Agenda

- MDwise history
- IHCP Overview
- MDwise Delivery System Model
- IHCP Program Overview
  - Hoosier Healthwise
  - Healthy Indiana Plan
  - Hoosier Care Connect
- Eligibility
- Prior Authorization
- Claims
- Member Management Programs
  - Care Management/Disease Management
  - Right Choices Program
- Behavioral Health
- Questions and Answers
MDwise is:

- A local, not-for-profit company serving Hoosier Healthwise, Hoosier Care Connect, and Healthy Indiana Plan members

- Exclusively serving Indiana families since 1994
  - Over 400,000 members
  - 2,000 primary medical providers
INDIANA HEALTH COVERAGE PROGRAMS

**Hoosier Healthwise**
Managed Care Initiative
Children under the age of 19 living in low-income households

**Hoosier Healthwise**
- MDwise Select Health Network (SHN)
- MDwise Excel Network
- MDwise Franciscan St. Margaret’s & St. Anthony
- MDwise Indiana University Health
- MDwise St. Vincent
- MDwise Community Health Network (CHN)
- MDwise Total Health

**MDwise**
Managed Health Services (MHS)

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**Traditional Medicaid**
Medicaid eligible members are placed in Fee for Service Medicaid pending their selection of a managed care plan and primary care providers for the Hoosier Healthwise program or their selection of a care management organization and primary care provider for the Hoosier Care Connect program.

**Healthy Indiana Plan (HIP)**
Coverage for qualified low-income Hoosiers ages 9 to 19

**Hoosier Care Connect**
(Managed Care Initiative)
Wards, foster children, aged, blind, and disabled

*What is a Delivery System Model?*
MDwise serves its Hoosier Healthwise and HIP members under a "delivery system model." The basis of this model is the localization of health care around a group of providers. These organizations, called "delivery systems," are comprised of hospital, primary care, specialty care, and ancillary providers. To serve Medicaid clients in the Hoosier Healthwise and HIP programs, behavioral health providers must be contracted as MDwise delivery system providers.
What is a delivery system model?

• MDwise serves its Hoosier Healthwise and Healthy Indiana Plan members under a “delivery system model”

• The basis of this model is the localization of health care around a group of providers
  • These organizations, called “delivery systems” are comprised of hospital, primary care, specialty care, and ancillary providers
MDwise Delivery System Model

- MDwise Select Health Network (SHN)
  - MDwise Franciscan St. Margaret & St. Anthony
  - MDwise Eskenazi Health
  - MDwise Indiana University Health
  - MDwise St. Vincent
  - MDwise Community Health Network CHN
  - MDwise Total Health
  - MDwise Excel Network
  - MDwise St. Catherine

MDwise Delivery Systems*

* MDwise Delivery Systems include MDwise Select Health Network (SHN) and its member networks.
MDwise participates in Hoosier Healthwise, which is Risk-Based Managed Care (RBMC)

• MDwise receives a capitated rate for members to manage their care

• Under Hoosier Healthwise, primary medical providers (PMPs) are responsible for coordinating all medical care for the members who are assigned to them
• Members select a PMP and are then enrolled in the network or managed care plan chosen by their PMP

• Primary Members
  • Children

• The member’s specific eligibility aid category establishes their benefit package
  • Determined by the Division of Family Resources (DFR)
Hoosier Healthwise is designed to meet the following goals:

- Ensure access to primary and preventative care
- Improve access to all necessary health care services
- Encourage quality, continuity and appropriateness of medical care
- Provide medical coverage in a cost-effective manner
Healthy Indiana Plan

• Extends health care coverage to certain low-income, uninsured Hoosiers without access to employer sponsored health insurance

• The Program represents a groundbreaking attempt to expand coverage while encouraging individuals to take a more proactive role in managing their health and the cost of their healthcare
The Program provides:

- A POWER Account valued at $2,500 per adult to pay for medical costs
  - Contributions to the account are made by the State and each participant (based on ability to pay)
  - No participant will pay more than 5% of his/her gross family income on the plan
- Coverage for non-Affordable Care Act preventative services are covered up to $500 per year
  - Coverage for Affordable Care Act preventative services do not have a cap
HIP Plus

- Members pay a monthly POWER Account Contribution (PAC) of up to 2% of their income
- No co-pays (except non-emergency use of the ER co-pay)
- Includes enhanced benefits such as vision and dental
- More extensive pharmacy options

HIP Basic

- Members do NOT make a PAC, but have co-payments for most services
- Plan maintains essential health benefits, but incorporates reduced benefit coverage (for example, fewer therapy visits)
- Does not include vision or dental coverage
- More limited pharmacy options
HIP State Plan—Plus

- Dental and pharmacy are carved in
- Transportation services are covered
- Members pay a monthly POWER Account Contribution (PAC) of up to 2% of their income
- No co-pays (except non-emergency use of the ER co-pay)

HIP State Plan—Basic

- Dental and pharmacy are carved in
- Transportation services are covered
- Members do NOT make a PAC, but have co-payments for services
Primary Members:

- Adults 19-64
- No access to employer sponsored health insurance
- Up to 138% Federal Poverty Level

The program is designed to:

- Foster personal responsibility
- Promote preventive care and healthy lifestyles
- Encourage participants to be value conscious consumers of health care
- Promote price and quality transparency
Hoosier Care Connect

- Coordinated care program for the following Indiana Health Coverage Programs (IHCP) members
  - Aged (ages 65 and over)
  - Blind
  - Physically and mentally disabled
- Hoosier Care Connect members will receive all Medicaid-covered benefits in addition to care coordination services
- Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s)
  - Hoosier Care Connect does **not** operate on a delivery system model
• Designed by the State to personalize and enhance care by:
  • Addressing the member’s medical and behavioral health needs holistically
  • Seeking input from the medical providers, behavioral health experts, family members and other care givers
  • Offering comprehensive care management for members
    • Members are identified for inclusion by the care management staff of each MCE
    • Care coordination services will be individualized based on a member’s assessed level of need determined through a health screening
  • This will result in the improvement of the quality of care and health outcomes for this population
When determining eligibility, verify:

- Is the member eligible for services today?
- Which Indiana Health Coverage Program plan are they enrolled (Hoosier Healthwise, Hoosier Care Connect, Healthy Indiana Plan)?
- If the member is in Hoosier Healthwise, Hoosier Care Connect, or Healthy Indiana Plan, which MCE are they assigned (MDwise, Anthem, MHS)?
- Who is the member’s Primary Medical Provider (PMP)?
- Where should prior authorization requests be submitted?
Verifying Eligibility

- Web InterChange verifies:
  - IHCP Program
  - MCE

- MDwise Provider Portal verifies:
  - Delivery System (Hoosier Healthwise/Healthy Indiana Plan)
  - Primary Medical Provider (PMP)
A searchable list of what requires a PA can be found on our website MDwise.org For Providers Forms PA

- The list is displayed by program and delivery system
- All services provided by a non-contracted provider requires prior authorization
- Otherwise if the CPT code is not found on our PA list(s) then a PA is not required
You will need two key items when filing a request for Medical Prior Authorization (PA):

1. Universal Prior Authorization Form
   • Located on our website

   It is very important that you completely fill out the universal PA form including the rendering provider’s NPI and TIN, the requestor’s name along with phone and fax number. Not completely filling out the universal PA form may delay the prior authorization timeframe.

2. Documentation to support the medical necessity for the service you are requesting to prior authorize:
   • Lab work
   • Medical records/physician notes
   • Test results
   • Therapy notes
Prior Authorization Submission

- We do not have an online method of filing a PA request
- The only way to submit requests is through faxing them to the proper PA fax number listed on our MDwise Delivery System Prior Authorization Contact Guide
  - This information is also located in our Quick Contact Guide
Prior Authorizations

MDwise Delivery System Prior Authorization Contact Guide

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<tr>
<th>Delivery System</th>
<th>PA Phone Number</th>
<th>PA Fax Number</th>
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<tr>
<td>MDwise Hoosier Care Connect</td>
<td>844-293-6309</td>
<td>844-407-4454</td>
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<td>317-822-7576</td>
<td>317-715-4214</td>
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<td>MDwise Excel Hoosier Healthwise</td>
<td>888-961-3100</td>
<td>888-463-5581</td>
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<td>MDwise Excel Healthy Indiana Plan (HIP)</td>
<td>888-961-3100</td>
<td>Inpatient: 866-613-1631</td>
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<td>Outpatient: 866-613-1642</td>
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<td>MDwise Select Health Hoosier Healthwise/Healthy Indiana Plan</td>
<td>855-325-8081</td>
<td>855-325-9093</td>
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<td>MDwise Total Health Hoosier Healthwise/Healthy Indiana Plan</td>
<td>877-822-7191</td>
<td>855-269-1842</td>
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<td>MDwise St. Catherine Hoosier Healthwise/Healthy Indiana Plan</td>
<td>Hospital notifications only: 219-392-7066</td>
<td>Hospital/Admissions/Surgery: 219-392-7356</td>
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<td>All Other authorizations: 219-392-7090</td>
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<td>Behavioral Health: 800-747-3893</td>
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<td>MDwise Indiana University Health Hoosier Healthwise/Healthy Indiana Plan</td>
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<td>888-309-8751</td>
<td>888-309-8741</td>
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<td>317-621-7575</td>
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<td>800-344-8672</td>
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<td>MDwise Select Health Marketplace</td>
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Prior Authorization

Prior Authorization Turn-Around Time

• Emergent requests - authorization is not required
  • Notification to MCE must occur within two (2) business days
• Urgent prior authorizations can take up to 3 business days
• Requests for non-urgent prior authorization will be resolved within 7 calendar days
  • It is important to note that resolved could mean a decision to pend for additional information
• If you have not heard response within the time frames above, contact the Prior Authorization Inquiry Team and they will investigate the issue
Appeals

- Providers can request an appeal on behalf of a member within 33 calendar days of receiving denial.
- Providers must request an appeal in writing to MDwise:
  Attention: MDwise Customer Service Department
  PO Box 441423
  Indianapolis, IN 46244-1426
- MDwise will resolve an appeal within 20 business days and notify the provider and member in writing of the appeal decision including the next steps.
- If you do not agree with the appeal decision, additional appeal procedure options are available.
Appeals

- The provider may request on behalf of the member an external review by an Independent Review Organization (IRO)
  - Request must be filed within 45 calendar days of receiving appeal determination

- MDwise responds to requests for external review, within 3 business days of receiving the request for an IRO review
  - A standard external review must be resolved within 15 business days after review is requested
  - Member will be notified within 72 hours of the IRO panel’s decision
Pharmacy Prior Authorizations

• For Pharmacy PA’s, you would need to contact the member’s Pharmacy Benefit Manager
  • Hoosier Healthwise
    • OptumRx: 855-577-6317
    • HIP/ Hoosier Care Connect
      • MedImpact: 844-336-2677
• For all questions regarding Pharmacy PA please contact the Pharmacy Benefit Managers
Claim Submission

Claims

• Claim Submission
  • Contracted providers must submit claims to MDwise within 90 days of the date of rendering the service

• Claim Inquiry
  • One Form for each MDwise Program
  • Claims Inquiry Form is located on our website
    • [http://www.mdwise.org/for-providers/forms/claims/](http://www.mdwise.org/for-providers/forms/claims/)

• Claim Disputes
  • Must be submitted within 60 days of the date on EOB
MDwise identifies case/care management as an integral part of medical management.

- Care management involves the development and implementation of a coordinated, member-focused plan of care that meets the member’s needs and promotes optimal outcomes

- Care management objectives include:
  - Developing and facilitating interventions that coordinate care across the continuum of health care services
  - Decreasing fragmentation or duplication of services
  - Promoting access or utilization of appropriate resources
The care management process includes:

- Identification and evaluation of member’s needs
- Review of clinical information
- Development of goals and treatment plan including behavioral and physical health
- On-going communication with the member or member’s family/caregivers
- Monitoring progress and adjusting care plan accordingly
- Transitioning member through levels of case management when appropriate (i.e. goals and needs met, member coverage terminated)
MDwise members are offered disease management programs that address the following conditions in which patient self-care efforts and empowerment are significant:

- Diabetes
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Congestive heart failure (CHF)
- Chronic kidney disease (CKD)
- Depression
- Attention-Deficit Hyperactivity Disorder (ADHD)
- Pervasive developmental disorder (PDD)
- Pregnancy
- Post Traumatic Stress Disorder (PTSD)
- Hypertension
Members are encouraged to actively participate in the management of their condition through disease education, self-management tools, and access to healthcare professionals.

There are several avenues by which members may be identified and referred to care managers to be evaluated for implementation of case management:

- Contacting the Care Management department
- Completing the electronic CM/DM Referral Form located on the MDwise Portal
The Right Choices (RCP) program was created to safeguard against unnecessary or inappropriate use of Medicaid services by identifying members who use Indiana Health Coverage Programs (IHCP) services more extensively than their peers.

MDwise considers multiple factors in enrolling a member into this program. They include, but are not limited to:

- ER utilization
- Pharmacy utilization
- Member compliance
- Outcomes of member interventions
- Referrals from providers
In the Right Choices program, members are assigned or “locked-in” to one primary medical provider (PMP), one pharmacy and one hospital.

- The goal of “lock-in” is to ensure members receive appropriate care and to prevent members from incorrect utilization of services.

The Right Choices program is available for Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect members.

- MDwise members are considered candidates for restriction if they continue to misuse benefits despite efforts on the part of MDwise and its provider(s) to educate and assist the member in modifying misuse patterns.

- Members that qualify are eligible for a two to five year lock-in.
The PMP manages the member’s care and determines whether a member requires evaluation or treatment by a specialty provider.

- Referrals are required by the PMP for most specialty medical providers (except self-referral services)
  - If a member goes outside of their assigned providers for care they will be liable for charges
- Specific physicians, not groups must be added to the lock in list and only those providers are eligible for reimbursement
- Referrals should be based on medical necessity and not solely on the desire of the member to see a specialist
- Emergency services for life-threatening or life-altering conditions are available at any hospital, but non-emergency services require a referral from the PMP
Member Management Programs

Right Choices Program

Without a written referral, services rendered by providers other than the member’s PMP will not be reimbursed.

Referral Requirements for the PMP

- PMP will need to complete a Right Choices Program Panel Add Form and fax to the number listed on the form
  - Right Choices Program Panel Add Form for MDwise Excel Network
    - Form required for Hoosier Healthwise and Healthy Indiana Plan RCP members
  - Right Choices Program Panel Add Form for Hoosier Care Connect
    - Form required for Hoosier Care Connect RCP members
Right Choices Program

Some of your MDwise patients may need extra guidance for making appropriate health care decisions. For those patients, MDwise offers the Right Choices Program.

The Right Choices program is available for Hoosier Healthwise, HIP, Care Select and Hoosier Care Connect members. Members are enrolled in the Right Choices program for two years. After two years, the member undergoes a review to determine whether the member would benefit from continuing in the program.

In the Right Choices program, members are assigned or "locked-in" to one primary medical provider (PMP), one pharmacy and one hospital. To receive health care outside of the assigned providers, the PMP is required to submit a referral. If a member goes outside of their assigned providers for care they will be liable for charges, except for self-referral services such as behavioral health or for true emergencies.

Members in the Right Choices program will be assigned a care manager to provide additional education.

If you believe one of your patients would benefit from participating in the Right Choices Program, you can make a referral by contacting MDwise customer service. The member’s case will be researched prior to being assigned to the Right Choices Program. If one of your patients is assigned to the Right Choices Program, you will be alerted in a letter from FSSA.

For more information see the Right Choices Program manual at IndianaMedicaid.com and MDwise Right Choices Program information for members.

Forms
Right Choices Program Panel Add Form for MDwise Excel Network
Right Choices Program Panel Add Form for Hoosier Care Connect
Inpatient Psychiatric Care

• All non-emergent inpatient admissions require authorization
  • Call for PA within 48 hours of admission
  • Complete 1261A Form within 14 days of phone authorization
  • Providers are still asked to submit this form until further notice

• Report emergency services to the member’s PMP within 48 hours

• Behavioral Health Prior Authorization poster is available from your Behavioral Health Provider Relations Representative
ABA Therapy is for the treatment of Autism Spectrum Disorder (ASD) for members ages 20 and under

- Initial diagnosis and comprehensive diagnostic evaluation done by a qualified individual and requires prior authorization (PA)
- Ongoing therapy required by qualified individual and requires PA
- Effective 2.6.16, per Bulletin BT201606, ABA therapy providers must use the U1-U3 modifiers along with the appropriate mid-level modifier