuant to 42 CFR 438.210(b), relating to authorization of services, the contracted MCEs must:

- Consult with contracting health care professionals in developing practice guidelines and must have mechanisms in place to ensure consistent application of review criteria for authorization decisions and consult with the provider that requested the services when appropriate
- Have sufficient staff with clinical expertise and training to interpret and apply the utilization management criteria and practice guidelines to providers' requests for health care or service authorizations for the contracted MCEs 'members

- Periodically review and update the guidelines, distribute the guidelines, or make them available to providers upon request and make the guidelines available to members upon request. Utilization management staff must receive ongoing training regarding interpretation and application of the utilization management guidelines
- Be prepared to provide a written training plan which shall include dates and subject matter, as well as training materials, upon request by OMPP

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

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

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

OMPP requires each MCE to report its medical necessity determination decisions and must describe its prior authorization and emergency room utilization management processes. When the MCE conducts a prudent layperson review to determine whether an emergency medical condition exists, the reviewer must not have more than a high school education and must not have training in a medical, nursing or social work-related field.

OMPP requires that each MCE's utilization management program:

- Include activities above and beyond traditional utilization management activities, such as prior authorization
- Integrate with other functional units as appropriate and support the Quality Management and Improvement Program
- Have policies, procedures and systems in place to assist utilization management staff to identify instances of over- and under-utilization of emergency room services and other health care services
- Have policies, procedures and systems in place to identify aberrant provider practice patterns related to the emergency room, inpatient services, transportation, drug utilization, preventive care and screening exams
- Utilize policies, procedures and systems in place to ensure positive outcomes, including active participation of a utilization review committee; evaluation of efficiency and appropriateness of service delivery; and incorporation of subcontractor's performance data and facilitate program management and long-term quality and identify the critical quality of care issues
- Connect members to disease management, care management and complex case management
- Encourage health literacy and informed responsible medical decision-making. For example, the MCE should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and obtain services in the

appropriate treatment setting. Each MCE is also responsible for identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care.

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

The MCEs must monitor pharmacy utilization as identified when stratifying a member for care. Pharmacy services for HHW, HIP and HCC members continue to be managed by the MCE through their own pharmacy benefits managers. As a part of the utilization review, the MCEs will assess a member's utilization as compliant with, contraindicated, or in conflict with their diagnoses and health care needs. The OMPP Pharmacy team is currently collaborating with Indiana's MCEs to align their pharmacy medical necessity criteria with the Medicaid fee for service program. This project will establish uniform prior authorization criteria and processes among the MCEs.

As part of its utilization review, the MCEs should monitor access to preventive care, specifically to identify members who are not accessing preventive care services in accordance with accepted preventive care standards such as those published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. The MCEs should target education, incentives, and outreach plans tailored to its member population to increase member compliance with preventive care standards and to decrease inappropriate use of health care.

To monitor the potential under- or over-utilization of physical and behavioral health services, the MCEs submit a variety of utilization reports to OMPP. The MCEs monitor the volume, type, effectiveness and timeliness of their prior authorization requirements. The MCEs also provide OMPP with the rates of assessment utilizing the state-approved health needs screen as well as their own comprehensive health assessments. OMPP also receives quarterly reporting on how members are stratified, upon completion of assessment(s), into the appropriate level of care coordination including disease management, care management, and complex case management. MCEs monitor the use of services for their members assessed with special needs as well as members with a diagnosis of serious emotional disturbance, severe mental illness and/or substance abuse.

Intermediate sanctions

It is the state's primary goal to ensure that the MCE and its subcontractors/vendors deliver quality care to members while maintaining the program integrity of the state of Indiana's Medicaid programs. Indiana MCE contracts include provisions for failure to perform remedies. Non-compliance remedies include a written warning, formal corrective actions, withhold of payments, suspending enrollments, immediate sanctions and contract termination. These remedies provide OMPP with an administrative procedure to address issues. To assure quality care for members, OMPP monitors quality and performance standards through several means including reporting and monthly onsite monitoring visits. OMPP works collaboratively with the contracted MCEs and holds them accountable for maintaining and improving Medicaid programs. The disposition of any corrective action depends upon the nature, severity, and duration of a deficiency or non-compliance. If a formal correction action is put into place, OMPP and the MCE then negotiate the specific sanction.

OMPP may enforce any of the remedies listed if the MCE does the following:

- Fails substantially to provide medically necessary services that the MCE is required to provide, under law or its contract with the state, to a member;
- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the HCC program;
- Acts to discriminate among members based on their health status or need for health care services, such as unlawful termination, refusal to re-enroll a member or engaging in any practice that would reasonably be expected to discourage enrollment by a potential enrollee whose medical condition or history indicates a probable need for substantial future medical services;
- Misrepresents or falsifies information that it furnishes to CMS or to the state;
- Misrepresents or falsifies information that it furnishes to a member, potential enrollee or health care provider;
- Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210;
- Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations

Structure and operations standards

Provider selection: provider enrollment and disenrollment

The contracted MCEs must follow established procedures to enroll and disenroll providers, including PMPs. In enrolling and disenrolling providers, the MCEs may distinguish whether the provider participates in HHW, HCC and/or HIP programs. The Managed Care Policies and Procedures Manual provides detailed information on PMP and provider enrollment and disenrollment procedures. Once enrolled at the MCE, enrollment information is entered into CoreMMIS with the fiscal agent to complete the enrollment process.

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

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

The MCE must make a good faith effort to provide written notice of a provider's disenrollment to any member who has received primary care services from that provider or otherwise sees the provider regularly. Such notice must be provided within 15 calendar days of the MCE's receipt or issuance of the provider termination notice.

Enrollee information

Member enrollment

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

New member materials

Within five calendar days of a new member's enrollment date, the MCE sends the new member a welcome packet. The welcome packet includes a minimum of a new member letter, an explanation of where to find information about the MCE's provider network, and a copy of the member handbook or member quick start guide. HHW, HCC and HIP members receive a member ID card within the same timeframe as the welcome packet. The member ID card includes the member's identification number and the applicable phone numbers for member assistance.

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

Primary medical provider selection

OMPP requires each MCE to ensure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. Following a member's enrollment, the MCE must assist the member in choosing a PMP. If the member has not selected a PMP within 30 calendar days of the member's enrollment, the MCE assigns the member to a PMP. Unless the member elects otherwise, the member must be assigned to a PMP within 30 miles of the member's residence and the MCE considers any prior provider relationships when making the assignment. OMPP approves the MCE's PMP auto-assignment process prior to implementation, and the process must comply with any guidelines set forth by the state.

The member may make PMP changes at any time. If the member was auto-assigned a PMP, the member may change to another provider which s/he prefers. The member may also work with the MCE to find a new PMP if he or she moves or otherwise desires a change.

Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians, gynecologists and endocrinologists (if primarily engaged in internal medicine). HCC allows any treating specialist to be a member's PMP due to the unique health needs of members.

Health needs screen

Since February 2011, each MCE has been required to conduct a health needs screen for new members. The health needs screen is used to identify the member's physical and/or behavioral health care needs, special health care needs, as well as the need for disease management, care management, and/or complex case management services. The health needs screen may be conducted in person, by phone, online or by mail. For 2022, some MCEs are utilizing kiosks located in retail businesses as well for members to be able to complete their health needs screen. All MCEs use an OMPP-approved standard health screening tool. The Health Needs Screen may be supplemented with additional questions developed by the MCE or partnered with the MCE's comprehensive health assessment tool. Any additions to the health screening tool must be approved by OMPP.

After an in-depth review in 2019, the OMPP Quality team decided to reduce the content of the Indiana HNS from 63 questions to 13 questions with the goals of increased member engagement, earlier completion of the necessary comprehensive health assessments, and increased numbers of members receiving care coordination services. These questions focus on the initial identification of member physical and behavioral health conditions, use of any medications, pregnancy status, smoking and vaping, lead testing, and the member's possible need regarding various social determinants of health. OMPP conducted routine reviews in 2021 to verify that each MCE was using this revised HNS and following their processes for all newly assigned members. MCEs must submit a monthly extract of completed HNS

to Optum on behalf of OMPP by the 15th of every month. The monthly file contains assessments completed in the previous month.

Table 14 below contains the 13 HNS questions:

Table 14	Health Needs Screen	
Question #	**Question**	**Responses**
1	Do you have any health concerns?	Yes No
2	Do you need help with any of your health concerns?	Yes No
3	Do you take any medications?	Yes No
4	Have you been seen by a doctor in the last six months?	Yes No
5	Have you been seen by a doctor in the emergency room in the last six months?	Yes No
6	Have you been a patient in the hospital in the last six months?	Yes No
7	Do you use or need anything to help you walk, talk, hear, see, bathe, toilet or eat?	Yes No
8	Do you feel down, anxious or have little interest in doing things?	Yes No
9	Do you use tobacco or vaping products of any kind?	Yes No
10	Do you worry about things like where you live? Getting food every day? Getting to the grocery or doctor appointments? Feeling safe?	Yes No
11	Have all children in the home been tested for lead poisoning?	Yes No
12 (females only)	Are you currently pregnant?	Yes No
13 (females only)	Have you had a baby in the last twelve months?	Yes No

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

The initial health screen is followed by a detailed comprehensive health assessment tool by a health care professional when a member is identified through the screening as having a special health care need or when there is a need to follow up on problem areas found in the initial health screening. OMPP also requires each MCE to conduct a subsequent comprehensive health assessment if a member's health care

status is multifaceted or has changed since the original screening. Possible overutilization of health care services as identified through claims review may also trigger a comprehensive health assessment.

The comprehensive health assessment may include, but is not limited to, discussion with the member, a review of the member's claims history and/or contact with the member's family or health care providers. These interactions must be documented and shall be available for review by OMPP. The MCE must maintain records of those members found to have special health care needs based on the health needs screen, including documentation of the follow-up comprehensive health assessment and contacts with the member, their family or health care providers. The detailed comprehensive health assessment is utilized to identify a member's individualized needs and ultimately allows for stratification into the appropriate level of care coordination whether it be disease management, care management or complex case management.

Children with special health care needs

OMPP requires each MCE to develop care plans to address the special needs populations and for the provision of medically necessary, specialty care through direct access to specialists. The HHW managed care program uses the definition and reference for children with special health care needs as adopted by the Maternal and Child Health Division of the Indiana Department of Health and published by the American Academy of Pediatrics:

> "Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." The health needs screening tool will assign children to one of the Living with Illness Measures screen health domains based on the National Committee on Quality Assurance study design. The scoring for the LWIM screen identifies a child as potentially having a special health care need if the screening identifies needs in one or more of seven different health domains:
>
> - Functional limitations only
> - Dependency on devices only
> - Service use or need only
> - Functional limitations and a dependency on devices
> - Functional limitations and a service use or need
> - Dependency on devices and a service use or need
> - Functional limitations, a dependency on devices, and a service use or need

Member disenrollment from contracted managed care entities

In accordance with 42 CFR 438.56(2) regarding enrollment and disenrollment, each MCE may neither terminate enrollment nor encourage a member to disenroll because of a member's health care needs or a change in a member's health care status. A member's health care utilization pattern may not serve as the basis for disenrollment from the contracted MCE.

The MCE must notify the local county FSSA Division of Family Resources office within 30 calendar days of the date it becomes aware of the death of one of its members, giving the member's full name, address, Social Security Number, member identification number and date of death. The MCE will have no authority to pursue recovery against the estate of a deceased Medicaid member.

Confidentiality

The MCE must ensure that member medical records and all other health and enrollment information that contain individually identifiable health information, is used and disclosed in accordance with the privacy requirements set forth in the Health Insurance Portability and Accountability Act Privacy Rule (see 45

CFR parts 160 and 164, subparts A and E, which address security and privacy of individually identifiable health information). OMPP requires that each MCE comply with all other applicable state and federal privacy and confidentiality requirements and have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements.

OMPP requires that each MCE's information system is in compliance with the HIPAA Transaction and Code Set requirements for electronic health information data exchange, National Provider Identifier requirements and Privacy and Security Rule standards. The MCEs' electronic mail encryption software for HIPAA security purposes must be as stringent as the state's security level. The MCEs' Information System plans for privacy and security shall include, but not be limited to:

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

Grievance systems

OMPP requires each MCE to establish written policies and procedures governing the resolution of grievances and appeals. The grievance system must include a grievance process, an appeal process, expedited review procedures, external review procedures, and access to the state's fair hearing system. The MCEs' grievances and appeals system, including the policies for record-keeping and reporting of grievances and appeals, must comply with state and federal regulations.

The MCEs' appeals process must:

- Allow members, or providers acting on the member's behalf, 60 days from the date of action notice within which to file an appeal
- Ensure that oral requests seeking to appeal an action are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution
- Maintain an expedited review process for appeals when the contracted MCE or the member's provider determines that pursuing the standard appeals process could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function

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

The MCE must provide specific information regarding member grievance, appeal and state fair hearing procedures and timeframes to members. This information is included in the MCE welcome packet and is available upon request. The MCE must also supply providers and subcontractors information on member grievance, appeal, and state fair hearing procedures and timeframes at the time they enter a contract with the MCE.

Sub-contractual relationships and delegation

According to IC 12-15-30-5, subcontracts, including provider agreements, cannot extend beyond the term of the contract between the MCE and the state. A reference to this provision and its requirements must be included in all provider agreements and subcontracts.

The MCE is responsible for the performance of any obligations that may result from the contract. Subcontractor agreements do not terminate the legal responsibility of the MCE to the state to ensure that

all activities under the contract are carried out. The MCE must oversee subcontractor activities and submit an annual report on its subcontractors' compliance, corrective actions, and outcomes of the contracted MCE's monitoring activities. The MCE will be held accountable for any functions and responsibilities that it delegates.

The MCE must comply with 42 CFR 438.230, which contains federal subcontracting requirements, and the following subcontracting requirements:

- The MCE must obtain the approval of OMPP before subcontracting any portion of the project's requirements. Subcontractors may include but are not limited to a transportation broker, behavioral health organizations, pharmacy benefits managers and physician-hospital organizations.
- All subcontractors must fulfill all state and federal requirements appropriate to the services or activities delegated under the subcontract.
- The MCEs must have policies and procedures addressing auditing and monitoring subcontractors' data, data submissions, and performance. The contracted MCEs must report contractor performance accurately and completely by integrating subcontractors' financial and performance data (as appropriate) into the contracted MCEs' information system to confirm contract compliance.

OMPP reserves the right to audit MCEs' subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. OMPP may require corrective actions and will assess liquidated damages, as specified in Contract Exhibit 2, for non-compliance with reporting requirements and performance standards.

If the MCE uses subcontractors to provide direct services to members, such as behavioral health services, the subcontractors must meet the same requirements as the MCE. The MCE must demonstrate its oversight and monitoring of the subcontractor's compliance with these requirements. The MCE 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.

MCE health information systems

OMPP requires all MCEs to operate and maintain an information system sufficient to support the HHW, HCC, and HIP program requirements and capable of collecting and transmitting required data and reports to OMPP in the format specified by OMPP. Each contracted MCE maintains an information system that collects, analyzes, integrates and reports data. Contracted MCEs report data to OMPP on:

- Utilization management: health needs screens, comprehensive health assessments screenings, prior authorization, care management, complex case management, disease management, services utilization, pregnancy identification
- Member services: member helpline, member portal, grievances, hearings and appeals, Consumer Assessment of Healthcare Providers and Systems
- Provider reports: claims disputes, credentialing, enrollments and disenrollments, geographic access, compliance
- Quality management and improvement: quality management and improvement work plan, program integrity report, quality improvement projects, HEDIS
- Financial reports: Third Party Liability, medical loss ratio and benefit costs
- Clinical reports: newborns, well-child visits, preventive exams, health screenings, ambulatory care, emergency department and inpatient utilization, follow-up after hospitalization and inpatient readmissions

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

OMPP requires that all contracted MCEs develop information system contingency plans in accordance with 45 CFR 164.308, which relates to administrative safeguards, and to comply with 42 CFR 438.242 relative to data. Contingency plans must include: Data Backup plans, Disaster Recovery plans, and Emergency Mode of Operation plans. Application and Data Criticality Analysis and Testing and Revisions procedures are also required to be addressed within the MCE's contingency plan documents.

Public health emergency implications

OMPP worked throughout the COVID-19 public health emergency to revise operations standards. The changes were communicated to providers using IHCP Bulletins. IHCP Bulletins provide official notice of new and revised policies, program changes and information about special initiatives. Bulletins were issued on an as-needed basis. Some examples of the operational changes that occurred during the public health emergency are listed below.

Member enrollment

Throughout the public health emergency, Medicaid eligibility was maintained in the current or better category. Disenrollment from Medicaid was limited to a member moving out of state, a member voluntarily withdrawing, death or a member aging out of the CHIP program. Redeterminations still occurred following the normal process but disenrollments were held until the end of the federal public health emergency.

Member contributions

During the public health emergency, all member cost-sharing, including copayments and premiums, were suspended. Members who typically had copayments did not have any copayments applied. This applies to all IHCP programs including CHIP, HIP and M.E.D. Works. It also included pharmacy copayments.

Prior authorizations

During the public health emergency, OMPP temporarily removed prior authorization requirements for some services and supplies. The policy changes included Traditional Medicaid (fee-for-service) as well as all managed care benefit programs. Some of the changes are as follows:

- PA was not required for some respiratory services and durable and home medical equipment repairs and replacements.
- IHCP also temporarily revised the PA process for acute care hospital inpatient admissions to streamline the process by only requiring basic information on the IHCP PA form. There was no requirement for clinical documentation to be submitted. Acute care hospital authorizations were also automatically approved for a period of 60 days from the date of admission of the member.
- Similar to acute care hospitals, the PA process for behavioral health services, LTAC and AIR facility admissions was streamlined and no clinical documentation was required.
- IHCP also revised the home health PA requirements to allow approval for a period of up to 180 days.

Pharmacy

Pharmacies were allowed to fill prescriptions with name-brand drugs in the event that the generic drug the member takes is out of supply. Pharmacies could also fill some prescriptions early and could fill maintenance prescriptions for 90 days, if requested.

Provider enrollment

During the public health emergency, IHCP made several temporary changes to provider enrollment procedures as listed below.

- Providers that were due for revalidation between March 1, 2020, and the end of the state emergency declaration were not required to revalidate until after the declaration.
- Provider enrollment screening requirements such as the application fee, site visit and criminal background check were temporarily waived.
- Newly enrolled providers were enrolled on a provisional basis and were assigned a risk level associated with their provider type and specialty without the additional screening measures.
- The state has waived the requirement that MCEs must fully credential providers before permitting those providers to bill claims for services to Indiana Medicaid members.
- Allowed enrolled rendering providers to participate with any currently enrolled group location without requiring the rendering provider to be linked to the group's service location enrollment.
- Enrolled rendering providers could bill for services through any enrolled service location.

Virtual telehealth services

Medicaid waiver providers were permitted to provide non-healthcare services virtually and receive IHCP reimbursement. Home health agencies could provide reasonable services to patients using telemedicine as long as the service is part of the patient's plan of care and did not replace needed in-person visits as ordered on the plan of care. Examples of reasonable services included mental status examinations, monitoring medication setup, and chronic disease education and management.

Monthly MCE onsite visits

OMPP conducts monthly onsite visits with each of the MCEs as part of monitoring and oversight. During the COVID-19 public health emergency, the Quality team has met virtually with the MCEs as part of the onsite requirement. The MCEs were asked to complete systems demonstrations and provide individual case reviews for members during these virtual meetings. Findings from the virtual onsite visits were documented and provided to the MCEs for response and resolution, if needed.

External quality review arrangements

OMPP has contracted with a new External Quality Review Organization, Qsource, to complete the 2021 EQR for all Indiana Medicaid programs. The EQRO contract with Qsource began in 2021 and is a four year contract with two one-year optional extensions. The EQR will apply to all Indiana Medicaid-managed care MCEs. The HHW, HCC and HIP EQR take place each summer and the results are reported each fall. The CHIP EQR is conducted each winter and the results are reported each spring.

Performance measures, PIPs, and standards related to elements in 42 CFR 438 subpart D and 438.330 are validated and reported by the EQRO per 42 CFR 438.364.

The 2021 EQR activities will include the following:

- Validation of all MCE PIPs
- Validation of performance measures specific to Report 0510 Institution for Mental Disease member use

- Review of compliance with Medicaid and CHIP Managed Care Regulations
- Validation of encounter data
- Review of network adequacy specific to primacy care providers

OMPP Quality and Outcomes staff provided training to all of the MCEs on Dec. 1, 2021, specific to the EQR review protocols for both the PIPs and the CMS QAPI requirements.

The revised EQR protocols require the use of a specific tool, Information Systems Capability Assessment, to validate managed care plan information systems, processes and data. The ISCA will be utilized for the mandatory EQR-related activity protocols including the performance report validation. By 2022, OMPP will ensure that the required portions of the ISCA are utilized as a part of the EQR activities.

Non-duplication option

The state does not leverage the non-duplication or exemption options offered by CMS. All mandatory External Quality Review-related activities are reviewed for all Managed Care Entities. A copy of the state's EQR is posted publicly at https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/.

SECTION VI. Updating the quality strategy

Updates due to significant changes

OMPP defines a significant change as a modification that occurs to an Indiana Medicaid program goal, objective, or priority; other than modifications done for clarity. This is inclusive not only to the Medicaid program's structure, goals or objectives but also includes changes resulting from legislative or other regulatory authority; unanticipated changes in MCE performance; achievement of quality goals and/or changes based on stakeholder input and feedback.

Review and evaluation of the quality strategy

OMPP will update the quality strategy no less than every three years. Indiana has historically updated its quality strategy plan every year as quality goals are periodically reviewed and updated according to the needs of Indiana Medicaid members. This also allows for updating the targets to be used in measuring the performance and improvement of Medicaid MCE.

OMPP reviews Pay-for-Outcome measures on an annual basis. The performance measures and targets are based on the priority areas established by 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. As progress is made towards the Pay-for-Outcomes and/or goals, the quality strategy is updated to reflect the new goal.

Lastly, evaluation of and updates to the quality strategy take into consideration the recommendations provided by an EQRO.

External quality review organization recommendations

OMPP contracted with Burns & Associates, Inc. to conduct the required External Quality Reviews for HHW, HCC, HIP and the Indiana's Children's Health Insurance Program in 2020. In Calendar Year 2020 B&A conducted the following for CY 2019 experience. The topic and recommendations for each topic using the results are provided in Table 15A.

Table 15A External Quality Recommendations

Topic	EQRO Recommendation
Validation of Performance Measures	The MCEs were provided technical assistance in regard to the report specifications and how data is to be collected.
Validation of MCE Performance Improvement Projects	Follow-up occurred in the form of required monthly QIP updates provided to OMPP; training on quality QIP development provided to the MCEs in December of 2021; and requirement of two specific QIPs for 2022.
Examination of Provider Network Adequacy at Each MCE	Network adequacy is monitored on an ongoing basis by the OMPP Compliance team through monthly on-site monitoring meetings, reviews of member grievances and appeals reporting, and informational queries. OMPP provided technical assistance to the MCEs specific to the completion of the 0902 and 0903 annual reports as well as added additional instructions to the MCE Reporting Manual.
Optional EQR Activity: Focus Study on Lead Testing	Follow-up completed in the form of monthly meetings between IDOH, the MCEs, and OMPP Quality to clarify and improve the quality of data shared.

Table 15A External Quality Recommendations	
Topic	**EQRO Recommendation**
Optional EQR Activity: Focus Study on the Utilization and Delivery of Non-Emergency Medical Transportation	Follow-up to occur with the MCEs via an upcoming monthly on-site monitoring meeting.
Optional EQR Activity: Focus Study on Claims Adjudication and Encounter Submissions	OMPP has provided clarification and technical assistance to the MCEs specific to the technical specifications for completing Reports 0101 Claims Adjudication and 0102 Encounter Submissions.

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

OMPP updates the quality strategy taking into consideration the recommendations provided by the EQRO. Similar to significant changes, EQRO recommendations may initiate a modification to a Medicaid program goal, objective or priority. Recommendations may also initiate a modification to the quality strategy. As an example with the EQRO recommended follow-up on lead testing, OMPP has implemented a quality strategy initiative and pay-for-outcome measure in the quality strategy for the HHW program.

SECTION VII. Improvement and Interventions

Improvements

OMPP's Quality Strategy Plan for 2022 builds upon the plans from 2020 and 2021. There is a continued focus on preventive health care for all programs as well as HHW and HIP priorities on healthy moms and healthy children to ensure that quality health care is provided to all IHCP members. While each MCE has identified quality improvements for 2022, there are several initiatives in place that encompass all Medicaid programs. The interventions listed in Table 15 are at the forefront of planning and implementation of this Quality Strategy. Ongoing monitoring will provide OMPP with quality-related data for future monitoring and planning.

Some of the interventions that encompass all Medicaid programs are tracked through the Pay-for-Outcomes measures described by OMPP within this document.

Table 15B displays all cross-cutting interventions for the managed care programs.

TABLE 15B Cross-Cutting Interventions for all Managed Care Programs

Intervention	Process	Stakeholders
Outcome-Based Contracting	• Pay-for-Outcomes • Maintain and improve current metrics • Reporting that matches the state's goals • Monitor enrollment in the Right Choices program • Assure member access to care	OMPP Contracted MCEs
Prenatal/Postpartum Care Initiatives	• Notification of pregnancy monitoring • Smoking cessation • initiatives for pregnant members • Monitoring member's access to care • Partnership with the IDOH • My Healthy Baby project • Indiana Pregnancy Promise Program that connects individuals to prenatal and postpartum care, other physical and mental health care, and treatment for opioid use disorder	OMPP Contracted MCEs IDOH Providers
Improve health care for Indiana's Children/EPSDT	• Increase the percentage of children and adolescents receiving well-care • Develop a protocol for provider adherence to in-depth physical and mental health screenings • Ongoing provider education, monitoring, and outreach • Collaborating with IDOH to increase blood lead testing rate in Indiana • Monitor collaboration efforts between mental health services, PRTF, and Money Follows the Person services	OMPP Contracted MCEs Gainwell DMHA EPSDT IDOH
Behavioral Health	• Collaborative project focused on follow-up after mental health hospitalization	OMPP DMHA Contracted MCEs

TABLE 15B Cross Cutting Interventions for all Managed Care Programs		
Intervention	Process	Stakeholders
	• Increase member access to SUD services and providers • Increase the number of IHCP enrolled SUD providers • Approval for and implementation of the SMI Waiver • Use of standard *IHCP residential/inpatient substance use disorder treatment prior* • *authorization request form* to request prior • authorization for inpatient and residential SUD treatment services	
Improving access to prenatal care and case management of high-risk pregnancies by improving the process for notification of pregnancy programs	• Monitor the improvements in the notification of pregnancy process	OMPP Contracted MCEs IDOH Providers

State health information technology

FSSA has concluded most of its work toward the achievement of the Health Information Technology for Economic and Clinical Health goals and objectives under the Medicaid Promoting Interoperability Program (formally the Electronic Health Records Incentive Program). By advancing health information technology and multi-statewide health information exchanges in Indiana through supporting the design, development, testing, and implementation of core infrastructure and technical solutions, FSSA has promoted health information exchange among Medicaid-eligible professionals and eligible hospitals. OMPP does and will continue to benefit greatly from this type of data sharing and coordination.

The Advance Planning Documents for HITECH and Medicaid Enterprise Systems and State Medicaid HIT Plan for 2022 focuses on multiple initiatives, including the following:

- HITECH closeout activities, including transition of initiatives to MES funding, a continuation of incentive payment auditing activities and other preparation of Indiana's final State Medicaid Health Information Technology Plan update under HITECH.
- Indiana Health Information Exchange connectivity, including the following:
- Further phases of the Indiana Department of Correction implementation of connection to HIE and enhanced coordination of care for offenders entering and exiting the correction system for the health and success of the person, decreasing duplication of services and creating efficiency with the Medicaid Managed Care Entities.
- Continue, and if possible expand, the connection of Federally Qualified Health Centers and FQHC Look-Alikes to HIE.
- Resumed Indiana Department of Homeland Security integration between Emergency Medical Services and HIE.
- Further interface development and implementation across the six State Psychiatric Hospitals).
- Implementation of Patient Access and Provider Directory APIs for Fee-for-Service per the CMS Interoperability and Patient Access Final Rule.

OMPP continues to share data with and utilize data from internal and external partners. A project currently in place to allow data exchange between OMPP and the Department of Child Services to enhance service coordination was initiated in 2020 and will continue to move forward in 2022.

MCE information systems are used to collect and submit data to the state to validate performance. State staff directly manages all MCE report submissions. This direct management supports and deepens the OMPP's capacity to align and increase oversight processes across the MCEs and the Medicaid programs. Through the course of this alignment, a full comparative review of the report submissions by the contracted MCEs takes place to ensure that key performance indicators, both operational and clinical, are effectively being identified, collected, validated and analyzed. Reporting dashboards are presented to the Quality Strategy Committee and sub-committees for review. The role of the Committee is to assist in the development and monitoring of the identified goals and strategic objectives of the written Quality Strategy and to advise and make recommendations to OMPP.

While the MCEs are required to submit annual HEDIS data, OMPP also collects quarterly reports on a variety of quality indicators for preventive health, children and adolescents, and mothers and newborns. The increased access to data allows OMPP to continually track and monitor performance on key quality indicators and steer the focus toward improvement activities. Annually, OMPP revises the MCE reporting manual to keep the manual relevant to the quality and oversight needs of OMPP.

During 2022, OMPP will continue to monitor and work with the MCEs, the state fiscal agent and the EDW to identify and decrease the limitations within their specific health information systems that prevent encounter claims from being provided and loaded in a timely and accurate manner.

Adult and child quality measures

In 2018, OMPP began an initiative of determining the best process by which to provide data to CMS on the Adult Quality Measures. In December 2019, OMPP reported (for the first time) to CMS on the Adult Quality Measures. The AQM data is calculated following CMS instructions in the *Consolidated Implementation Guide* and the *Technical Specifications and Resource Manual*. Data is collected for enrollees in managed care and fee-for-service members. Rates were calculated across all reporting MCEs for 16 HEDIS measures. For 2020, OMPP submitted rates for 17 Adult Core Quality Measures to CMS, sourced from both HEDIS and AHRQ measures. OMPP is prepared to submit rates for 22 Adult Core Quality Measures in 2021.

OMPP has tracked and monitored the Child Core Quality Measures since the initiation by CMS. The Child Quality Measures are created and tracked by an outside vendor, Burns and Associates. For 2021, OMPP reported on 22 of the 23 Child Core Quality Measures.

OMPP utilized the lessons learned from the 2019 and 2020 submissions to accurately define members to be included in the denominators and numerators for all measures. OMPP met the goals of enhancing the quality of data and the number of measures in the 2021 submissions. Future goals will include further data enhancement as well as identification of additional data sources to allow for reporting on additional measures.

Information systems capability assessment

The revised EQR protocols require the use of a specific tool, Information Systems Capability Assessment, to validate managed care plan information systems, processes, and data. The ISCA is utilized for EQR-related activity protocols including the MCE performance report validation. For 2022, OMPP will ensure that the required portions of the ISCA are utilized as a part of the EQR activities.

SECTION VIII. OMPP 2022 initiatives

Standard monitoring compliance for 2022

Normal duties for monitoring compliance and ensuring quality health care is delivered to members will continue in 2022.

Hoosier Healthwise

The primary aim of the HHW program is to provide comprehensive health care coverage for uninsured Hoosiers to improve overall health, promote prevention and encourage healthy lifestyles. A strong focus is on healthy moms and healthy babies to improve birth outcomes. Families have access to health care through the same PMP for each member whenever possible. Continuity of care for family members provides enhanced opportunities for health care to all members of the household.

Healthy Indiana Plan

The primary aim of the HIP program is to provide adults access to a health care plan that empowers them to take charge of their health and prepares them to move to private insurance as they improve their lives. HIP provides incentives for members to be more health-conscious by accessing preventive health care and encourages appropriate use of the emergency room.

Hoosier Care Connect

The primary aim of HCC in 2015 was to transition eligible members who are age 65 and over or who had blindness or a disability to a coordinated care program where their multiple health needs could be coordinated. This program also includes current and former wards and foster children. In 2022, health needs screens and comprehensive health assessments will continue to be monitored as pay-for-outcome measures as they remain instrumental in identifying individual member needs, coordinating care, improving quality outcomes, and maintaining consistency of care for these vulnerable members.

Right Choices Program

The primary aim of the Right Choices Program is to assist risk-based managed care and fee-for-service members in obtaining the right care at the right time in the right place for each member. Within this model, RCP members may be restricted to one PMP and one pharmacy. This allows all care to be managed by the member's PMP to ensure the member is receiving appropriate care. The MCEs evaluate members for potential enrollment in the program when members are identified as not utilizing health care services appropriately such as, multiple emergency room visits, pharmacy visits, and physician visits that are not medically necessary. The program's design is to assist RCP enrollees by creating a medical home to support the member in obtaining the appropriate care at the right time in the right place.

For 2022, the focus of the Right Choices Program will include a monthly analysis of pharmacy claims identifying those members who have utilized opioids and controlled substances at a rate higher than the standard mean. This information will be uploaded into a single portal that can be accessed by MCE and OMPP staff as needed for review and analysis of Medicaid member usage.

Initiatives for 2022

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

Policy governance

The OMPP Coverage and Benefits team within the Clinical Outcomes Section continues to facilitate the structured Policy Consideration process to advance a value-driven program, focusing on cost-effective improvements to the health of the Indiana Health Coverage Programs population. The Policy Consideration process was designed to give internal and external stakeholders the ability to request

changes and updates to the Medicaid coverage policies. This process defines how requests are submitted and reviewed by the office. Submitted requests go through a rigorous research and review process before policy changes are/can be made.

Monitoring and reporting quality

The OMPP Quality and Outcomes staff works collaboratively with internal stakeholders (e.g., functional sections outside of Quality & Outcomes) and the MCEs to improve the oversight and reporting processes by ensuring that all contracted MCEs are measuring, calculating, and reporting in the same manner. Quality team staff reviewed the MCEs' proposed 2022 QMIP Work Plans and QIPs. QMIP Work Plan progress is monitored during onsite monitoring visits.

Under the alignment of programming described in this quality strategy, the OMPP Quality and Outcomes Section will continue to collaborate to identify areas needing improvements, such as pharmacy and program integrity, and determine a collaborative approach to monitoring and reporting.

Health equity

As part of our agency's health equity initiative, OMPP began focusing on infant mortality in 2021 with the goal of improving transparency and accountability recognizing that health disparities account for preventable mortality in minority populations. This initiative allows OMPP to expand our health equity commitment beyond the annual infant mortality data and analysis that is currently being completed.

A detailed presentation on Indiana Medicaid's 2018 and 2019 infant mortality rate was provided by OMPP staff during the December 2021 Quality meeting. The study analyzed infant mortality cases for Medicaid eligible babies from claims housed in the FSSA Enterprise Data Warehouse. Due to the timing of claims run out, data from 2019 was presented and compared to 2018. The study examined maternal age, diagnosis, prenatal care, race and ZIP code residence.

The infant mortality rate for 2019 was 5.34 and showed a decrease of 1.24 from 2018 translating to 56 less infant deaths. Maternal age remained constant at 26.73 years in 2018 and 27.98 years in 2019. Most infant mortality cases (30% in 2018 and 33.64% in 2019) involved babies that passed within the first 30 days of life. The average age at death was 63.8 days in 2019 compared to 62.4 days in 2018.

TABLE 16: Infant Mortality in Medicaid

Measure	2019	2018
Infant Mortality Rate *(Rate per 1,000 births)*	5.34	6.55
Number of Live Medicaid Births	40,099	41,202
Number of Infant Deaths	214	270
Average Age in Days of Infant Death	63.8	62.4
Percentage of Deaths within First 30 Days of Birth	33.64%	30.00%

Birth weight is a significant factor in the health of an infant. The percentage of all Indiana live Medicaid births with low birth weight (less than 2,500 grams) in 2019 was 9.3%, a decrease of 0.66% from 2018 and lower than the 2019 National Average Medicaid rate of 9.7%.

TABLE 17: Child Core Measures for Medicaid and CHIP				
Child Core Measure	Description of Measure	2019	2018	National Medicaid Rate 2019
Prenatal and Post-Partum Care (PPC-CH)	Percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.	82.9%	86.8%	75.7%
Low Birth Weight	Percentage of live Medicaid births that weighed less than 2,500 grams in the state during the reporting period.	9.3%	9.9%	9.7%

Tobacco use continues to be a concern for Indiana Medicaid mothers and babies. In 2019, 47.73% of mothers in infant mortality cases used tobacco, and 32.95% smoked more than 10 cigarettes/day. Another area of great concern is the amount and timing of prenatal care received. In an average non-complicated pregnancy, one could expect a pregnant mother to receive approximately 29 prenatal visits, however, the average number of visits in Indiana Medicaid infant mortality cases in 2019 was 11.25 with a median of 14. Of mothers with an infant death 5.68% had no prenatal care, 20.45% had 6-10 prenatal visits and 11.93% had 21 or more prenatal visits. Thirty-eight infant mortality cases were unable to be matched to a mother; these members were not included in the prenatal visit analysis.

TABLE 18: Prenatal Care in Medicaid Infant Mortality Cases		
Measure	2019	2018
Average Number of Prenatal Visits for Pregnancy	11.25	11.78
Median Number of Prenatal Visits	14	10
Number of Mothers with No Prenatal Visits	10	8
Number of Mothers Unable to Locate	38	65
Percent of Mothers with No Prenatal Care	5.68%	3.90%

A normal un-complicated pregnancy would typically consist of 28-29 prenatal care visits. Table 19 represents the number of prenatal care visits in infant mortality cases for 2018.

TABLE 19A: Prenatal Care in Medicaid Infant Mortality Cases in 2019		
Number of Prenatal Care Visits	Number of Members	Percent of Members
0 Prenatal Visits	10	5.68%
1-5	46	26.14%
6-10	36	20.45%
11-15	34	19.32%
16-20	29	16.48%
21 or more	21	11.93%

TABLE 19B: Prenatal Care Visits in a Normal Non Complicated Pregnancy	
Every 4 weeks until 28 weeks	7 Visits
Every 2 weeks until 36 weeks	18 Visits
Weekly until delivery	3-4 Visits
Total Prenatal Care Visits	**28-29 Visits Total**

OMPP monitors each MCE's timeliness of ongoing prenatal care and referrals to the Indiana Tobacco Quitline, a state-funded free phone-based counseling service that helps Indiana smokers quit, with Pay-for-Performance programs to facilitate improvement in these measures. The MCEs also must submit document reviews and case study demonstrations related to the coordination of care for pregnant members enrolled in the respective MCEs. Out of the 214 infant mortality cases in 2019, excluding mothers unable to be matched to an infant mortality case, 33 mothers were enrolled in an MCE for less than one month. Most members (45.45%) were enrolled with an MCE for 7 or more months of their pregnancy; 58 (32.95%) members in infant mortality cases were enrolled with an MCE during the full 9 months of pregnancy.

TABLE 20: Length of Managed Care Enrollment for Mothers in Infant Mortality Cases, 2019	
Maternal Months	Number of Members Insured on Managed Care
0 months	33
1-3 months	22
4-6 months	41
7-9 months	80

Maternal demographic information contained in the Indiana Medicaid claims demonstrated health disparities for African American/Black and Hispanic/Latinx populations. Maternal race information was successfully pulled from claims for 168 out of 214 cases for 2019; maternal race information was not available for 38 members who could not be matched to the infant and 8 mothers who declined to provide race. The percent of infant mortality cases in 2019 from African American/Black mothers was 27.84%, for Hispanic/Latinx mothers 5.11% and for white mothers 60.80%.

TABLE 21: Prenatal Visits by Maternal Race in Infant Mortality Cases, 2018			
Number of Prenatal Visits	All *(n=176)*	White *(n=107)*	African American/Black *(n=49)*
0 Visits	5.68%	4.67%	4.08%
1-5 Visits	26.14%	26.17%	28.57%
6-10 Visits	20.45%	20.56%	22.45%
11-15 Visits	19.32%	18.69%	20.41%
16-20	16.48%	14.02%	20.41%
21 or More	11.93%	15.89%	4.08%

The average number of prenatal visits for African American/Black members was 10.02, 6.56 for Hispanic/Latinx members and 11.90 for white members. The overall average number of prenatal visits with maternal race included was 11.25.

TABLE 22: Percent of Infant Mortality Cases by Maternal Race			
Maternal Race	Average Prenatal Visits 2019	Range Prenatal Visits 2019	Average Prenatal Visits 2018
All	11.25	0-44	11.78
White	11.90	0-44	12.31
African American/Black	10.02	0-30	11.11
Hispanic/Latinx	6.56	0-20	10.41

Maternal diagnoses by race were also examined. Of the members studied, African American/Black members had a higher-than-average rate of diagnoses of anemia, diabetes, hypertension and pre-eclampsia, current preterm complications, and high-risk pregnancy. White members had higher rates of tobacco and substance use. The average rate of diabetes for all Medicaid members in infant mortality cases in 2019 was 8.52%, however the average rate for white members was 7.48%, compared to higher-than-average rates of 10.20% for African American/Black members. On average the rate of diagnosis for hypertension or pre-eclampsia in 2019 was 17.05% but higher-than-average for African American/Black members at 22.45%.

TABLE 23: Maternal Diagnosis by Race in Infant Mortality Cases, 2019				
Maternal Diagnosis	All Races *(n=176)*	White *(n=107)*	African American/Black *(n=49)*	Hispanic/Latinx *(n=9)*
Tobacco	47.73%	53.27%	42.86%	11.11%
Smoking > 10/day	32.95%	35.51%	30.61%	11.11%
Substance Use Disorder	22.16%	27.10%	14.29%	0.00%
Anemia	25.00%	20.56%	28.57%	22.22%
Preeclampsia	17.05%	17.76%	22.45%	0.00%
Diabetes	8.52%	7.48%	10.20%	0.00%
Obesity	24.43%	24.30%	30.61%	11.11%
Respiratory Disease	9.66%	8.41%	8.16%	0.00%
Multipara	22.16%	22.43%	22.45%	11.11%
Excessive Vomiting	36.36%	31.78%	46.94%	11.11%
Current Preterm Complications	34.66%	34.58%	38.78%	22.22%
Current Preterm Labor	40.34%	39.25%	44.90%	22.22%
Potential Structural Complications of Pregnancy or Delivery	24.43%	20.56%	30.61%	33.33%

The results of this study were shared and discussed with each MCE. Further work will be conducted to collaborate with the MCEs and the Indiana Department of Health in lowering the rates of infant mortality with specific attention to lowering the rates of underserved populations. In October 2021, OMPP conducted on onsite review that included a quality review of infant mortality cases. OMPP will continue to monitor services to pregnant HIP members and the subsequent birth outcomes using the same metrics as previously used in HHW. Additionally, OMPP will measure the number of pregnant members in both HHW and HIP who receive prenatal depression screenings. OMPP will continue to use this data to not only identify HIP quality initiatives in 2021 but also to deepen partnerships with other state agencies such

as the Indiana Department of Health's Maternal and Child Division to decrease infant mortality in the state of Indiana.

In 2019, OMPP began work with the Indiana Department of Health, the Indiana FSSA and the Indiana Department of Child Services on the My Healthy Baby Program. This initiative built a network of services and supports for moms and babies with a goal of creating healthier outcomes for both. The goal of this program is to identify Medicaid members early in their pregnancies and connect them with a home visitor who provides personalized guidance and support to the woman during her pregnancy continuing through at least the first six to 12 months after her baby's birth. OMPP collaboration efforts have included making changes to the presumptive eligibility application to inform members about the program and establishing a data feed between IDOH and FSSA containing the demographic information on pregnant members identified through presumptive eligibility. In 2020, My Healthy Baby services were expanded into 22 targeted Indiana counties identified as having the highest rates and risk for infant mortality. OMPP will continue collaboration efforts specific to this initiative in 2021.

In December of 2019, CMS selected Indiana's Family and Social Services Agency as one of ten states to be awarded a five-year $50,000,000 Maternal Opioid Misuse Model grant. For this cooperative grant OMPP will serve as a liaison between FSSA and the MCEs and will provide quality expertise. The MOM model was developed to improve the quality of care and reduce expenditures for pregnant and postpartum Medicaid beneficiaries with Opioid Use Disorder as well as their infants. The MOM grant aims to increase access to evidence-based treatments, provide continuous screening and referrals for health-related social needs and create sustainable coverage and payment strategies that support ongoing coordination and integration of care. The MOM model, named the Pregnancy Promise Program, provides the opportunity for healthcare providers to improve care for mothers and infants affected by the opioid crisis by engaging providers in specialized training initiatives. The model is aimed at enhancing MCE care coordination and integration of care. By supporting the coordination of clinical care and integration of other services critical for health, wellbeing, and recovery, the Pregnancy Promise Program has the potential to improve quality of care and reduce the cost of providing medical care to mothers and infants. The Pregnancy Promise Program is one of several statewide initiatives to reduce maternal and infant mortality rates. Indiana will use these grant funds over the next five years to transition into the new model of care, and then full implementation of the plan will be realized in years three through five.

Smoking cessation

The Indiana Health Coverage Programs has enhanced its coverage of tobacco cessation drug treatment through the pharmacy benefit. Effective Feb. 1, 2020, IHCP no longer requires copayments for tobacco cessation drugs. These drugs include but are not limited to, varenicline, bupropion for tobacco cessation, and nicotine replacement therapies. In 2019, IHCP also removed the requirement for prior authorizations for exceeding 180 days of tobacco cessation therapy. Other enhancements to the program include allowance of preferred agents, including Chantix, to be used as first-line therapy and the ability to use Chantix concurrently with other nicotine replacement therapy. The goal of the program is to significantly improve the health of Medicaid members and to reduce the disease and economic burden that tobacco use places on them.

The MCEs provided detailed information on their smoking cessation initiatives and incentive programs during the April 2020 Quality Onsite meeting. In turn, IDOH has implemented their new vaping initiative that began statewide in 2020.

OMPP works closely with the IDOH Indiana Tobacco Quitline. The Indiana Tobacco Quitline is a free phone-based counseling service that helps Indiana smokers quit. OMPP in collaboration with IDOH, has facilitated increased quality of the monthly Quitline reports provided to the MCEs. OMPP and IDOH meet monthly to discuss any issues and trends with the reporting data. This partnership has resulted in a greatly increased accuracy of the reports being submitted to the MCEs, allowing for enhancement of their smoking cessation programs. This collaboration has strengthened the relationship between the MCEs and

IDOH. In July 2021, IDOH began to have regular quarterly meetings with the MCEs to discuss their smoking cessation outreach practices and programs. OMPP and IDOH will continue this close and beneficial collaboration through 2022 with the continuation of monthly meetings between representatives from the two agencies.

MCE alignment

A core of OMPP's updated mission is to increase efficiency and reduce the administrative burden for both members and providers participating in Indiana Medicaid. In 2022, OMPP will continue to work on our strategic initiative of aligning MCE activities so provider and member experiences among the four MCEs are more uniform.

In late 2019, OMPP kicked off the work on this strategic initiative by aligning managed care practices around emergency department payment and MCE substance use disorder authorization letters.

In response to the COVID-19 pandemic, OMPP revised the prior authorization requirements for many services to eliminate the burden on hospitals, long-term care, and mental health facilities and hasten the transition of members between levels of care. OMPP required alignment between Fee for Service and all MCEs in adherence to all COVID-19 related policies.

The OMPP Pharmacy team is currently collaborating with Indiana's MCEs to align their pharmacy medical necessity criteria with the Medicaid fee for service program. This project will establish uniform prior authorization criteria and processes among the MCEs.

Substance use disorder

Effective February 2018, the Indiana Family and Social Services Administration received federal approval from the Centers of Medicare and Medicaid Services to implement a Section 1115 Substance Use Disorder demonstration waiver. IHCP utilized this waiver to expand coverage for inpatient stays for opioid use disorder and other substance use disorder treatment to members 21 through 64 years of age in facilities that qualify as Institutions for Mental Disease, providing a compendium of services for members dealing with substance use addiction. Similarly in December 2019, the Indiana Family and Social Services Administration received federal approval from CMS for a Section 1115 Serious Mental Illness demonstration waiver that gives Indiana Medicaid the authority to pay for acute inpatient stays in institutions for mental disease for individuals diagnosed with a serious mental illness. Both the SUD and SMI waivers were extended on Oct. 26, 2020, and remain in effect through Dec. 31, 2025. Prior to these waivers, Medicaid law prevented or restricted funding from being used for inpatient and residential SMI/SUD treatment at hospitals, nursing facilities, or other institutions with more than 16 beds. Under these waivers patients receive longer, more appropriate inpatient stays aiding in achieving stabilization and more successful transitions back into their homes and communities. The change is expected to ultimately drive down the costs associated with overuse emergency departments for mental health and substance use disorder crises as well as other costs caused by lack of access to appropriate care settings.

To oversee implementation of these waivers, OMPP hosts a monthly combined SUD/SMI waiver workgroup in partnership with the Division of Mental Health and Addiction. Priorities of the workgroup highlighted for 2021 included improving continuity of care between providers/SUD levels and post IMD discharge, exploring partnerships and initiatives to enhance access to SUD/SMI treatment, supporting telehealth initiatives, and restructuring opioid treatment program reimbursement rates/codes. Additionally, OMPP and the Division of Mental Health and Addiction virtually hosted a SUD/SMI/MCE and Provider conference in August 2021 to provide education on practice standards and new policy initiatives, as well as serve as a forum for providers to ask questions to OMPP and DMHA.

Adult quality measures

Work on this project will continue with the goal of enhancing the quality of the data and number of measures being reported as part of the 2022 Adult Quality Measures submission to CMS.

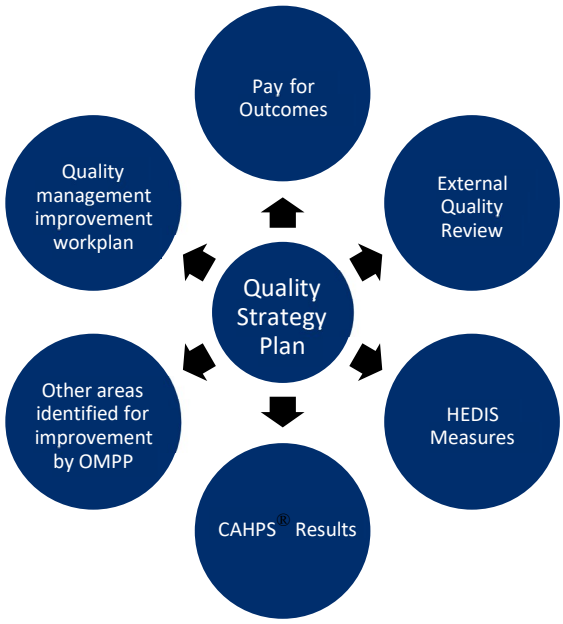
Section IX. Conclusion

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

Indiana continues to utilize data from seven primary sources in developing the Quality Strategy Plan. These seven sources include Indiana's annual External Quality Review, the MCEs' HEDIS measures, the MCEs' CAHPS® survey results, the Quality Management Improvement Work Plans, OMPP contractual pay-for-outcomes results, the CMS Core Set Adult and Child Health Care Quality Measures for Medicaid and any other areas identified for improvement via MCE reporting, onsite meetings or other data and analytics provided to OMPP.

Collaboration among the MCEs, state agencies, providers, advocacy groups and OMPP is representative of the state's dedication to performance and quality. Throughout the process of developing and narrowing the focus for improvements in 2022, OMPP gathered input for this Quality Strategy from a variety of staff and stakeholders. Additionally, the Quality Strategy Committee will drill down further to sculpt the focus of the strategic objectives described in this Quality Strategy Plan to monitor outcomes and plan for future endeavors.

The IHCP 2022 Quality Strategy Plan will be presented to the Quality Strategy Committee, released for public comment, and will be made available through a public posting on the state website at https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/.



Appendix I: Risk-based managed care historical timeline

1994 Began with PCCM delivery system

1996 Enrollment into MCE contracted health plans was optional

1998 Expanded to include CHIP Package A (Medicaid Expansion up to 150% FPL)

2000 Expanded to include CHIP Package C (Separate state-designed benefit package; to 200% FPL)

2005 Enrollment into MCE contracted health plans became mandatory statewide, PCCM discontinued

2007 New MCE contracted health plans contract cycle; Behavioral health "carved-into" MCE capitation rates

2007 Expansion of pregnancy-related coverage (Package B) from 150 to 200 % FPL

2007 Indiana Check-up Plan legislation signed into law authorizing the Healthy Indiana Plan and a Request for Services is released to procure MCEs; Initial 1115 Demonstration Waiver Application submitted to CMS and is approved in December; DFR began processing applications

2008 Expansion of CHIP Package C from 200 to 250 % FPL

2008 Implementation of HIP

2008 Enrollment into HIP began

2009 HIP waitlist began. Waitlist opened in November of 2009 and 5,000 individuals on the waitlist were invited to apply for HIP

2009 Implementation of Open Enrollment (Plan Lock-in); Notification of Pregnancy; Pharmacy carve-out implemented.

2011 Implementation of the POWER account debit card; HIP opens 8,000 slots and waitlist members are invited to apply

2011 HIP and Hoosier Healthwise aligned under a family-focused approach.

2013 House Enrolled Act 1328 (HEA 1328) was passed by the Indiana General Assembly. This act tasked FSSA with managing care of the aged, blind, and disabled Medicaid enrollees. In response, FSSA convened the ABD Taskforce comprised of staff from across key FSSA divisions.

2014 HIP-ESP is folded into the HIP program

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

2015 Hoosier Care Connect was implemented on April 1. Pharmacy, Dental, and Vision services are carved-in

2015 Care Select program expired in August after complete integration of the HCC program

2016 RFP completed for the HHW and HIP programs with contracts awarded to Anthem, MDwise, MHS, and CareSource, effective Jan. 1, 2017

2017 Pharmacy and Dental services carved in for HHW

2021 RFP completed for the HCC program with contracts awarded to Anthem, MHS and UnitedHealthcare, effective April 1, 2021

Appendix II: Hoosier Healthwise historical timeline

1994 Began with PCCM delivery system

1996 Enrollment into MCE contracted health plans was optional

1998 Expanded to include CHIP Package A (Medicaid Expansion up to 150% FPL)

2000 Expanded to include CHIP Package C (Separate state-designed benefit package; to 200% FPL)

2005 Enrollment into MCE contracted health plans became mandatory statewide, PCCM discontinued

2007 New MCE contracted health plans contract cycle; Behavioral health "carved-into" MCE plans' capitation

2007 Expansion of pregnancy-related coverage (Package B) from 150 to 200 %FPL

2008 Expansion of CHIP Package C from 200 to 250 %FPL

2009 Implementation of Open Enrollment (Plan Lock-in); Notification of Pregnancy; Pharmacy carve-out implemented.

2011 HIP and Hoosier Healthwise aligned under a family-focused approach.

2016 RFP completed for the HHW and HIP programs with contracts awarded to Anthem, MDwise, MHS and CareSource effective Jan. 1, 2017

2017 Pharmacy and Dental services carved in for HHW

Appendix III: Healthy Indiana Plan & enhanced services plan historical timeline

2007 Indiana Check-up Plan legislation signed into law authorizing the Healthy Indiana Plan and a Request for Services is released to procure MCEs; Initial 1115 Demonstration Waiver Application submitted to CMS and is approved in December; DFR began processing applications

2008 Enrollment into HIP began

2009 HIP waitlist began. Waitlist opened in November of 2009 and 5,000 individuals on the waitlist were invited to apply for HIP

2011 Implementation of the POWER account debit card; HIP and HHW aligned under a family-focused approach; HIP opens 8,000 slots and waitlist members are invited to apply

2014 HIP-ESP is folded into the HIP program

2015 HIP 2.0 takes on a new focus for individuals to be more accountable with their health care choices

2016 RFP completed for the HHW and HIP programs with contracts awarded to Anthem, MDwise, MHS and CareSource, effective Jan. 1, 2017

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

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

2020 Gateway to Work is suspended

2021 CMS approves HIP waiver for 10 years

Appendix IV: Care Select historical timeline

2007 Start of Care Select program in the Central Region

2008 Auto-assignment began in the Central Region

2008 Rollout of Care Select program in other regions

2008 Auto-assignment of remaining members

2008 Inclusion of wards and fosters in Care Select

2009 Auto-assignment of wards and fosters in Care Select

2010 Auto-assignment of remaining HCBS waiver members into Care Select

2010 Redesign of Care Select

2014 Redesign of Care Select, adding COPD as a disease state

2015 Care Select Program expires after implementation of Hoosier Care Connect

Appendix V: Hoosier Care Connect historical timeline

2013 House Enrolled Act 1328 (HEA 1328) was passed by the Indiana General Assembly. This act tasked FSSA with managing care of the aged, blind and disabled Medicaid enrollees. In response, FSSA convened the ABD Task Force (Task Force) which was comprised of staff from across key FSSA divisions.

2015 HCC was implemented on April 1. Pharmacy, Dental and Vision services were carved into managed care.

2015 Complete integration of Hoosier Care Connect occurs August 1.

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

2021 RFP completed for the Hoosier Care Connect programs with contracts awarded to Anthem, MHS and UnitedHealthcare, effective April 1, 2021.