As many as 24 million Americans may have chronic obstructive pulmonary disease (COPD) but approximately half don’t know it and remain undiagnosed. DRIVE4COPD, launched in February 2010 by founding sponsor Boehringer Ingelheim Pharmaceuticals, Inc. is a multi-year public health initiative that aims to help people recognize the signs and symptoms of COPD and to take action to see if they may be at risk. It encourages people to talk to a healthcare professional. DRIVE4COPD has been embraced by leading health, business, entertainment and sports organizations with a common goal of driving fundamental change in COPD awareness in the United States.

Because it is a largely unrecognized disease, the DRIVE4COPD campaign offers a brief five-question screener to help people identify their risk for COPD. In the program’s first year, DRIVE4COPD screened more than one million Americans for COPD risk. For many, taking the screener may be the first time they have considered if they are at risk for COPD.

This validated COPD Population Screener™ can be by members and providers by going to MDwise.org/wellness/smokefree and clicking the DRIVE4COPD logo. Providers are encouraged to download and print copies of the screener for use in their offices or place copies in patient waiting areas to encourage discussion about COPD. In addition, MDwise has COPD member materials on our website. Go to MDwise.org/dm and click on the “Chronic Obstructive Pulmonary Disease, COPD” link.

Learn more about the DRIVE4COPD campaign at drive4copd.org/about.aspx.
40 Weeks Toolkit Developed for New Pregnancy Initiative

MDwise is participating in a new state-wide quality initiative to educate provider offices called “40 Weeks of Pregnancy, Every Week Counts.” This initiative was created to address the concern about the 41 percent increase in late preterm births in Indiana, due to elective inductions and Cesarean sections over the past 16 years. The goal of the quality initiative is to reduce the number of elective inductions and Caesarean deliveries prior to 39 weeks of gestation.

The toolkit is designed with a set of resources for both the provider office and the patients, along with managed care resources. The provider offices that will be targeted for the quality education will be primary medical providers (PMPs) who provide OB services in their office, as well as contracted OB/GYN specialists.

The provider relations teams will be reaching out to schedule a provider office visit in order to hand deliver the 40 Weeks Toolkit and to discuss in detail the content of the toolkit as well as any additional needs provider offices might have for improving birth outcomes. The provider relations team will also conduct a follow-up call with each office later this year to determine whether they found the toolkit and its contents useful.

Thank you in advance for your participation and support of improved birth outcomes for Indiana.

The toolkit can also be found on MDwise.org at MDwise.org/hoosierhealthwise/providers/docs/heidis/40weeks-prov-toolkit.pdf

MDwise Medical Management

MDwise medical management makes prior authorization decisions based on appropriateness of care and coverage rules. MDwise medical management staff and our delegates who perform prior authorization DO NOT receive incentives or rewards, financial or otherwise, for making denial decisions and are not rewarded for making utilization management (UM) decisions that decrease utilization of services by MDwise members. As always, upon receiving notification of a decision to reduce or not authorize services, you may request the clinical guideline that was used to make the decision by calling the medical management department.

Reviewer Availability
As an NCQA accredited organization, MDwise complies with NCQA standard UM 7. Our delivery system medical management departments have an appropriate practitioner available to discuss medical or behavioral health cases with the treating or attending practitioner. If you or your office receive notification of an impending denial, you should also receive a reminder regarding the availability to have this peer to peer discussion, as well as how to initiate the discussion.

If you have questions about the peer to peer review or need assistance, please contact the medical management department that you submitted the request to authorize or you may call the MDwise customer service at 1-800-356-1204 or 317-630-2831.

Hoosier Healthwise Member Rights and Responsibilities

The MDwise Hoosier Healthwise Member Rights and Responsibilities statement is available on the MDwise website at MDwise.org/hhw-hip/member-rights/eng-mr.pdf. For a printed copy of this information, call us at 1-800-356-1204 or 317-630-2831 in the Indianapolis area.
**MDwise Incentive Affirmation Statement Concerning Medical Management**

Prior authorization decisions are based only on appropriateness of care and service and existence of coverage. Compensation plans for physicians and staff who conduct medical management determinations do not contain incentives or rewards, directly or indirectly, for issuing denials, or that encourage decisions that result in underutilization or barriers to care and service.

Qualified medical management staff with the required knowledge and skills to assess clinical information used to support medical management decisions will perform first-level medical management determinations. MDwise employs licensed nurse reviewers whose education and experience meet the job qualifications to perform the initial review of the clinical information against criteria.

A specialized behavioral health team of clinical case managers are responsible for the day-to-day medical management functions surrounding the delivery of behavioral health services including service review determinations and coordination of physical and behavioral health needs. Behavioral health care managers are comprised of licensed behavioral health care professionals, such as board-certified psychiatrists, psychologists and master’s-level nurses and clinicians who reach utilization management decisions based on safe and quality driven standards and practices.

A physician, appropriate behavioral health professional, dentist or clinical pharmacist, as appropriate, reviews any denials of services based on medical necessity.

Qualifications for practitioners who review denials of care based on medical necessity include education, training or professional experience in medical or clinical practice and a current U.S. license to practice without restriction. Behavioral health practitioners, including psychiatrists, doctoral-level clinical psychologists or certified addiction medicine specialists review denials of behavioral health care based on medical necessity.

Board-certified physicians may be utilized to provide specialty expertise in the medical necessity review of individual cases.

MDwise requires that all practitioner consultants used in the review of grievances, appeals and claims disputes meet established credentials criteria. The criteria evaluates whether such practitioners have the required knowledge and skills to assess clinical information provided in the review of member and provider appeals of a MDwise determination.

It is a MDwise practice to make the reviewer available to the treating or attending provider to discuss any medical management denial decision. This can be accomplished by calling the appropriate utilization management (UM) department in the Quick Contact Guide at [MDwise.org/docs/provider-quickcontact.pdf](http://MDwise.org/docs/provider-quickcontact.pdf) or MDwise customer service and asking to be connected with the delivery system UM department. The MDwise customer service department can be reached by calling 1-800-356-1204 or 317-630-2831.

**Please Note:** Eligibility must be checked every time a service is rendered. Failure to do so may result in denial of payment. Prior authorization of a referral/service is not a guarantee of payment, for example if benefits expired prior to the service date. The practitioner/provider must always check member eligibility at the time of service during the referral/authorization time period to avoid denial of payment for services provided due to member no longer being eligible on the date of service.

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**New ID Cards for MDwise Members Enrolled in the Healthy Indiana Plan (HIP)**

MDwise has issued new ID cards for the HIP program to all enrolled and newly enrolled members. The card displays the member’s name and member ID. The ID can be used to check the member’s eligibility at the time of service, as well as the member’s primary medical provider (PMP) and other contact information. You can also log on to myMDwise provider portal to get member information.

Contact information for the pharmacy benefit can be found on the back of the card.

Questions regarding HIP can be directed to MDwise customer service at 1-800-356-1204 or 317-630-2831 in the Indianapolis area.
The Right Choices program (RCP) was designed by the Office of Medicaid Policy and Planning (OMPP) to safeguard against unnecessary or inappropriate use of Medicaid services. MDwise and its three IHCP programs, Hoosier Healthwise, Care Select and Healthy Indiana Plan (HIP), administer the program using uniform criteria and policies established by the State.

The RCP case managers, in partnership with the member's PMP, provide intensive member education, care coordination and utilization management for members enrolled in the Right Choices program. Case managers also support providers in the management of their RCP members.

RCP stakeholders (i.e. the health plan's case manager and the member's primary medical provider) collaborate to create a medical home for RCP members to achieve the goal of delivering quality health care for RCP members. RCP members are assigned and “locked in” to a team of experts consisting of one primary medical provider (PMP), one pharmacy and one hospital. If a member requires specialty services or needs to see any practitioner other than the PMP (including any physicians in the same clinic or group), the PMP must make a written referral for those services to be authorized for reimbursement. This includes situations of self-referral (for example, dentists and psychiatrists). Referrals must include the following:

- The IHCP member's name and recipient identification number (RID)
- The first and last name of the referring physician (member's assigned PMP)
- The first and last name of the referral physician
- The referral physician's National Provider Identifier (NPI)
- Date of the referral
- Dates of service for which the referral is valid
- PMP’s manual or electronic signature

MDwise seeks PMP support for the objectives of the Right Choices program which are to:

- Improve the individual's health status by increasing the level of care coordination and utilization control for members enrolled in the RCP.
- Reduce inappropriate outpatient hospital use, especially use of the emergency room.
- Reduce inappropriate use of pharmacy services, especially controlled substances and other items with potential for misuse or abuse.
- Reduce medical expenditures related to inappropriate use and/or overuse of services.
- Increase provider participation and improve provider satisfaction with the RCP.

Providers receive a notification letter when they have been selected by the member to participate on the member's medical home team. Information regarding the member's authorized providers is also available via Web interChange. Members are notified in writing of their selection and enrollment into the Right Choices program. The letter indicates the member's assigned or chosen PMP, pharmacy and hospital. RCP member enrollment information is entered into Web interChange so providers can identify the individual as a member of the Right Choices program when they check a patient's Medicaid eligibility. A member's RCP enrollment stays intact regardless of member movement between programs or health plans.

For additional information, contact MDwise customer service at 1-800-356-1204 or 317-630-2831. Please do not contact medical management or prior authorization for questions or assistance regarding the Right Choices program as they do not maintain information for the program. Providers can always check member eligibility on Web interChange to determine the member's Right Choices program status and a list of approved Right Choices program providers for that member.
IHCP-Covered Services Excluded from Hoosier Healthwise

Scenarios that require members’ disenrollment from risk-based managed care (RBMC)

Several situations, resulting from a change in health status, require that an Indiana Health Coverage Programs (IHCP) member be disenrolled from the Hoosier Healthwise risk-based managed care (RBMC) program. These situations include members who are transitioning to a long-term care facility, a psychiatric residential treatment facility (PRTF), hospice care, a waiver program or to the 590 Program. In most cases, a level of care designation is required to trigger disenrollment from RBMC. Until the Hoosier Healthwise disenrollment occurs, fee-for-service (FFS) claims (except for carved-out services) for these members will be denied. Therefore, it is important to be proactive and use the following disenrollment processes.

Long-term institutional care

Hoosier Healthwise members requiring long-term care in a nursing facility or intermediate care facility for the mentally retarded (ICF/MR) must be disenrolled from RBMC. Before the facility can be reimbursed for FFS claims, members must be disenrolled from the managed care entity (MCE) with which they are enrolled.

The nursing facility or ICF/MR must request a Pre-Admission Screening Resident Review (PASRR) for facility placement. The facility should initiate the PASRR in advance of admission and before submitting claims. The facility also must notify the member’s MCE of the request within 72 hours.

If the facility fails to verify an IHCP member’s coverage or fails to contact the MCE within 72 hours of admission, the provider is responsible for any charges incurred until the member is disenrolled from the MCE.

If the facility fails to complete the paperwork for the appropriate level of care determination, and the member is still enrolled in Hoosier Healthwise after two months, the MCE is no longer liable for payment. However, as long as the patient remains a member of the MCE, FFS claims will be denied payment.

An MCE may obtain services for its members in a nursing facility on a short-term basis, for example, fewer than 30 days. Short-term stays in nursing facilities are more cost-effective than other options and the member can obtain the care and services needed from the nursing facility. The MCE can negotiate rates for reimbursing the nursing facilities for these short-term stays.

It is possible for a member’s PASRR process to be under way (but not complete) while the member is linked to an MCE. In this situation, the financial responsibility lies with the MCE for no more than 60 days.

1. The State approves the PASRR request and designates the appropriate level of care in IndianaAIM.

2. A level of care automatically triggers RBMC disenrollment and is processed the same date as the processing date of the level of care.

More detail is available in the IHCP Hospice Provider Manual and Chapter 14 of the IHCP Provider Manual.
IHCP-Covered Services Excluded from Hoosier Healthwise (continued)

Psychiatric residential treatment facility services

Hoosier Healthwise members receiving treatment in a PRTF must be disenrolled from RBMC. Before the facility can be reimbursed for FFS claims, members must be disenrolled from the managed care entity (MCE) with which they are enrolled.

1. The PRTF provider must submit a PRTF prior authorization (PA) request for the member to the prior authorization vendor, ADVANTAGE Health Solutions. The fax number is 1-800-689-2759. The PRTF facility must also contact the MCE with which the member is enrolled before the member is admitted to the PRTF, or immediately on admission to the PRTF if advance notice is not possible.

2. ADVANTAGE approves the PA request as appropriate and enters the PRTF level of care in IndianaAIM.

3. A PRTF level of care code automatically triggers RBMC disenrollment and is processed on the same date ADVANTAGE enters the level of care. Therefore, the disenrollment date and the level of care date are the same.

4. The PRTF must notify ADVANTAGE when the member is discharged.

5. ADVANTAGE end-dates the level of care for the member.

6. Once the level of care is end-dated, and if the member is still eligible for RBMC, the auto-assignment process immediately reassigns the member to his or her previous MCE with an effective date of the first or the 15th of the month, depending on when the member was disenrolled from the PRTF.

More detail is available in Chapter 6 of the IHCP Provider Manual.

Hospice care

Hospice care is not covered under Hoosier Healthwise. However, terminally ill members may qualify for hospice care under the FFS Medicaid program once they are disenrolled from RBMC.

1. Hospice providers must submit a hospice election form for the member via fax to ADVANTAGE. The fax number is 1-800-689-2759. The hospice facility must also contact the MCE in which the member is enrolled.

2. ADVANTAGE approves the request as appropriate and designates the appropriate hospice level of care in IndianaAIM.

3. A level of care segment automatically triggers RBMC disenrollment and is processed the same date as the processing date of the level of care. RBMC disenrollment documentation is faxed to 317-810-4488; the dedicated fax number.

4. The MCE must coordinate care for its members who are transitioning into hospice, including providing the IHCP hospice provider with any information required to complete the hospice election form.

More detail is available in the IHCP Hospice Provider Manual and Chapter 6 of the IHCP Provider Manual.
Charging Members for Services

Federal and state regulations prohibit providers from charging any Indiana Health Coverage Programs (IHCP) member, or the family of a member, for any amount not paid following a reimbursement determination by the IHCP. See Code of Federal Regulations, Title 42, Part 447, Subpart A, Section 447.15; Indiana Administrative Code, Title 405, Article 1, Rule 1, Sections 3(i). Furthermore, the IHCP Provider Agreement contains the following provision:

“To accept payment as payment in full the amounts determined by Indiana Family and Social Services Administration or its fiscal agent, in accordance with the Federal and State statutes as the appropriate payment for Medicaid or CHIP members (recipients). Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for Medicaid or any member of a recipient's family, for any additional charge for Medicaid or CHIP covered services, excluding any copayment permitted by law.”

The clear intent of this provision is to ensure that no member or family of a member is billed in excess of the amount paid by the IHCP.

As a condition of the provider's participation in the IHCP, the provider must accept the IHCP determination of payment as payment in full, whether the IHCP is the primary or secondary payer. If the provider disagrees with the Medicaid determination of payment, the provider's right of recourse is limited to an adjustment request, administrative review and appeal as provided in 405 IAC 1-1-3. Violation of this section constitutes grounds for the termination of the provider agreement and decertification of the provider at the option of the Indiana Family and Social Service Administration (IFSSA).

Billing Exceptions

An IHCP provider can bill an IHCP member only when the following conditions are met:

• The service must be an IHCP noncovered service or a covered service for which the member has exceeded the program limitations for the particular service.

• The member is a qualified Medicare beneficiary (QMB) only or a specified low income Medicare beneficiary (SLMB) only, and the IHCP pays only the coinsurance and deductible, but does not provide medical coverage.

• The IHCP member must understand, before receiving the service, that the service is not covered under the IHCP and that the member is responsible for the service charges.

Note: If a waiver is used to document that a member has been informed that a service is noncovered, the waiver must not include conditional language such as “if the service is not covered by the IHCP, or not authorized by the member's primary medical provider (PMP), then the member is responsible for payment.” This language appears to circumvent the need for the provider to verify eligibility or seek PMP authorization or PA as needed.

The provider must maintain documentation in the member's file that the member voluntarily chose to receive the service, knowing the IHCP did not cover it.

Clinical Care Guidelines

Clinical care guidelines, which contain preventive health guidelines, can be accessed on the provider section of MDwise.org under Provider Tools. For a printed copy of this information, call us at 1-800-356-1204 or 317-630-2831 in the Indianapolis area.
Concurrent Hospice and Curative Care Services for Children

The Affordable Care Act (ACA) requires that hospice services be provided to children without forgoing any other service to which the child is entitled under Medicaid for treatment of a terminal condition. The Indiana Health Coverage Programs (IHCP) now covers all medically necessary curative treatment for terminally ill children, 20 years of age and under, concurrently with hospice care for dates of service on or after March 23, 2010. As a result, the following hospice forms on the forms page of IndianaMedicaid.com have been updated:

- **The Medicaid Hospice Plan of Care for Curative Care–Members 20 Years and Younger Form:** This is a new form that allows providers to include care information related to the curative services.
- **Medicaid Hospice Election Form:** The election statement section of this form has been updated to include language related to receiving concurrent services up to the age of 21.

Availability of Guidelines Used for Medical Management

MDwise is an NCQA accredited organization and complies with all NCQA utilization management (UM) standards including UM 2 regarding criteria availability. Please remember that if you receive notification of an adverse decision, which includes the determination to deny, modify or reduce the services for which you requested authorization, you may request the clinical guideline or criteria that applied to make the decision. To make this request, call the medical management department for the MDwise delivery system the member is assigned. This contact information can be found in the Quick Contact Guide at MDwise.org/docs/provider-quickcontact.pdf.

The medical management department will work with you to provide you with the guideline or criteria in the most acceptable form of communication: fax, email, phone or mail.
The term appeal is defined as a request for review of an action. An action, as defined in 42 CFR 438.400(b), is the:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined by the State;
- Failure of an MCE to act within the required time frames; or
- Denial of the member’s request to exercise his or her right, under CFR 438.52(b)(2)(9ii), to obtain services outside of the network, for members who live in rural areas where MDwise is the only contractor.

An appeal must be filed within 33 calendar days from the date of action notice. Members may file the appeal orally; however, the oral filing must be followed with a written, signed appeal unless the member or provider requests an expedited appeal.

Authorized representatives may act on behalf of members with respect to requesting an appeal and the procedures involved. The member is allowed the opportunity for representation by anyone he or she chooses, including a provider or attorney.

For expedited appeals, a health care practitioner with knowledge of the member’s condition (e.g. a treating practitioner) may act as the member’s authorized representative. The member and member representative may present evidence or testimony in person as well as in writing.

For standard appeals, MDwise responds to all oral and written appeals within three business days of receiving the request. The appeal must be resolved within 20 business days of receiving the appeal. Written notification of the appeal resolution must be sent to the member within five business days after the decision is made. If the member requests an extension, or if MDwise is unable to make a decision within 20 business days because additional information has been requested but not provided, the member is notified of the delay before the twentieth day. MDwise provides the member with written notice of the delay, demonstrating in the notice that the extension is in the member’s best interest and that a decision will be granted within 10 additional business days.

MDwise resolves expedited appeals that meet the MDwise criteria within 48 hours of receiving the request and the attending physician and member are notified immediately by telephone. This timeframe can be extended pursuant to 42 CFR 438.408. A written confirmation of the decision is also sent by mail to the member within 48 hours of notification.

A member may request continuation of services during the appeal process if an authorized service is being terminated, reduced or suspended before the expiration of the original authorization date. The member is informed of the financial obligations if services are continued during the appeal process and the final decision is adverse to the member.

MDwise also offers members, at any time during the appeal process, reasonable access and ability to examine the relevant contents in the appeal file, including medical records and any other supporting documentation considered by MDwise. MDwise informs members of these rights in all communications about the appeal process and in all correspondence generated for a specific appeal.
MDwise Quality Improvement Program

MDwise has a quality improvement (QI) program to monitor and evaluate the health care services used by our members. Services are monitored to see that they meet quality guidelines, are appropriate, efficient and effective. The quality management team (QMT), with input from the medical advisory council and the various QI program subcommittees, oversee the QI program. The QMT is made up of MDwise executive leadership and health care professionals. Each year, the QI program sets goals to improve member health outcomes and services, and conducts activities to meet those goals. The QI program manages and analyzes data and takes action to manage risks and improve outcomes.

Evaluation

Each year, MDwise evaluates its QI program to see how well it met its goals. We look at all parts of the QI program, including clinical, behavioral and service activities. The evaluation includes suggestions to improve the QI program and goals for the next year. It also identifies the resources needed to meet the goals and objectives.

Accomplishments for 2011 QI Program

- The MDwise network improvement program (NIP) team provided support and guidance to our providers and delivery systems. A key premise of NIP strategies is that significant improvements are primarily driven through efforts and systems changes within provider offices. Using the well-received “Well-Child First” campaign, NIP created performance reporting, toolkits and best practices to share with provider offices. The impact of NIP was evident in the significant increase in HEDIS 2011 scores for adolescent well-care.

- For the MDwise pay for performance (P4P) program, a significant portion of P4P earnings were shared with both delivery systems and individual MDwise providers. Provider-awarded earnings were used to recognize those who performed well on key measures (well-child and postpartum care). To recognize providers who were performing well on new measures (e.g., ER bounce back, C-section rates, 7-day follow-up visit after behavioral health inpatient stay), a recognition program was created for hospitals based on performance. This was MDwise’s first effort to recognize hospitals for their performance on quality measures. Many providers were recognized with both a monetary reward and a celebration thank you visit that included a cake for providers to share with their staff.

- Primary care/behavioral health integration grants awarded to providers by MDwise demonstrate that for those who have been delivering care longer than one year, there is a greater impact on lowering costs with the most dramatic change to our sickest members. MDwise is working with federally qualified health center (FQHC) and community mental health center (CMHC) partners to increase the number of settings in the State where integrated care occurs.

- For disease management/care management, the new OMPP contract in 2011 created new contractual definitions and requirements resulting in new specifications for disease registry inclusion and stratification criteria. The disease registry specifications were based both on claims and on implementation of a new OMPP health risk screener (HRS) created by OMPP. The OMPP screener is comprehensive (37 questions), but MDwise chose to augment the OMPP screener by adding evidence-based, disease-specific screeners for each of the disease registries. These disease-specific screeners allowed for initial stratification based on member response to the HRS that is very effective in queuing up members for comprehensive assessment by a care manager. MDwise also developed online disease management trainings for delivery system care management and MDwise providers which are posted on MDwise.org. In addition, MDwise developed information-rich member resources which were posted to the member section of the MDwise website at MDwise.org/dm.

- The MDwise Rewards program for members was successfully designed, approved and implemented in April of 2011. The program began counting points for members who completed an HRS, joined the myMDwise member portal and successfully obtained preventive exams and screenings starting on January 1, 2011.
The “40 Weeks of Pregnancy, Every Week Counts” initiative was developed during the latter half of 2011. MDwise worked collaboratively with OMPP and the other Hoosier Healthwise MCEs to create a provider toolkit in support of the national and state-wide campaign to reduce early inductions and C-sections. The collaborative effort included the Indiana Perinatal Network, March of Dimes, the Indiana Chapters of the American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP), the Indiana State Department of Health, IU School of Medicine and others. The toolkit was created with a unique program logo, created by MDwise, and training was developed for provider relations staff from all three MCEs.

The Community Advisory Council program has grown to five areas of Indiana in 2011: North Central (Howard and surrounding counties), West Central (Vigo and surrounding counties), Northeast (Allen and surrounding counties) Southeast (Clark/Floyd and surrounding counties) and Northwest (Lake and surrounding counties). Feedback collected from participants indicates a high percentage of participants have had an above average to excellent experience with MDwise. Valuable input from these community partners is considered when developing or revising programs to improve quality of care.

Key Program Goals for 2012 are to:

- Complete work started in 2011 on building out the Network Improvement toolset: to include the well-child 0–15 months measure, pregnancy measures including C-section rates and NOP completion rates.
- Continue outreach to behavioral health inpatient and outpatient providers on 7-day follow-up following an inpatient behavioral health stay.
- Conduct strategic planning sessions for 2012/2013 involving delivery system quality and medical management staff on the key focus areas of well-child, pregnancy and diabetes.
- Incorporate preventive and disease specific care gaps into JIVA and feed to the CRM for customer service and develop or update corresponding scripts.
- Develop new reporting to address new ER utilization (including the ER bounce back measure) for providers to support member outreach and education.
- Increase promotion of the MDwise Rewards program to incentivize members for preventive wellness exams, screenings and achieving CM/DM goals.
- Continue collaboration with OMPP and MCEs to further promote Early and Periodic Screening, Diagnostic and Treatment (EPSDT) to the provider community.
- Implement the planned campaign, ITPC Preferred Provider Program, to promote smoking cessation, documentation and data capture for current provider-centered smoking cessation interventions.
- Utilize national experts to provide training (e.g. conferences and follow-up webinars) for providers on practice improvement and quality improvement.

Information on the QI program and evaluation report is available on MDwise.org. A paper copy of the QI program information is available upon request by contacting MDwise customer service at 1-800-356-1204 or 317-630-2831.