Agenda

• Member Eligibility
• Care Management
• Disease Management Focus
  – Levels of Care
  – Complex Case Management
• Prior Authorization
  – General Overview
  – Recent updates
• 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)
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) at (866) 963-7383.
Member Eligibility

PMP Selection

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

• If no selection is 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
Referring 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 (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)
Goals of Care Management

- Decrease non-emergent ER visits.
- Decrease inpatient stays related to medical and behavioral health diagnoses specific to our conditions of interest.
- Increase outpatient visits to meet care gaps and to contribute to Goals 1 and 2.
Care Management Referral Sources

• Indiana Health Information Exchange (IHIE): ER referrals for inappropriate use or visits for assault victims
• 24 hour nurse line from Medical Management
• Behavioral Health inpatient stays: Care Select members receive post discharge follow up call (HHW/HIP members are followed for 180 days)
• Right Choices Program: members with significant needs who may or may not be appropriate for RCP
• Customer Service
• Member interventions and web referrals (will eventually be the same)
• Lead screening
• High risk pregnancy
• State requests
• Potential Quality Issues (PQI’s)
• Psychiatric Testing Referrals
Disease Management Focus

- 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
Disease Management Focus

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.
Levels of Care:

**Care Level 1**— initial level applied to all newly enrolled members with the CMO

- Established specific chronic disease(s)
- Assessment to determine appropriate care level
- Evidence based disease management mailings
- Evidence based disease management interventions once per year
- Population based interventions
- No specific DM care plan
Member Assessment – Initial Screening

- Performed using the State’s approved health risk assessment to identify the member’s immediate physical and/or behavioral health care needs, as well as the need for Disease Management, Care Management, and/or Care Coordination
- Conducted by phone or by mail
- CMOs will:
  - Review member’s claims history
  - Identify any access or accommodation needs, language barriers, or other additional assistance needs
  - Identify members who have complex or serious medical conditions which require an expedited PMP appointment
Disease Management Focus

Member Assessment

• Initial screening and stratification must be completed within 120 days of a member’s enrollment in the CMO

• All members can be reassessed when
  – Indicated by a change in clinical status
  – Identification of a new care gap
  – Indicated by utilization or claims review
  – Notification from the PMP
  – Notification from member or member advocate
  – Periodic reassessment may result in stratification to a new level
Disease Management Focus

Levels of Care:

**Care Level 2** – member relatively stable medically and demographically

- Member educated about chronic condition
- Care plan based on clinical guidelines
- Design goals and health outcomes with member
- Identify and address any unique health needs/barriers
- Monthly phone call from disease manager
- Annual PMP case conference upon request
Levels of Care:

**Care Level 3** – members who require disease management plus more intensive care management

- Includes all elements of Level 1 and Level 2 disease management services
- Development of a care plan that includes a more comprehensive detailed assessment that addresses the clinical, psychosocial, functional, and financial needs of the member
- Will have one assigned care manager who serves as a primary point-of-contact responsible for coordinating with a team of health care providers from multiple disciplines to provide integrated care
- PMPs, advocates, and persons involved in member’s care may contact the care manager for care coordination and consultation.
Complex Case Management

Care Plan Development

• Data analysis and predictive modeling
  - Identify members at high risk for hospitalization or relapse
  - Identify members at risk for high cost and/or high utilization in the future
  - Identify gaps in current treatment approach and communicate findings to the member’s PMP

• Care Plan Information Sources – Levels 2 & 3
  - Gather information about existing care/case management plans being received; for example, through a CMHC
  - Collect and review:
    • Medical and educational information
    • Family and caregiver input
    • Claims data
    • Initial screening
    • Medical records
Complex Case Management

Monitoring

- Ongoing consultation with physical and behavioral health providers
- Sharing of clinical information
- Gathering of information about the care plan’s activities, interventions, and services
- Determine the care plan’s effectiveness in addressing care gaps and reaching evidence based outcomes
- Update care plan as needed
- Modify Level 3 members’ care plans via feedback from member, families, PMP, BH and other providers
State Reporting

On a regular basis (at least quarterly), the CMOs report the overall success of the care management program to the State

- Performance data related to:
  - Quality of care management
  - Medical necessity determinations
  - UM management
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

General PA Overview

- New PA form is to be used by all providers for all PA requests, except dental and pharmacy.

- Since January 1, 2011, only the new form has been accepted by Traditional FFS PA, the CMO’s (Care Select) & MCE’s (HHW & HIP).

- Provider PA decision letters sent to “mail to” address in IndianaAIM or noted on PA request form (Note: Ensure “Mail to” address is updated).

- Please refer to BT201045 for further information.

Please note: The MCE Outpatient Therapy Request (OTR) PA form must be used when requesting non-MRO behavioral health PA for HHW and HIP members.
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)
Prior Authorization

Determine if a service or item requires PA in Traditional Medicaid and Care Select (CS):

• Use the IHCP fee schedule: 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.
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.
Prior Authorization

The following provider types can submit PA requests via Web interChange:

- Chiropractor
- Dentist
- Doctor of Medicine
- Doctor of Osteopathy
- Home Health Agency (authorized agent)
- Hospice
- Hospitals
- Optometrist
- Podiatrist
- Psychologist endorsed as a Health Service Practitioner in Psychology (HSPP)
- Transportation providers

*NOTE:* **ALL** provider types can check PA request status via **Web interChange**.
Prior Authorization

PA Department Contact Information
- ADVANTAGE Health Solutions, Inc.™
  - www.advantageplan.com/advcaresselect
  - 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
**PRIOR AUTHORIZATION UPDATE**

- For Behavioral Health providers who have submitted a PA for a Care Select member where the date spans from 2012 into 2013, providers will need to submit a system update form to reflect the new psychiatric CPT codes and number of units.

Questions?

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