2012 Indiana Health Coverage Programs Annual Seminar

*Care Select 101:*
Indiana *Care Select Program* Overview

Presented by
ADVANTAGE Health Solutions, Inc.
and MDwise, Inc.
Agenda

• Program Goals
• Member Eligibility Requirements
• Disease Management Focus
• Complex Case Management
• General Prior Authorization Guidelines
• Right Choices Program (RCP)
• 2012 Quality Measures
• Questions & Answers
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 32,000 Medicaid members are currently enrolled in the disease management program.
Member Eligibility

Care Select Care Management Organizations (CMOs)
- ADVANTAGE Health Solutions, Inc. sm
- MDwise, Inc.

State-wide Populations Served
- The aged, if not eligible for Medicare
- Blind members
- Physically and/or mentally disabled members
  (collectively known as the ABD population)
- 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)
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](http://www.indianamedicaid.com) 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)*
Disease Management Focus

• Members 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

Step 1. Assess Member Needs

Step 2. Design Care Plan

Step 3. Coordinate Care

Step 4. Measure Results
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.
Disease Management Focus

Levels of Care:

**Care Level 1**— initial level applied to all newly enrolled members with the primary focus of initial member outreach & assessment
- Established specific chronic disease(s)
- Assessment to determine appropriate care level
  - Once assessment completed member becomes either level 2 or 3
- Evidence based disease management mailings
- Evidence based disease management interventions once per year
- Population based interventions
- No specific DM care plan
Disease Management Focus

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
Disease Management Focus

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
Complex Case Management

Care Plan Development

- 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
Complex Case Management

State Reporting

- Modify Level 3 members’ care plans via feedback from member, families, PMP, BH and other providers
- 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
General PA Overview

There are two Care Management Organizations (CMOs):

- ADVANTAGE Health Solutions, Inc. \(^{sm}\)
- MDwise, Inc.

*Note: ADVANTAGE adjudicates all Traditional Medicaid, Medicaid Rehabilitation Option (MRO), and PRTF PA requests*

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
IHCP adopts new PA Request Form!!

- 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 \textit{(Care Select)} & MCE’s \textit{(HHW & HIP)}.
- Provider PA decision letters sent to “mail to” address in \textit{IndianaAIM} or noted on PA request form (Note: Ensure “Mail to” address is updated).
- Please refer to BT201045 for further information.

\textit{Please note: The MCE Outpatient Therapy Request \textit{(OTR)} PA form must be used when requesting non-MRO behavioral health PA for HHW and HIP members.}
General PA Overview

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)
General PA Overview

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.
General PA Overview

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.
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.*
Right Choices Program

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)
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
Right Choices Program

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.
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
Right Choices Program
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
Quality Measures

2012 Care Management Organization (CMO) Performance Measures:

- Follow-Up After Hospitalization for Mental Illness – Percentage of members who receive follow-up visit within 7 days of discharge from hospital for mental health diagnosis.
- Cholesterol Screening for Members with Diabetes (Type 1 or Type 2) – Percentage of members age 18-75 with diabetes (1 or 2) who had a LDL-C Screening.
- Medical Attention for Nephropathy for those with Diabetes (Type 1 or 2) – Percentage of members age 18-75 with diabetes who had a screening or treatment for Nephropathy.
Quality Measures

2012 CMO Performance Measures (continued):

• Annual Monitoring for Members Angiotension Converting Enzyme (ACE) Inhibitors or Angiotension Receptor Blockers (ARB) – Percentage of members age 18 + who received at least 180 days supply of ACE or ARB.

• Asthma Medications – Use of appropriate asthma medications for members age 5 – 50.

• Emergency Room (ER) Bounce Back within 30 Days – Percentage of members who had more than one emergency room visit within 30 – calendar day period.
2012 CMO Performance Measures (continued):

- Inpatient Bounce Back (30 Days) – Percentage of members who were readmitted to an inpatient facility within 30 calendar days of a prior inpatient discharge.

*Note:* All measures are based on HEDIS technical specifications, reviewed annually based on adjudicated claims data obtained from HP and reported by the CMO to the Office of Medicaid Policy and Planning (OMPP). HP processes and adjudicates all Indiana Care Select claims.
CMO Contact Information

ADVANTAGE Care Select:
1-800-784-3981

MDwise Care Select:
1-800-356-1204
Questions & Answers

Thank you for attending!