2013 IHCP 2nd Quarter Provider Workshop
Indiana Care Select Program

This presentation can be downloaded at:
www.advantageplan.com/advcaresselect
http://www.mdwise.org/providers-workshops.html
Agenda

• Care Select Overview
  – Member Eligibility
  – Member Program Referrals
  – Provider Enrollment
  – Disease/Care Management Case Studies

• Prior Authorization
  – General Overview
  – Recent updates

• Right Choices Program Overview

• Questions
Member Eligibility

Care Select Care Management Organizations (CMOs)

• ADVANTAGE Health Solutions, Inc. sm
• MDwise, Inc.

Statewide Populations Served

• The aged, blind, and physically and/or mentally disabled members (collectively known as the ABD population), if not eligible for Medicare
• Wards of the court and foster children
• Children on adoption assistance
Member Eligibility

Eligible Care Select Member conditions

- Asthma
- Diabetes
- Congestive Heart Failure
- Coronary Heart Disease
- Hypertension
- Chronic Kidney Disease
- Severe Mental Illness (SMI) and Depression
- Serious Emotional Disturbance (SED)
Program Goals

A disease management program focusing on members with chronic conditions to help them achieve:

- Improved health status
- Enhanced quality of life and autonomy
- Improved member safety
- Adherence to treatment plans

About 31,820 Medicaid members are currently enrolled in the Care Select program.
Member Eligibility

Member Opt-out Process

- Members can opt-out if they are eligible to participate in the Care Select program

- Members who opt-out will be enrolled in Traditional Medicaid

- Members with a chronic disease who opt-out can opt back in by contacting Maximus (State’s enrollment broker)
Member Eligibility

PMP Selection

– New members who don’t opt-out will have 60 days to choose a PMP

– If no selection made, member will be auto-assigned to a PMP
  • Member’s previous PMP in same CMO
  • Member’s previous PMP/group in another CMO
  • Member’s previous CMO
  • Family member’s previous PMP
  • Default

– Member can change PMP assignment by contacting their CMO or Maximus
**Member Eligibility**

**Nominating members for Care Select Participation**

– PMPs can contact Maximus to refer a Traditional Medicaid member for inclusion in the *Care Select* program
  
  • Use the Provider Referral Form located on the “Forms” page at [www.indianamedicaid.com](http://www.indianamedicaid.com) (fax number is listed on the form)

– Member must meet *Care Select* program eligibility requirements

– Maximus will outreach to the member to opt-in or opt-out

  • *IHCP Bulletin BT201130 (June 30, 2011)*
PMP Enrollment

What is a PMP and why is having one so important?

- Linked to each *Care Select* member as the member’s medical home
- Connects primary and specialty health care
  - Provides referrals to specialists via telephone or in writing
- Works with member and disease manager to improve the health of the member

Who can be a PMP?

- Primary care physicians
  - i.e. family practice, general practice, general internist, pediatrician, and OB/GYN
- Specialists
How does a PMP enroll?
- PMPs in Care Select may contract with one or both CMOs.

Why are there two CMOs?
- IHCP wants to give both members and providers a choice

How does this affect a member’s choice between CMOs?
- The member is enrolled in the CMO with which his or her PMP is contracted
- Members with no prior PMP linkage will receive a letter and call from the enrollment broker to assist in choosing a PMP
- Members can change PMPs by contacting their CMO or Maximus
- Those who do not choose a PMP get auto-assigned to one
What are the PMP incentives?
- All claims are submitted to HP and paid per the current IHCP Provider Fee Schedule
- Quick claim adjudication
- $6 PMPM Administrative fee paid by the State
- Care Coordination Conferences reimbursed at $20.00 per member (one in a 12 month rolling period, upon PMP request)
Disease/Care Management Case Studies

• Members with a chronic condition will have access to additional education resources within the CMO

• Increased compliance with disease management treatment plans including medication compliance and appropriate preventative care visits

• Disease specific assessments and care plans

• Goals: individualized and preventive care
Types of Interventions:

• Population-based Interventions
• Member Specific – Disease Management Interventions
• Member Specific – Care Management Interventions

Note: These interventions are based on the member’s established level of care at the time of the intervention.
<table>
<thead>
<tr>
<th>Interventions</th>
<th>LEVEL 1 (New Members)</th>
<th>LEVEL 2 (Active Members)</th>
<th>LEVEL 3 (Active Members)</th>
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<tr>
<td>Welcome Letter Mailings</td>
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<td>Unable to Reach Letter Mailings</td>
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<td>Disease Management Plan</td>
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<tr>
<td>Care Plan</td>
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<tr>
<td>Provide Community Resources</td>
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<td>24 Hour Nurse Line</td>
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<td>Monitor Claims for ER, Inpatient Utilization, and Medication.</td>
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<tr>
<td>At a minimum, Yearly Live Call and update the Disease Management Plan</td>
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<tr>
<td>At a minimum, Every 6-8 Weeks a Live Call and update the Care Plan as needed</td>
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<td>Provider can request Conference Call or Face to Face Meeting to discuss the Member and Treatment Plan</td>
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<td>Behavioral Health Assessment</td>
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</tr>
<tr>
<td>Disease Management Assessment</td>
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<tr>
<td>Assistance with Transportation and Provider Appointment Scheduling</td>
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<tr>
<td>Assistance with Transportation and PMP Scheduling if member is unable to do so on his/her own.</td>
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<tr>
<td>Behavioral Health Admission Follow-Up</td>
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<tr>
<td>Inpatient Elective Admission Follow-Up</td>
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Disease/Care Management Case Studies

**Level 2 Member**

Female member, age 58, the member has the following diagnoses: 
Asthma, CHF, HTN, and Depression

A Health Risk Assessment was completed and Gaps in care were reviewed. The member is reportedly adherent with her medication and treatment plan - verified by claims. The member has not had an ER or an Inpatient stay within the last 6 months. The member is scheduled to see the PMP every two months with the next appointment in three weeks. She lives alone, but has a strong support system from her daughters. CM reviewed Medicaid benefits. Medications reviewed.

CM discussed DM Plan for CHF with the mbr. She continues to monitor her weight daily in the morning and follows her action plan to contact her doctor if she gains more than 3 pounds in a day. The member has a BP cuff at home and monitors her BP daily- her BP is averaging 130/80. No issues with transportation or setting her own appointments. Community Resource Information and contact numbers were provided to the member. Educational Material related to her Congestive Heart Failure was mailed to the member. The member was stratified as a level 2 low risk member. Follow-up with this member will be within 12 months, sooner if deemed clinically necessary, or if the member needs assistance prior to that time.
Disease/Care Management Case Studies

**Level 3 Member**

Female member, age 45, Member has the following diagnoses: SMI and Asthma.

CMA (Care Management Associate) had successful outreach with member; During HRA completion attempt, member began to cry and voiced that she was ill and out of her medications. Member also voiced other barriers preventing her from following ordered treatment plan. With member’s permission, CMA warm transferred member to a CM (Care Manager) for comprehensive care coordination.

CM spoke to member. Member voiced complaints of “flu like symptoms” and chest pain rated 8 on pain scale while continuing to cry. Member also voiced non-adherence with Behavioral Health therapy for the past 2 months along with medication non-adherence due to financial difficulties with co-pays. CM focused on the member’s immediate problem with her physical health. CM encouraged the member to go to the hospital and the member agreed to allow the CM to call 911 for her. Upon EMS arrival, CM spoke with EMS personnel to confirm was being transferred to Hospital for evaluation.
Level 3 Member
Continued

CM contacted the Member, who is an inpatient at Hospital and agreeable to complete a Health Risk Assessment. The Member reports several mental and physical health concerns including Anxiety, Depression, Bipolar, Schizophrenia, substance abuse, Asthma, HTN, Heart Disorder, Osteoarthritis, Anemia, Blurry vision, poor dental health, and tobacco abuse. Member had problems with medication compliance due to financial difficulties.

Member does have some monthly income from SSI/food stamps. Member has little social support. Member also reports limited literacy. Member tells CM that hospital staff including social services, pharmacy, and behavioral health department have been assisting her while in the hospital. CM provided positive reinforcement for member seeking ongoing treatment and support. CM agreeable to outreaching local agency on aging for possible resources for member. CM stratified member as a level 3 due to hospitalization and the member’s barriers to following treatment plan after discharge.
Disease/Care Management Case Studies

Level 3 Member
Continued

Care plan set and discussed with the member for SMI. CICOA (outpatient mental health services) was outreached by CM and an intake appointment was set for the member. CM worked with discharge planner at the hospital to ensure things were set-up prior to the member’s discharge home.

CM mailed letter to member’s PMP for inpatient admission notification.

The member was discharged to home with transportation to her appointments for therapy and her PMP. Daily Med (mail-order) was set-up for her prescriptions, CICOA intake was completed, and the member had received community resources for assistance from a food pantry. The member was educated again on the importance of medication and treatment plan adherence. The member’s Care Plan was reviewed and updated. The member was then scheduled to be outreached again in 3 days.
Prior Authorization

There are two Care Management Organizations (CMOs):

- ADVANTAGE Health Solutions, Inc. sm
- MDwise, Inc.

*Note: ADVANTAGE adjudicates all Traditional Medicaid, Medicaid Rehabilitation Option (MRO), PRTF PA requests, and Traumatic Brain Injury (TBI) Program admissions*

By contract, the CMOs are responsible for:

- Processing PA requests
- Making medical necessity determinations
- PA decisions based on OMPP approved guidelines
- Notifying providers and members of the determination
Helpful Hints to Get Started for all PA Requests

- Always verify eligibility on PA submission date and date of service

- Suspended PA requests must be completed within 30 days by the provider

- PA decisions made within five (5) business days for CS and ten (10) business days for Traditional Medicaid

- Submit PA to the member’s health plan
  - **Fax** the PA form along with supporting documents together
  - **Web interChange** allows providers to submit non-pharmacy PA requests
  - **Mail** – Submit PA request form along with supporting documents
Prior Authorization

Required forms located at www.indianamedicaid.com in "forms"

- Universal PA for medical and behavioral health (Care Select or Traditional Medicaid only)
- Prior Review and Authorization Dental Request form
- System Update Form
- Certificate of medical necessity forms (i.e. oxygen, hearing aids, hospital beds, etc)
Determine if a service or item requires PA in Traditional Medicaid and Care Select (CS):

- Use the IHCP fee schedule: [www.indianamedicaid.com](http://www.indianamedicaid.com).
- More information found in the IHCP Provider Manual Ch. 6, Indiana Administrative Code (IAC), bulletins, banner pages, and newsletters.
- Providers can review billing and coverage information in Ch. 8.
- Check PA status using PA inquiry function in Web interChange PRIOR to contacting the CMO.
- Providers must submit PA supporting documentation via fax or mail.
Prior Authorization

Supporting PA Documentation

• PA must be submitted on the appropriate PA request form and be supported by appropriate medical necessity documentation.

• Examples of Supporting Documentation:
  – certificate of medical necessity form
  – treatment plan/plan of care
  – physician order
  – physician notes
  – other documentation supporting medical necessity

Note: The CMOs retain the right to suspend a PA request to request additional information to make medical necessity determinations.
BANNER BR201313

- IHCP requires PA for mental health services provided in an outpatient or office setting in excess of **20 units** per member, per **rendering** provider, per rolling 12-month period.

  Providers must submit a **current** plan of treatment and progress notes explaining the necessity and effectiveness of therapy with the PA request and make the plan available for audit purposes;

- Outpatient mental health services rendered in combination with E&M services; PA requirements for **both** must be met.

  PA is required for E&M services in excess of **30 visits** per member, per **rendering** provider, per rolling 12-month period.

- Please see Banner BR201313 for a listing of E/M CPT codes subject to mental health services limitations and PA requirements.
Prior Authorization

PA Department Contact Information

– ADVANTAGE Health Solutions, Inc.<sup>sm</sup>
  • www.advantageplan.com/advcareselect
  • 1-800-784-3981 – Care Select PA
  • 1-800-269-5720 – Traditional PA

Note: ADVANTAGE adjudicates all Traditional Medicaid, Medicaid Rehabilitation Option (MRO), PRTF PA requests, and Traumatic Brain Injury (TBI) Program admissions

– MDwise, Inc.
  • www.mdwise.org
  • 1-800-356-1204 – Care Select PA

Note: All PA for prescription drugs are processed and adjudicated by Catamaran Corporation and not the CMOs
The Right Choices Program (RCP) includes members who have shown a pattern of potential mis-utilization or over-utilization of services

- Non-emergent use of the ER
- “Drug seeking” behavior
- Resistance to PCP interventions

- The RCP is:
  - Not a loss of benefits
  - Not a reduction in benefits
  - Not a punitive action, but is a legal action

Note: Members are still eligible for all medically necessary IHCP services. However, those services must be ordered or authorized in writing by the member’s assigned PMP.
The RCP identifies members appropriate for assignment and subsequent “lock-in” to:

- One Primary Medical Provider (PMP)
- One pharmacy
- One hospital

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

*Note: The Right Choices Program applies to ALL Medicaid members (Care Select, Hoosier Healthwise, HIP, and Traditional Medicaid)*
Right Choices Program

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)
  - The CMOs add those specific physicians (NOT groups) to the member’s provider list in order for the specialty provider to be reimbursed
- 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
Right Choices Program

Self Referral Services

- Behavioral Health (except prescriptions)
- Chiropractic services
- Dental services (except prescriptions)
- Diabetes self-management services
- Family planning services
- HIV/AIDS targeted case management

- Home health care
- Hospice
- Podiatric services (except prescriptions)
- Transportation
- Vision care (except surgery)
- Waiver service
Adding Providers to a Right Choices Member’s “Lock-in” List

– Additional providers may be “locked-in”, either short-term or on an ongoing basis, if the PMP sends a written referral to the CMO.
– Providers may be “locked-in” for one specified date of service or for any defined duration of time up to one year.

The list of approved providers on a member’s “lock-in” list is available in Web interChange on the member’s eligibility profile.

– For Traditional Medicaid members, their profile will show they’re in the Right Choices Program but NOT list who the “lock-in” PMP is. You will need to contact ADVANTAGE Health Solutions to determine which physician that is.
### Right Choices Program

#### Member Information

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#### Managed Care Information

- **Care Select from 04/11/2012 to 04/11/2012**
- **Primary Provider**: DANIEL W PALMER
- **Phone**: 765-327-8061
- **Managed Care Entity Name**: ADVANTAGE HEALTH SOLUTIONS INC
- **Phone**: 800-764-3061

#### Provider Information

- **FAYETTE REGIONAL HEALTH SYSTEM**
- **JEFFERY LOVINS**
- **DANIEL PALMER**
- **GRANDVIEW PHARMACY**
- **LESLEY MILLINGS**
- **ELSE BEATTY**
### Right Choices Program

#### Member Information

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#### Medical Information

- **Eligibility Information**
  - Member is Eligible from 04/11/2012 to 04/11/2012 for PACKAGE A STANDARD PLAN
  - Inquiry completed at 10:14:17 AM on 4/11/2012

- **Medicaid Information**
  - Member ID
  - Medicare Number
  - Patient Liability
Referral Guidelines for the PMP

- Referrals must be faxed or mailed to the CMO
- Referrals may be legibly handwritten on letterhead or a prescription pad, however they must include the following information:
  - IHCP member’s name and RID
  - First and last name and specialty of the physician to whom the member is being referred
  - Primary “lock-in” physician’s signature (not that of a staff member)
  - Date and duration of referral
Contact Information

**ADVANTAGE**

ADVANTAGE Health Solutions
– Traditional FFS
Attn: Right Choices Program
P.O. Box 40789
Indianapolis, IN 46240
1-800-784-3981
Fax: 877-392-6894

ADVANTAGE Health Solutions
- Care Select
Attn: Right Choices Program
P.O. Box 40789
Indianapolis, IN 46240
1-800-784-3981
Fax: 877-392-6894

**MDwise**

MDwise Care Select
Attn: Care Management
P.O. Box 44214
Indianapolis, Indiana 46244-0214
Phone: 1-800-356-1204 or
317-630-2831
Fax: 1-877-822-7187 or
317-822-7517
Questions?

ADVANTAGE

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Marc Baker
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Matthew McGarry
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Marvin Davis
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Thank you!

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1-800-784-3981

MDwise Care Select
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