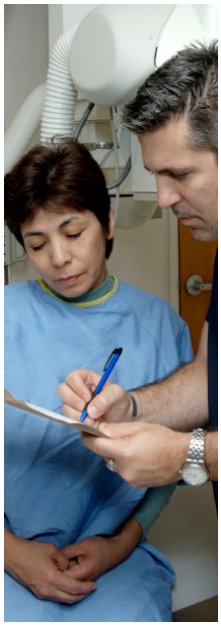
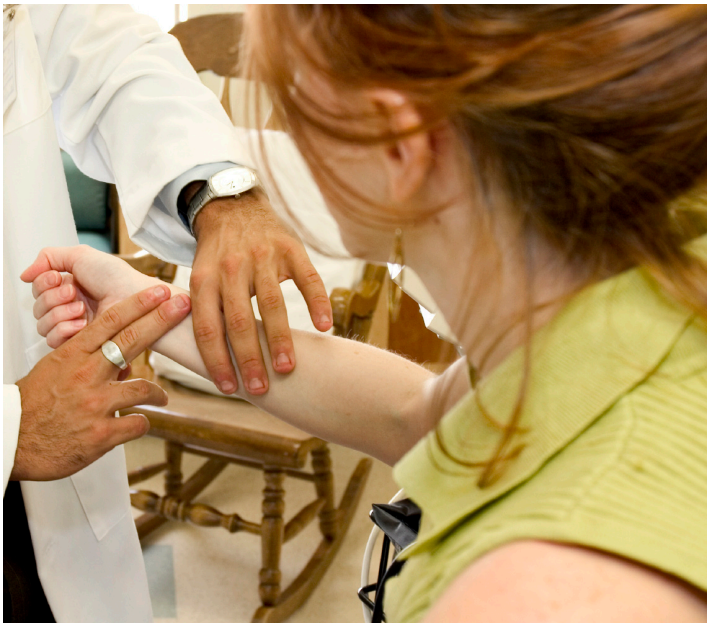
# External Quality Review of Indiana's Hoosier Healthwise Program and Healthy Indiana Plan for the Review Year Calendar 2009

Final Report – November 30, 2010



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# EXECUTIVE SUMMARY

Indiana's Office of Medicaid Policy and Planning (OMPP) has implemented two managed care programs using Section 1115 waiver authority. The Hoosier Healthwise (HHW) program covers children, pregnant women, and low-income families. As of the end of Calendar Year (CY) 2009, there were nearly 750,000 enrollees in the program—608,793 children and 139,410 adults. The other program is the Healthy Indiana Plan (HIP), which was introduced in January 2008. As of the end of CY 2009, the HIP had 45,701 adult enrollees. The HIP covers two expansion populations:

- Uninsured custodial parents and caretaker relatives of children eligible for Medicaid or the Children's Health Insurance Program (CHIP) with family income up to 200 percent of the Federal Poverty Level (FPL) but are not otherwise eligible for Medicaid or Medicare (the "HIP Caretakers")

- Uninsured noncustodial parents and childless adults ages 19 through 64 who are not otherwise eligible for Medicaid or Medicare with family income up to 200 percent of the FPL (the "HIP Adults")

In 2010, the OMPP hired Burns & Associates, Inc. (B&A) to conduct an external quality review (EQR) of both the HHW and HIP programs for the review year CY 2009. In prior years, B&A has conducted EQRs of both programs. In CY 2008, B&A conducted a general review of all MCO functions in HHW to coincide with a new contract period. A similar type of review was completed in CY 2009 for the HIP since CY 2008 was the first year of operations for the HIP. In both cases, B&A utilized the protocol defined by the Centers for Medicare and Medicaid (CMS) in *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al."* published in February 2003.

In this year's EQR, B&A developed an EQR approach in cooperation with the OMPP that consists of a series of focus studies that are applicable to both the HHW and the HIP. The results from each focus study appear as a section in this report. In most cases, the processes reviewed for the HHW and HIP were the same, but it is often the case that findings are reported for each program independently. The focus areas identified for this year' review include:

- A review of MCO initiatives to address cultural competency
- A review of program integrity activities at each MCO
- An examination of member's accessibility to providers and the availability of these providers to serve HHW and HIP members
- A clinical review of retroactive authorizations and claim denials as well as an administrative review of claims dispute cases
- Validation of six performance measures
- Validation of nine performance improvement projects (PIPs)

In each section, B&A's approach to the review is discussed as well as review findings, best practices identified, and recommendations for either the OMPP or the MCOs.

## Review of MCO Cultural Competency Initiatives

Per 42 CFR §438.206(c)(2), each Medicaid MCO must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Although the OMPP does not require specific actions with respect to cultural competency in the HHW or HIP contracts, it does encourage the MCOs to develop community partnerships and to develop specific educational activities to reduce barriers to health care and to improve outcomes for members.

For this EQR, B&A reviewed cultural competency initiatives that the HHW and HIP MCOs have developed in the context of 14 national CLAS (Culturally and Linguistically Appropriate Services) standards which were developed in 2000 by the U.S. Department of Health and Human Service's Office of Minority Health. For each standard, B&A cites areas where the HHW and HIP MCOs fulfilled the standard, developed best practices, or where there are opportunities for improvement.

Best Practices found in HHW and HIP Cultural Competency Initiatives

1. Anthem's Cultural Competency Toolkit to providers, recently introduced, is specific to their state-sponsored business which focuses on Medicaid beneficiaries. It is used as an in-person tool to educate providers on cultural competency (Standard #12).

2. MDwise releases all of its materials in English and Spanish, avoiding the need for Spanish-speaking members to have to specifically request these materials. Additionally, they release materials specific to different communities in their program which are customized to the targeted group they are trying to outreach (Standards #5, #7).

3. MHS has already completed a CLAS standards internal evaluation and is taking action on items to develop protocols that adhere to the 14 CLAS standards (Standard #8).

4. All of the MCOs illustrated numerous examples of different ways that they outreach with a variety of communities that may participate with in HHW and HIP. Additionally, the HHW MCOs worked together collaboratively to develop culturally sensitive materials and procedures for working with the growing Burmese population in Allen County (Standard #12).

Areas of Opportunity to Enhance Cultural Competency Initiatives

1. It is apparent to the review team that both Anthem and MDwise have numerous initiatives related to cultural competency, but B&A would encourage both MCOs to utilize the CLAS standards as a tool to ensure that their strategic work plan for cultural competency encompasses all elements cited in the CLAS (Standard #8).

2. Anthem and MHS may want to consider making at least some materials available in English and Spanish upon release like MDwise does (Standard #7).

3. Now that race/ethnicity data has become more readily available from the OMPP, B&A recommends that the MCOs utilize this data more proactively in conjunction with claims data to better target health disparities within HHW and HIP populations (Standard #10).

4. MCOs may consider sharing the primary language spoken by the member as soon as they are aware of it with the member's primary medical provider (Standard #11).

5. Use the credentialing and recredentialing process to assist in tracking languages spoken by providers since they may appear on the application (Standard #11).

6. MCOs should run a random sample audit of physician offices that self-report that they speak non-English languages to ensure that this is true (Standard #11).

7. MCOs should conduct ongoing assessments of CLAS-related activities (Standard #9) and grievance processes (Standard #13) with an eye for cultural competency.

## Review of MCO Efforts to Address Program Integrity

B&A reviewed MCO policies and procedures related to the credentialing and recredentialing of providers as well as procedures to detect member, provider or employee fraud and abuse. For each topic, the EQR team interviewed the appropriate staff at each MCO that are responsible for these program integrity efforts. Additionally, B&A reviewed 20 credentialing files at each MCO/program. We discussed our findings from the case file reviews with MCO staff responsible for this function. The MCOs also presented five fraud or abuse cases within each MCO/program to B&A in an onsite session so that B&A could gain a better understanding of the processes used to ensure program integrity.

The credentialing and recredentialing function of contracted providers is a coordinated effort at each of the HHW and HIP MCOs. The actual activity of conducting the verifications for credentialing or recredentialing is completed by delegated entities (for MDwise and MHS) or other subsidiaries of the organization (Anthem). But the final decision to accept the recommendation to credential or recredential providers is completed by a credentialing committee housed at the MCO's headquarters.

B&A found that all three MCOs had thorough written policies and procedures related to credentialing. Through interviews, we determined that the staff responsible for following these procedures have a clear understanding of them and follow the procedures as written.

In our review of specific credentialing files, MDwise and MHS were fully compliant with all requirements as specified by the National Committee for Quality Assurance (NCQA). Anthem had one of ten items reviewed missing from six of the 40 cases reviewed and two items missing in one other case. It appeared from an internal checklist that the required tasks were completed, but they were not evident in the file provided to B&A.

With respect to detecting fraud and abuse, the Special Investigations Unit (SIU) at all of the HHW/HIP MCOs in CY 2009 was fairly stagnant. But a renewed emphasis was placed at each

MCO on examining potential fraud and abuse early in 2010. This included an expansion of staff assigned to these activities as well as the number of actual investigations. For example, Anthem investigated 17 cases (HHW and HIP) in CY 2009 but has surpassed this already through August 2010. MDwise had nine cases in CY 2009 and has already had 24 through August 2010. MHS had 14 cases last year investigated and have 14 opened so far through September 2010.

The basic approach described by each MCO to investigate member and provider cases is fairly similar, although Anthem appears to have a more comprehensive approach than the other MCOs. A set of 10 questions was asked by B&A in relation to each case that the MCO presented in the onsite sessions. The cases reviewed by B&A indicated to us that multiple actions are considered to resolve the case given the circumstances of the investigation. In each instance, it appeared that the MCOs were utilizing the most appropriate action given the evidence that was compiled.

Best Practices Cited Related to Program Integrity

1. Anthem's new staff within the HHW and HIP SIU has a very strong process for handling investigations. Among the three MCOs, Anthem's group best illustrated to B&A how the results from SIU investigations often get fed back as improved processes on the front end to other parts of the organization to prevent fraud and abuse.

2. MHS has a solid cross section of talent performing the SIU function and also has a rigorous continuing education for its staff.

3. The monthly meeting of MCO SIU staff with the OMPP and the MFCU provides an excellent way to share information about items detected in cases and to alert other entities of member or provider practices that may need to be investigated. This work group is especially important given that providers can contract with multiple MCOs and with both the HHW and HIP programs.

Areas of Opportunity in Program Integrity

1. Recognizing that the SIU team is new at MDwise and that some training is being planned for 2010, B&A suggests that the MDwise staff adopt an ongoing training schedule in line with the other MCOs.

2. There were a number of investigations reviewed by B&A with the MCOs that were excellent examples of inappropriate provider billing that were properly handled by the MCO. B&A encourages when these cases are resolved that the MCOs take more of the issues identified in a single case and, when appropriate, expand the review globally to all providers in the peer group of the provider being investigated.

## Review of Accessibility and Availability of Providers

Federal requirements state that states must ensure that each MCO "maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract" (42 CFR §438.206).

The OMPP requires the HHW and HIP MCOs to have sufficient availability of Primary Medical Providers (PMPs) so that there is one within 30 miles of each member's residence. In HHW, for particular specialty providers there must be two of each specialty type within 60 miles of the member's residence. For HIP, there must be just one of each specialty type within 60 miles but the list is expanded to 30 different types of specialty providers.

Accessibility was examined by B&A in multiple dimensions to verify that these standards were being met:

- B&A reviewed the results of GeoAccess reports submitted annually to the OMPP by each MCO in HHW and HIP.

- Using encounter data, B&A examined HHW and HIP member's visits to primary care and specialist physicians within their county of residence, in a contiguous county of their residence, or in a non-contiguous county.

- A random sample of HHW and HIP members were selected to test the actual distance traveled between their residence and the PMP or specialist office they visited.

Our review of the GeoAccess reports found that for HHW primary care, there is full compliance of the 30 mile requirement. For HHW specialists where the 60 mile requirement is in place, there is desired access among all MCOs for orthopedic surgeons and psychiatrists or other behavioral health providers. In all but a few counties, there is also desired access for cardiologists and urologists. Both Anthem and MDwise did not report on the accessibility of DME or home health providers in the GeoAccess reports. For MHS, these are two areas where access can be enhanced.

For HIP, both MCOs have desired access for PMPs. In most cases, the MCOs are meeting the desired access among the 30 specialties where they are required to have one provider in the specialty within 60 miles. There is one specialty (speech pathologist) where both Anthem and MDwise do not meet the desired access in many counties and two other specialties (neurological surgery and pathology) where Anthem does not meet desired access in 10-15 counties.

B&A's review of HHW and HIP encounters to identify where members are seeking services showed that access to primary care is very high in HHW but not as high in the HIP. Among HHW children, 75 percent of their PMP visits were in their home county and 93 percent were in their home county or a contiguous county. Among HHW adults, these rates were 73 percent and 93 percent, respectively. In the HIP, the rates were 51 percent and 66 percent.

It should be noted, however, that the actual distance was not measured here and traveling to a contiguous county or even a non-contiguous county may still be within the 30 mile threshold set by the OMPP.

The location of specialists visited by HHW and HIP members varied significantly by the type of specialist seen. But more than half of all specialist visits for both HHW children (52% overall) and HHW adults (58% overall) were in the member's home county and more than three-quarters

were in the home county or a contiguous county. Some of the specialists seen most often by HHW children and adults (cardiologists, general surgeons, oncologists and orthopedic surgeons) were also the specialists in closest proximity to where the members live. Alternatively, there were a number of specialists seen by HIP members where the majority of the time they saw a provider in a non-contiguous county, but collectively these only represented 12 percent of all HIP specialist encounters.

B&A also examined the availability of providers both in seeking appointments and in seeking access on a 24x7 basis.

- B&A measured the availability of PMPs and specialists in both the HHW and HIP for members to make appointments for urgent care, well care, and consultation visits.

- A separate analysis was conducted on a sample of the physicians contacted by the HHW and HIP MCOs in their 24-hour availability audits to confirm the results they reported to the OMPP.

With respect to setting appointments, B&A found that almost every PMP in HHW would be available to see their patient for a same day appointment if it was an urgent situation. Between 87.2 and 92.5 percent (depending upon the MCO) would be available to see their doctor within two weeks for a routine exam. The rate of obtaining a consultation with a specialist within two weeks varied by MCO, but at least two-thirds of providers could see the HHW member within two weeks. The rates for obtaining a primary care routine visit or a consultation with a specialist within two weeks were even higher among HIP providers than HHW providers.

The results of our calls to HHW and HIP providers testing 24x7 access found that more than 90 percent of the time, the doctors in our sample had an outbound message on their office answering machine. This is an acceptable method from OMPP so long as the message includes information as to how the member can get in contact with the doctor. The OMPP does not explicitly state that MCOs must ensure that providers give out information if the patient calling has an emergency (e.g. call 911 or go the ER). Rather, it is required that providers give out a number that the patient can call to reach the provider if the situation is urgent. About 68 percent of Anthem and MHS providers sampled have a message instructing what to do in an emergency and 80 percent of MDwise providers had it. Three-quarters of MDwise providers had messages for both an emergency and to how to contact their doctor, yet just over half of the Anthem and MHS providers had both messages. For the audit for HIP providers, Anthem did better than the results found for their providers in HHW. MDwise scored slightly worse.

### Review of Retrospective Authorizations, Claim Denials and Claim Disputes

In last year's EQRs of HHW and the HIP, B&A conducted an extensive review of the MCOs' policies and procedures related to the authorization of services and utilization management. The review last year included an extensive sample of cases (960), primarily for prior authorization requests. A number of recommendations were made in this area to improve processes. These recommendations were given to the MCOs in January 2010.

This year, a more targeted review was conducted of retrospective authorizations (n=84) as well as clinical review of cases that resulted in claim denials (n=205). This review was completed by the B&A Clinical Review Team. Separately, B&A non-clinical staff reviewed the process for handling provider claims disputes with claims processing staff at each MCO. In addition to a review of policies and procedures, we examined a sample of 20 cases with the MCO staff during our onsite visits.

Observations Pertaining to Clinical Reviews of Authorizations or Claim Denials

Many of the issues or observations that B&A found were also identified in last year's EQR. Recognizing that these were not communicated back to the MCOs in time for improved outcomes in CY 2009, we look forward to a follow-up review in a future EQR after the MCOs have had an opportunity to make policy and procedure changes. That being said, some items remain noteworthy from this year's review of cases.

1. The definition of terms remains a challenge. The terms *retro authorization*, *claim appeal*, *claim dispute* and *grievance* mean different things to each MCO.

2. Format differences of how the MCOs collect and manage authorizations and claims data remains so distinctly different from each other that it significantly impairs a reviewer's (whether an EQRO, the OMPP or CMS) ability to easily collect and compare data and information. This observation is above and beyond the definition issue cited above.

3. It appeared that the MCOs did a better job providing clinical documentation for this year's EQR study.

4. Overall, the clinical review team found very few actual clinical issues that were disputed in either retro-authorization or claims disputes. The exception to this is the ER visits where the "prudent layperson" (PLP) rule was cited. Most cases in the sample were denied for administrative reasons. One example of this is "out of network" or "OON". Although we agree that this is a key issue in a managed care model of health care delivery, the fact that it is so often referenced in our very small sample raises the question of how effectively the MCOs are educating both the members and providers about this issue. We agree with the legitimacy of denying a claim for OON; however, it can be an ongoing reason why there is animosity and/or lack of participation by providers. It deserves to be looked at to see what more can be done to reduce the frequency of OON denials.

5. Although ER visits were not supposed to be included in the sample because of a previous PLP study conducted by the OMPP last year, a large percentage of retrospective authorization review cases included ER visits. It was our finding that not meeting the PLP rule was the main reason for denial. Our clinical review agreed that these denials were appropriately made by the MCO, at least when adequate records were included.

Other MCO-specific observations are cited in the report.

Findings Pertaining to the Review of Claim Disputes

The total number of disputes in both HHW and HIP is low as compared to the total number of claims denied. In HHW in CY 2009, there were 17,797 claim disputes reported across the three MCOs; in HIP, the total was only 1,147. On average, 3.0 percent of the claims denied in HHW were disputed by providers in CY 2009. This did not vary much between the MCOs (Anthem- 3.0%; MDwise- 2.0%; MHS- 3.8%). In HIP, 0.2 percent of Anthem's denied claims were disputed and 4.7 percent of MDwise's claims were disputed by providers.

From our onsite meetings, B&A made the following observations with respect to the specific cases reviewed in our sample:

1. Each MCO has a systematic process to intake, record and research the disputes received from providers.

2. Although each MCO has a specific form for providers to complete related to disputes, they each accepted any type of written communication (by fax or mail) that represented the provider's dispute.

3. The notes in the dispute file were complete enough to provide justification as to why the dispute was either upheld or overturned by the MCO.

4. There were situations where the MCO overturned its original denial and B&A concurred with this change. This was usually due to the MCO's error in how it processed the claim originally. In other cases where the denial was upheld, B&A also concurred with the MCO's rationale.

5. This being said, there was a preponderance of cases reviewed where the denial was upheld due to "untimely filing" of the dispute by the provider. It was often the case that the provider gave the MCO additional information to support overturning the denial, but this information was not considered by the MCO because the provider submitted the information past the 60 day filing limit post-adjudication. Although each MCO does allow for a few additional days to address mailing time (e.g., 65 to 67 days), it appears that additional provider education may be warranted as to their rights to dispute claims that are denied.

## Validation of Performance Measures

B&A utilized Attachment I from *"Validating Performance Measures: A protocol for use in conducting Medicaid External Quality Review activities" (May 2002)* as the template for assessing the validity of performance measure results reported by the HHW and HIP MCOs. The tool was customized based on the performance measure. For this year's EQR, some performance measures selected for validation are required to be reported in both HHW and HIP while others are unique to one of the programs. In all, four HHW measures were validated and four HIP measures were validated.

B&A reviewed the actual reports submitted to the OMPP from each MCO as part of a desk review. Onsite visits were held with MCO representatives familiar with each Performance Measure to discuss the methodology used to compile the data that was submitted on each report. The MCO representatives were instructed to be prepared to present to the reviewers a step-by-step methodology utilized to tabulate the results of the measure.

The purpose of the review was to ascertain the validity of the processes utilized within the reporting structures more so than the actual numbers on the reports. Specifically, B&A asked about how the data is accumulated and counted to determine if the MCOs were complying with reporting standards and definitions set forth by the OMPP. To the degree that the process was valid at each MCO, then results of each measure can be compared across MCOs.

Key findings from each measure reviewed revealed the following:

1. The actual data reported on *Provider Claims Disputes* reports appeared to be valid, but there were different interpretations among the MCOs on what information to provide on the report. As such, the results cannot be compared across the MCOs. Also, there were some data points that none of the MCOs counted on this report per OMPP instructions.

2. The data used to measure provider compliance in the MCOs' *24 Hour Availability Audit* reports appeared to be valid, but the OMPP should provide more clarity on the sampling methodology requirements and also what, in fact, defines compliance for providers that use an answering machine with an outbound message as their tool to meet the MCO requirement for 24 hour availability.

3. In the HHW report of *Maternity Inpatient Utilization*, the data elements that were required to be reported changed mid-year in 2009 by the OMPP. Additionally, MDwise appeared to be counting cases that they should not have. Overall, the data reported by MHS appeared to be valid but there were elements of the Anthem and MDwise reports that could not be validated.

4. In the HHW report of *Child Emergency Room Utilization*, the data used by each MCO to count ER visits appears to be valid, but the claims that are counted differ between Anthem and MDwise (paid claims only) and MHS (paid and denied claims). There is confusion as to what OMPP requires, but the different data sources means that the MCOs cannot be compared against each other.

5. The data reported on the HIP report for *Member Pregnancy Identification* appeared to be valid for both MCOs, but B&A offers suggestions to the OMPP on how to improve the report itself.

6. The data reported on the HIP report for *POWER Employer Participation* also appeared to be valid for both MCOs.

## Validation of Performance Improvement Projects

In our review of performance improvement projects (PIP), B&A utilized the CMS document "*Validating Performance Improvement Projects: A protocol for use in conducting Medicaid External Quality Review activities*" (May 2002) as the foundation for assessing the validity of PIP results reported by HHW MCOs. This tool focuses on the validity of the data reported rather than a critique of actual performance improvement, but the EQR organization is to assess whether there was any "real" improvement in the measure.

In this year's EQR, B&A examined three PIPs from each MCO in HHW. No PIPs were reviewed in the HIP since none were required by the OMPP in CY 2009. B&A used a CMS protocol for validating PIPs as was done for the validation of performance measures. During the onsite visits, B&A met with the MCO representatives familiar with each PIP to walk through the NCQA form that was completed on the PIP. In addition to a review of the data sources and methodology used to compile the results, B&A discussed with the MCO the interventions employed by the MCO in an effort to achieve real improvement. The PIPs that were validated included the following:

*Anthem*

1. Planning for follow-up care after hospitalization with a behavioral health diagnosis
2. Breast cancer screening rate
3. Lead screening in children

*MDwise*

1. Follow-up care for children prescribed ADHD medication, initiation phase
2. Adolescent well care visits
3. Comprehensive diabetes care LCL-C screening

*MHS*

1. Follow-up care after hospitalization with a behavioral health diagnosis
2. Breast cancer screening rate
3. Timely prenatal and post-partum visits

The MCOs each developed PIPs that were appropriate to the populations that they serve and were meaningful in working to improve outcomes in areas where unmet need was identified. Since all but one of the PIPs is related to a HEDIS[1] measure (Anthem's PIP #1 is similar to, but not the exact definition of, a HEDIS measure), B&A had confidence in the data that was collected and reported since the data sources were already validated by a HEDIS auditor. The MCOs did not always see "real" improvement in every PIP, but this was the first year that the MCOs submitted formalized PIPs to the OMPP. B&A encourages the MCOs to work cooperatively with the OMPP to share information that is most meaningful to measure "real" improvement in each PIP, specifically as it relates to detailed information on the interventions that were used as well as feedback on which interventions were most meaningful. This will encourage the sharing of best practices among the MCOs for use in all of HHW.

[1] Healthcare Effectiveness Data and Information Set. HEDIS is a registered trademark of NCQA.

# SECTION I: OVERVIEW OF INDIANA'S MEDICAID MANAGED CARE PROGRAMS

## Introduction

As the single state agency responsible for Indiana's Medicaid program, the Indiana Office of Medicaid Policy and Planning (OMPP) has implemented two managed care programs using Section 1115 waiver authority. The Hoosier Healthwise (HHW) program covers children, pregnant women, and low-income families. The program began in 1994 and was fully implemented in 1997. By the end of 2005, all Medicaid members that had previously enrolled in the HHW Primary Care Case Management (PCCM) system were transitioned into managed care organizations (MCOs). Effective January 1, 2008, the HHW program which had been implemented under a Section 1915(b) waiver was subsumed under the state's recently approved Section 1115 waiver.

Also part of the January 2008 Section 1115 approval was the creation of the Healthy Indiana Plan (HIP). The HIP covers two expansion populations[2]:

- Uninsured custodial parents and caretaker relatives of children eligible for Medicaid or the Children's Health Insurance Program (CHIP) with family income up to 200 percent of the Federal Poverty Level (FPL) but are not otherwise eligible for Medicaid or Medicare (the "HIP Caretakers")

- Uninsured noncustodial parents and childless adults ages 19 through 64 who are not otherwise eligible for Medicaid or Medicare with family income up to 200 percent of the FPL (the "HIP Adults")

For both Caretakers and Adults, eligibles cannot have access to employer-sponsored health insurance and must be uninsured for at least six months prior to enrollment in the HIP.

During the review period and in Calendar Year 2010, once members in HHW are notified of their eligibility for the program, they are asked to choose both the managed care organization (MCO) that they would like to enroll with as well as their primary medical provider (PMP). In the HIP, the choice of MCO is made at the time of application. A PMP selection is made later if the member chooses the MDwise MCO. If the member selects the Anthem MCO, no PMP selection is made since Anthem does not require this[3].

In both programs, if a new member does not select an MCO, the member is auto-assigned to a health plan by the OMPP. In the HIP, the applicant also fills out a health questionnaire during the application process. If it is determined that the applicant is eligible for HIP and meets the requirements for the ESP, then the new member is automatically enrolled in ESP.

[2] The HIP also has a very small fee-for-service component—known as the Enhanced Services Plan, or ESP—to provide services for eligibles with high risk conditions. A review of the ESP is not covered in this year's EQR.
[3] The policies mentioned in this paragraph will change effective with a new contract period in CY 2011.

## Benefit Package

The benefit package for the HIP is more limited in amount, duration and scope than the Package A HHW program. Exhibit I.1 outlines the benefits in both programs and limitations in the HIP.

**Exhibit I.1**
**Benefit Package for Members in the Hoosier Healthwise Program and Healthy Indiana Plan**

| Benefit | HHW | HIP | Notes on Benefit for HHW and HIP or Limits if Covered in the HIP |
|---|---|---|---|
| Inpatient Medical/Surgical | X | X | |
| Emergency room services | X | X | Self-referral<br>Co-pay for services for HIP members when the service is determined to be non-emergent |
| Urgent care | X | X | |
| Outpatient hospital | X | X | |
| Outpatient Mental Health and Substance Abuse | X | X | Medicaid Rehabilitation Option (MRO) and Psychiatric Residential Treatment Facility (PRTF) services are not the responsibility of the MCOs; Psychiatry is a self-referred service |
| Primary care physician services | X | X | |
| Preventive care services | X | X | |
| Immunizations | X | | Self-referral |
| EPSDT services | X | X | In HIP, lead screening only for members age 19 and 20 |
| Specialist physician services | X | X | |
| Radiology and pathology | X | X | |
| Physical, occupational and speech therapy | X | X | In HIP, 25-visit annual maximum for each type of therapy |
| Chiropractic services | X | | Self-referral |
| Podiatry services | X | | Self-referral |
| Eye care services | X | | Self-referral; excludes surgical services |
| Prescription Drug | X | X | Brand name drugs are not covered where a generic substitute is available. |
| Home health/Home IV therapy | X | X | Excludes custodial care but includes case management |
| Skilled Nursing Facility | X | X | |
| Ambulance | X | X | Emergency ambulance transportation only |
| Durable Medical Equipment | X | X | |
| Family Planning Services | X | X | Self-referral; excludes abortions, abortifacients |
| Hearing Aids | X | X | In HIP, ages 19 and 20 only |
| FQHC and Rural Health Center Services | X | X | In HIP, subject to the benefit coverage limits |
| Disease Management Services | X | X | |
| HIV/AIDS targeted case management | X | | Limited to 60 hrs/quarter to Package A and Package B members only |
| Diabetes self-management | X | | |
| Transportation | X | | |

Dental coverage is also available to HHW members, but this is not managed by the MCOs. The OMPP contracts with dentists and pays for these services on a fee-for-service basis. Additionally, HHW members are eligible for Individualized Education Plans (IEPs) and early intervention services (First Steps), but these are also carved out of the MCO capitation payment.

HIP POWER Account

The Personal Wellness and Responsibility (POWER) Account is the feature of the HIP that makes it unique among programs developed nationally for the low-income uninsured. The POWER Account is modeled on the concept of a Health Savings Account (HSA). A $1,100 allocation is created for each HIP member in his/her POWER Account annually. These dollars are funded through contributions from the member, the State (with federal matching dollars) and, in some cases, the member's employer. The member's annual household income is calculated at eligibility determination. The member's contribution to the $1,100 balance is calculated based upon household income (refer to Exhibit I.2 below). The member is billed for their POWER account contribution in 12 monthly installments throughout the year.

**Exhibit I.2**
**POWER Account Contributions**

| Annual Household Income | Maximum POWER Account Contribution |
|---|---|
| All enrollees at or below 100% FPL | No more than 2% of income |
| All enrollees above 100% through 125% FPL | No more than 3% of income |
| All enrollees above 125% through 150% FPL | No more than 4% of income |
| HIP Caretakers above 150% through 200% FPL | No more than 4.5% of income |
| HIP Adults above 150% through 200% FPL | No more than 5% of income |

A member's POWER Account contribution amount may be changed during the year due to extenuating circumstances causing a change in income. At a minimum, the POWER Account contribution is reviewed annually at redetermination when household income is also reviewed.

The POWER Account is intended for members to use to purchase health care services. However, in an effort to promote preventive care, the first $500 in preventive care benefits are not drawn against a member's POWER Account.

There is a financial incentive for members to seek the required preventive care for their age, gender and health status. If a HIP member is deemed to be eligible upon redetermination 12 months after enrolling and there are funds remaining in the member's POWER Account, the funds are rolled over into the next year's account if the member has met the program requirements for seeking annual preventive care. This will effectively reduce the amount of the member's monthly POWER Account contribution in year two.

If a member utilizes services in excess of the $1,100 in the POWER Account, s/he is not at risk. These costs are covered by the State.

## MCOs Contracted in the Hoosier Healthwise and Healthy Indiana Plan

The OMPP contracts with MCOs[4] to provide most services available to HHW and HIP members. The OMPP pays the MCOs a capitation rate per member per month (PMPM). Individual providers have the option to contract with one or more MCOs in HHW, the HIP, or both.

In HHW, there are three MCOs participating MCOs—Anthem, MDwise and Managed Health Services. In the HIP, two of these MCOs (Anthem and MDwise) are under contract with the OMPP[5].

Anthem

Anthem Blue Cross and Blue Shield is a licensed subsidiary of WellPoint which offers group and individual health benefits, life and disability products nationwide. In 2004, WellPoint Health Networks Inc. and Anthem, Inc. merged to create the largest commercial health benefits company in the United States. WellPoint is the parent company of 14 independent licensees of the Blue Cross and Blue Shield Association. As the nation's largest Medicaid managed care company, the state-sponsored business unit serves more than two million members in 14 states and Puerto Rico. WellPoint is based in Indianapolis. In Indiana, Anthem has subcontracted the management of behavioral health services to Magellan Health Services. Anthem has been under contract in HHW since January 2007 and in HIP since its inception in January 2008.

MDwise

MDwise is a locally-owned, non-profit MCO that has been participating in Hoosier Healthwise since its inception, first as a subcontractor and later as a prime contractor. In 2001, MDwise affiliated with the IU Health Plan, Inc. In January 2007, MDwise obtained its own HMO license with the State. MDwise subcontracts the management of services to ten delivery systems. At the beginning of the current contract period (effective January 2007), MDwise subcontracted the management of behavioral health services to CompCare. In January 2009, this was transitioned back to the ten delivery systems. Supplementing the delivery systems are networks for pharmacy and transportation services. MDwise is based in Indianapolis.

Managed Health Services

Managed Health Services (MHS) is a subsidiary of Centene Corporation, a St. Louis-based Medicaid managed care company serving beneficiaries in eight states. MHS began serving the Hoosier Healthwise population in 1994. MHS's headquarters is located in Indianapolis. MHS utilizes another Centene subsidiary, Cenpatico, for the management of behavioral health services in HHW. It also leverages other Centene-owned subsidiaries such as NurseWise (nurse hotline), US Script (pharmacy benefit manager), Cardium Health (disease management) and AirLogix (respiratory disease management).

[4] In the HIP, the OMPP refers to the contracted entities as health plans, not MCOs. For the purpose of this EQR report, B&A uses the term MCO to refer to both the Hoosier Healthwise MCOs and the HIP health plans.
[5] Effective January 1, 2011, Managed Health Services will also be a participating MCO in the HIP.

## Profile of Hoosier Healthwise and Healthy Indiana Plan Members

Enrollment in HHW was near 750,000 by the end of CY 2009 and enrollment in HIP was just above 45,000 members. Enrollment grew among HHW children by 6.0 percent from the end of 2008 to the end of 2009, while enrollment among HHW adults remained flat. The HIP enrollment grew 29.2 percent in CY 2009 which is a result of the fact that the program was just introduced in January 2008.

**Exhibit I.3**
**Enrollment Trends in Hoosier Healthwise and Healthy Indiana Plan**

| | Hoosier Healthwise Children | Hoosier Healthwise Adults | HIP Members |
|---|---|---|---|
| December 2007 | 551,083 | 132,568 | |
| December 2008 | 574,477 | 138,998 | 35,381 |
| December 2009 | 608,793 | 139,410 | 45,701 |
| **Pct Change 08-09** | **6.0%** | **0.3%** | **29.2%** |

Source: MedInsight, OMPP's Data Warehouse
B&A retrieved enrollment data the week of May 10, 2010

When member months for all of CY 2009 were analyzed in HHW and the HIP, it was found that MDwise had the largest share of both HHW children and adults. MHS's share of HHW children was smaller than MDwise but larger than Anthem. The share of HHW adults was similar between Anthem and MHS. In the HIP, Anthem has two-thirds of the membership and MDwise has one-third. There is a similar distribution of members by race/ethnicity between HHW children and adults. The composition of the HIP, however, is more heavily weighted towards Caucasians.

**Exhibit I.4**
**Profile of Members in Hoosier Healthwise and Healthy Indiana Plan**
**For the Calendar Year 2009**

| | Hoosier Healthwise Children | Hoosier Healthwise Adults | Healthy Indiana Plan Members |
|---|---|---|---|
| By MCO | | | |
| Anthem | 23% | 29% | 66% |
| MDwise | 45% | 43% | 34% |
| MHS | 32% | 28% | |
| By Race/Ethnicity | | | |
| Caucasian | 62% | 65% | 82% |
| African-American | 22% | 23% | 13% |
| Hispanic | 13% | 10% | 3% |
| Other | 3% | 3% | 3% |

Source: MedInsight, OMPP's Data Warehouse
B&A retrieved enrollment data the week of May 10, 2010

# SECTION II: APPROACH TO THIS YEAR'S EXTERNAL QUALITY REVIEW

## Background

In CY 2008, Burns & Associates (B&A) conducted an external quality review (EQR) of all aspects of managed care organization (MCO) operations in the Hoosier Healthwise (HHW) program. This was the first year of a new contracting cycle (the new contract period took effect January 1, 2007 and the EQR covered the CY 2007 period). The methodology used to make our assessment followed a protocol defined by CMS in *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al."* published in February 2003. In some instances, B&A developed additional review criteria in addition to what the Code of Federal Regulations (CFR) required in order to review specific contract provisions that were put in place by the Office of Medicaid Policy and Planning (OMPP) which oversees the HHW program.

B&A also conducted the validation of performance measures but did not validate any performance improvement projects since none were specifically required by the OMPP in this contract year.

In CY 2009, B&A conducted focus studies on three aspects of the HHW:

- A review of prior authorization policies, procedures and functions as well an examination of the consistency of application of those policies across 960 cases
- A review of claims edit, adjudication and audit functions and a review of 100 case files to test policies, procedures and pricing logic
- A survey of Primary Medical Providers (PMPs) to assess their satisfaction in working with the MCO they are contracted with and with the OMPP

Also in CY 2009, B&A conducted an EQR of all aspects of managed care operations for the MCOs participating in the Healthy Indiana Plan (HIP) since this was the first EQR study for the HIP (the program began January 1, 2008). Again, the CMS protocol was used as the basis for assessing MCO compliance with CFR requirements and OMPP-defined contractual requirements.

## External Quality Review in CY 2010

In 2010, the OMPP once again contracted with B&A to conduct EQRs of both the HHW and the HIP. This year, in cooperation with the OMPP staff, B&A developed an EQR approach that consists of a series of focus studies that are applicable to both the HHW and the HIP. The results from each focus study appear as a chapter in this report. In most cases, the processes reviewed for the HHW and HIP were the same, but it is often the case that findings are reported for each program independently. The focus areas identified for this year' review include:

- A review of MCO initiatives to address cultural competency
- A review of program integrity activities at each MCO
- An examination of member's accessibility to providers and the availability of these providers to serve HHW and HIP members
- A clinical review of retroactive authorizations and some claim denials as well as an administrative review of claims dispute cases
- Validation of six performance measures
- Validation of nine performance improvement projects (PIPs)

In preparation for this year's review, B&A developed an initial list of interview questions for each MCO related to data collection activities. The answers to these questions informed the EQR Guide which was released to the MCOs on June 22. The EQR Guide (included as Appendix A of this report) described in broad terms the goals of each focus study and provided an information request list of items related to each focus study. One series of materials were due back to B&A on July 6th; a second set of materials were due back July 13th.

The B&A EQR team conducted a desk review of the materials in July. Also during this time, a listing of case files was provided to each MCO for review either during onsite sessions in August or as part of the desk review. These included:

- Provider credentialing and recredentialing files
- Cases led by the Program Integrity unit that investigated potential fraud or abuse
- Retroactive authorizations and claims that were denied on the basis of clinical reasons
- Provider claim disputes

The EQR team spent two full days and one half day onsite with each MCO (Anthem, MDwise and MHS) during the period August 3-5, August 23-25 and September 9-10. For each onsite session, B&A prepared structured interviews to discuss in more detail the desk materials reviewed. During some of the sessions, case files were also reviewed. The first sessions addressed cultural competency and program integrity. The second sessions were spent validating performance measures. The third sessions were spent validating PIPs. The reviews for provider accessibility and availability and the clinical reviews were all completed as desk reviews.

For all review items, the EQR team worked in pairs or trios so that reviewers could compare findings and collaborate on how to structure the onsite interviews. The same personnel were responsible for all aspects within a focus study, including the desk review, the onsite interviews and writing up the findings for this report. This year's review team included the following staff:

- Mark Podrazik- Project Manager, Burns & Associates, Inc. Participated in all aspects of the review and primary report author. Previously, Mr. Podrazik has led the EQRs of HHW in CY 2005 and CYs 2007-2009 as well as the EQR for the HIP in CY 2009.

- Steven Abele- Senior Consultant, Burns & Associates, Inc. Participated in the validation of performance measures and performance improvement projects.

- Cindy Collier, Cindy Collier Consulting, LLC. Participated in the review of cultural competency and program integrity functions as well as the provider availability audit. Ms. Collier also participated in B&A's EQRs for Indiana programs in CYs 2007-2009.

- Dr. Linda Gunn, AGS Consulting, Inc. Participated in the review of cultural competency and program integrity functions. Dr. Gunn also participated in the 2009 EQR of the HIP.

- Dr. CJ Hindman and Dr. Judy Beckner, Kachina Medical Consultants. Dr. Hindman served as the Clinical Lead for the authorizations review. Both physicians reviewed the individual case files. They also served on last year's EQR Clinical Review Team.

- Rae Bennett, RN, Brightstar Healthcare. Assisted Dr. Hindman in the authorizations review. Ms. Bennett also participated in B&A's authorization review last year.

- Additional technical assistance was provided by Burns & Associates staff in relation to the analysis of provider accessibility and availability—Jesse Eng, Ryan Kelly and Barry Smith.

# SECTION III: REVIEW OF CULTURAL COMPETENCY INITIATIVES

## Introduction

Federal regulations mandate that managed care organizations (MCOs) participating in the Medicaid program must adhere to state initiatives that address cultural competency.

> 42 CFR §438.206(c)(2) *Cultural considerations.*
> Each MCO …. participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

In the current contracts for the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP), the Office of Medicare Policy and Planning (OMPP) has not stated specific requirements other than to encourage the MCOs to outreach to a number of stakeholders that may assist in addressing the cultural needs of its members in an effort to reduce health disparities.

> *From the Hoosier Healthwise Scope of Work*
> *Section 3.2.2 Member Information and Education Programs*
> The MCO will be responsible for developing and maintaining member education programs designed to provide the members with clear, concise, and accurate information about the MCO's program, the MCO's network, and the Hoosier Healthwise program. The State encourages the MCO to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs. The State encourages the MCO to develop community partnerships with these types of organizations, in particular with school based health centers, community mental health centers, WIC clinics, county health departments, and prenatal clinics to promote health and wellness within its Hoosier Healthwise membership.
>
> The MCO's educational activities and services should also address the special needs of specific Hoosier Healthwise subpopulations (e.g., pregnant women, newborns, early childhood, at-risk members, children with special needs) as well as its general membership. The MCO must demonstrate how these educational interventions reduce barriers to health care and improve health outcomes for members.
>
> *From the Healthy Indiana Plan Scope of Work, Section 4.8 Cultural Competency*
> The Plan will be required to comply with cultural competency standards established by OMPP, which will include standards for non-English speaking, minority and disabled populations.

For this external quality review, Burns & Associates, Inc. (B&A) reviewed cultural competency initiatives that the HHW and HIP MCOs have developed in the context of national CLAS (Culturally and Linguistically Appropriate Services) standards. Finalized in December 2000 by the U.S. Department of Health and Human Service's Office of Minority Health, the CLAS standards were developed to support "a more consistent and comprehensive approach to cultural and linguistic competence in health care[6].

[6] National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report. U.S. Department of Health and Human Services, OPHS, Office of Minority Health. March 2001, Washington, DC

## The Fourteen CLAS Standards

**Standard 1 -** Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

**Standard 2 -** Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

**Standard 3** - Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

**Standard 4** - Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

**Standard 5** - Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

**Standard 6** - Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

**Standard 7** - Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

**Standard 8 -** Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

**Standard 9 -** Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

**Standard 10 -** Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

**Standard 11 -** Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

**Standard 12 -** Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

**Standard 13 -** Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

**Standard 14 -** Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

According to the Office of Minority Health's report, the CLAS standards are intended for use primarily by health care organizations. However, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible.

## MCO Approaches to Cultural Competency

B&A reviewed materials from the HHW and HIP MCOs provided to us for this review as they relate to cultural competency. We also conducted in-person interviews with MCO staff that have primary responsibility for cultural competency initiatives. This included MCO staff in the member services, provider relations, compliance, human resources and quality areas at each organization. Anthem and MDwise served both the HHW and HIP populations in CY 2009. Both reported that they had one cultural competency approach to serve both programs, so B&A did not conduct an HHW-specific nor a HIP-specific cultural competency program.

In the following pages, we report our findings from each MCO to address cultural competency as they relate to the CLAS standards. Many of the findings were common among all three MCOs. Initiatives unique to an MCO are identified separately.

Standard 1 — Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

All three MCOs track member grievance and appeals and identify those specific to quality of care issues. Where appropriate, the MCO will intervene to assess when the provider/member relationship can be improved. Citations in a provider's file expressing quality of care concerns from members are factored into the provider recredentialing process.

Standard 2 — Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Anthem did not report non-English languages spoken by HHW and HIP member services representatives. MDwise reported that they have an unofficial rule to hire another non-English speaking customer service representative (CSR) for every 10 percent of the population that speaks the non-English language. However, they reported that currently more than a half dozen languages (including Burmese) are spoken by CSR staff in addition to English. MHS reported that they have three CSRs on staff that speak Spanish as well as two Connections (social workers out in the field) that speak Spanish. They are also looking to hire a Burmese-speaking CSR.

Standard 3 — Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Each MCO reported that all new hires at the MCO receive at a minimum one training session on cultural competency and in understanding how the Medicaid program differs from commercial

plans. Training logs are kept to ensure that everyone has received this training. Additional training is provided to front-line staff that interacts with members on a day-to-day basis (e.g. member services, nurses). Anthem also stated that there is a corporate diversity training module that is optional which employees can access via the web. MDwise stated that it is in the process of adding three training sessions to a cultural competency curriculum.

Each MCO identified somewhat different approaches to training the providers that they contract with. Anthem has changed the manner in which it compensates primary medical providers for quality from an automatic per member per month (PMPM) stipend to quality-based incentive payments based on member's care. Representatives from Anthem's Community Resource Centers (CRCs) meet with providers in their office to reiterate all of the tools available to providers to best serve their HHW or HIP panel. Separately, provider network staff conduct an orientation with new providers and address Anthem's cultural competency initiatives at that time. Providers are given a Cultural Competency Toolkit which includes tips on cultural competency, language barriers, translation services and office signage.

MDwise focuses its provider training on member's health literacy. The focus is on providing guidance to providers to enable them to explain the health care that members are receiving in a way that members can understand, whether it be in English or a non-English language.

MHS stated that they are working toward developing training to providers that suits the professional level of the provider. The latest set of training materials were vetted both internally and externally for appropriateness.

All three MCOs mentioned targeted training to a select group of providers in Allen and Marion Counties that have started to serve the burgeoning Burmese-speaking population in Indiana (see more information in the *Spotlight on Cultural Competency: Preparing for the Influx of Burmese in Hoosier Healthwise*). They each have on their website a link for providers that shows how they can receive CME credit for taking a cultural competency course online.

Standard 4 — Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

The three MCOs cited English and Spanish as the two primary languages spoken in the Member Services call center. MDwise also reported that five other languages are spoken by specific representatives. When a language is needed that is not spoken in the call center, all three MCOs utilize an AT&T Language Line where more than 150 languages are available. Although the MCOs reported that the language line is used infrequently, the most common use lately is to translate information into Burmese for members.

The MCOs each give its provider offices instructions on accessing the Language Line if translation services are needed at the office. Each has also provided a quick reference chart of

***Spotlight on Cultural Competency: Preparing for the Influx of Burmese in Hoosier Healthwise***

Since 2007, with the support of groups like Catholic Charities, Burmese refugees have been migrating to Fort Wayne, Indiana and more recently to Indianapolis. Fort Wayne now has the largest population of Burmese people in the world living outside of Burma. As refugees, many of these individuals became eligible for Medicaid and were enrolled in the state's Hoosier Healthwise program.

The health care needs of this population were significant, confounded by the fact that the Burmese language in both verbal and written form is unfamiliar to most Americans. In an effort to address the needs of this population, the three Hoosier Healthwise MCOs collaboratively worked with the OMPP to develop information for the newly-eligible Medicaid enrollees on how to access health care.

It was quickly learned that there were additional challenges to serve this population. Notwithstanding their lack of English proficiency, as refugees many individuals also had limited reading skills in the Burmese language as well. There are also a number of dialects in the Burmese language, each with its own unique syntax.

The Hoosier Healthwise MCOs learned and adapted the cultural needs of this new population in how they deliver services. For example,

- The Hoosier Healthwise Member Handbook was translated into Burmese along with a number of flyers containing key points of basic health care guidelines.

- The MCOs collectively sponsored training with local advocacy groups in Fort Wayne that serve the Burmese population about what to expect in the Medicaid program, how to navigate the system, and information sources at each MCO.

- Informational sessions were held in "Little Burma" in the apartment complexes in Fort Wayne where a number of the Burmese refugees live.

- The MCOs identified individual providers in Fort Wayne and Indianapolis that were willing to accept Burmese members and gave them educational training about Burmese customs related to religious beliefs, family structure and decision-making and the local Burmese population.

- The MCOs identified transportation providers that would transport Burmese individuals to medical appointments. There was some initial frustration because some Burmese would not answer a car horn or a knock at the door from the transportation provider during family dinner hour. Also, members were confused when they were dropped off by the transportation provider because they did not know what to do next. The MCOs developed specific protocols to work with the Burmese members so that a translator accompanies the member to the doctor's office visit.

- The MCOs also provided materials to the doctor's office that show pictograms that assist doctors and the member's translator understand if the Burmese members understand the health care information that is being explained to them.

In addition to these efforts, the MCOs are working to expand their own staffing to be culturally aware of the Burmese population's needs. MDwise hired a Burmese-speaking customer service representative and MHS has been actively recruiting for one. The transportation vendor that subcontracts to both Anthem and MHS also hired a Burmese individual to assist with coordinating transportation.

common non-English languages listed (including American Sign Language) so members can point to the language that they need information translated into.

Standard 5 Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Members from all three MCOs are notified of the availability of translator services (verbal or written) free of change in the Member Handbook, once a year in the member newsletter, and on the MCO's website.

Standard 6 Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

The MCOs expressly stated that the use of family or friends was not the most appropriate resource to use to translate information to HHW and HIP members. This is because of a concern of the health literacy of the translator and the relationship of the translator to the member in conveying information on health status (e.g. daughter to mother). The MCOs inquire if a physician's practice (either the doctor or staff member) speaks a language other than English, but it is self-reported with no confirmation for competency.

Standard 7 Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

MDwise's corporate policy is to have all materials sent out in both English and Spanish to alleviate the need for requests to translate into Spanish. Anthem and MHS have some materials commonly requested already translated into Spanish which can be produced rapidly (e.g. within a day). Because of the influx of the Burmese-speaking population, both MDwise and MHS have already printed Member Handbooks and other fliers in Burmese that are ready to be sent out.

The decision on materials that are available quickly in non-English format is decided by each MCO. The three MCOs have named English, Spanish and Burmese as "threshold" languages. Depending upon the language and the materials to be translated, the timing of translation can vary. Anthem reported that it can take between three and 21 days to translate into another language or into Braille. MDwise reported that it typically can take between four and five days. MHS reported between one and two weeks for some materials but only a few days for others. Each MCO identified a specific entity that they use to translate all materials upon request. Materials are also vetted by internal staff after the translation firm produces the document for verification that the information was not only translated properly, but that is also conveys the correct tone or is stated in a way that is easy to understand. Most recently, this process was done for materials translated into Burmese and some materials were even translated into multiple dialects in the Burmese language.

Standard 8 Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Anthem reported that their strategic plan for cultural competency is developed at the national level for both the commercial and state-sponsored business combined. The focus of this strategic plan is based on the CLAS standards; however, there is not a specific strategic plan articulated for the Indiana HHW and HIP programs. Also, the implementation of strategic plan initiatives was put on hold in the past year as the whole strategic plan was overhauled.

MDwise stated that its strategic plan for cultural competency is interwoven into all of its departments as part of its core mission. In its corporate policy labeled Cultural Competency, it states that MDwise

> "…recognizes the need to provide care and services to members with diverse values, beliefs and behaviors, including tailoring delivery to meet members' ethnic, cultural, and linguistic needs. Cultural competency requires the recognition and integration by MDwise providers and staff of members' behaviors, values, norms, practices, attitudes and beliefs about disease causation and prevention into administrative and health care services provided."

Within the policy, specific responsibilities are assigned to the Compliance Officer, Director of Customer Service, Director of Provider Relations, and the Director of Human Resources.

MHS developed a CLAS Committee in late CY 2009 which is intended to meet ten times per year. The Committee is composed of representatives from Member Services, Provider Services, Human Resources, Marketing and Outreach, Quality and Compliance and reports to the Quality Improvement Committee. The initial task of the Committee was to compare existing MHS initiatives against the 14 CLAS standards to identify areas for improvement.

Standard 9 Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

To date, none of the MCOs has conducted a formal review of CLAS-related activities, but this may be because many of the activities were just put into place in late 2009 or early 2010. MHS did report that they have retained a contractor to conduct a survey of members every other year to assess member attitudes towards HHW. They have also recently started tracking member complaint data to identify those complaints that are related to cultural competency.

Standard 10 Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

When asked about the data that is tracked in information systems about their members, all three MCOs cited that they store the member's race. This information has been recently provided to the MCOs by the OMPP, so the MCOs also use other sources to obtain race in addition to the data feed from the state, such as member assessments, calls with members, and case tracking in the disease management program. Ethnicity is not recorded on a systematic basis except for Hispanic members, since this is provided by the state. Members' language is only recorded when the MCOs come into contact with the member through customer service, case management, or face-to-face meetings (e.g., Anthem's CRC team or MHS's Connections teams that are in the field). MDwise also reported that they track the number of calls into the Member Services line that are initiated by non-English speaking members.

Because of the recent increase in Burmese-speaking members, the three MCOs also cited that they are tracking the refugee status of new members that is sent to them on enrollment files from the state since most of the refugees are coming from Burma (although the country of origin is not indicated in the data provided by the OMPP).

Anthem reports that they have used race and ethnicity to measure disparities in some, but not all, HEDIS measures. MDwise stated that they use this information to conduct a care gap analysis. One example was stratifying the incidence of low birth weight babies by race/ethnicity.

Standard 11 Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Anthem, MDwise and MHS reported that they are using GeoAccess reports to overlay the location of Spanish-speaking members with Spanish-speaking providers to identify where gaps may occur in their provider base. The MCOs stated that they use multiple approaches to address this gap. First, they work with existing providers who speak Spanish to expand the provider's panel size. Second, they are accessing other state provider lists to try to recruit providers known to speak Spanish. Third, they are calling providers in the gap area to identify if someone in the office other than the provider can translate into Spanish. MDwise had as a quality initiative in CY 2009 a goal to have a Spanish-speaking primary care provider within 30 miles of all members throughout the state.

Standard 12 Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Each MCO identified specific initiatives that they have conducted to collaborate with people outside their organization to facilitate community and patient involvement in their own health care.

*Anthem*

1. Led health parties in the apartment complexes in Allen County where a significant number of Burmese refugees live and at the Buddhist Center in Fort Wayne to educate new members about accessing health care.
2. Coordinate "Anthem Days" at local Federally Qualified Health Centers (FQHCs) to educate members and to identify members that may have additional needs due to cultural differences.
3. Developed an outreach program of customized interventions among pregnant African-American teens in their communities related to smoking cessation.

*MDwise*

1. Implemented a Text4Babies program that gives pregnant Hispanic women a phone in which she can receive periodic texts related to caring for her newborn.
2. Work with the Office of Minority Health at the Indiana Department of Health to provide an education booth at the annual INShape Indiana Black and Minority Health Fair held each year.
3. Outreach work with the Mexican consulate in Indianapolis.

*MHS*

1. Free seminars called Healthy Lifestyles in which MHS partners with faith-based communities at their location to promote healthy lifestyles.
2. Free phones to members with pre-recorded numbers to call primary medical providers, transportation providers, or MHS in an effort to promote accessing health care.
3. Health fairs at other community events around the state such as the Boys and Girls Club, State Fair's Hispanic Latino Music Day, Parents Empowerment Summit at the Indiana Black Expo, Shalom Back to School Health and Safety Fair, Mid-North Back-to-School event, and the Hispanic Latino Health Coalition Fair.

Standard 13 Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Thus far, there has been limited emphasis on this standard among the HHW and HIP MCOs. MHS, however, has stated that in 2010 it has begun to specially track grievances and appeals that have a cultural concern. One other item that recently surfaced was resolving expectations between transportation providers and Burmese members, since both the transportation providers and the members needed to be educated as to what the members are expected to do when the taxi driver is waiting outside the member's residence.

Standard 14 Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Anthem holds community advisory committee meetings at the Community Resource Centers on a quarterly basis. MHS has a member advisory council in place where opinions are sought from members on outreach ideas and materials. MHS and MDwise hold baby showers for new mothers which are used as an opportunity to measure quality of services delivered to members. MDwise began community advisory groups in 2010 to bring in regional leaders to better understand regional differences in accessing health care for MDwise members. MDwise's marketing department will also conduct focus groups on the efficacy of promotional materials, for example, on Spanish language fliers.

## Best Practices

1. Anthem's Cultural Competency Toolkit to providers, recently introduced, is specific to their state-sponsored business which focuses on Medicaid beneficiaries. It is used as an in-person tool to educate providers on cultural competency (Standard #12).

2. MDwise releases all of its materials in English and Spanish, avoiding the need for Spanish-speaking members to have to specifically request these materials. Additionally, they release materials specific to different communities in their program which are customized to the targeted group they are trying to outreach (Standards #5, #7).

3. MHS has already completed a CLAS standards internal evaluation and is taking action on items to develop protocols that adhere to the 14 CLAS standards (Standard #8).

4. All of the MCOs illustrated numerous examples of different ways that they outreach with a variety of communities that may participate in HHW and HIP. Additionally, the HHW MCOs worked together collaboratively to develop culturally sensitive materials and procedures for working with the growing Burmese population in Allen County (Standard #12).

## Areas of Opportunity

1. It is apparent to the review team that both Anthem and MDwise have numerous initiatives related to cultural competency, but B&A would encourage both MCOs to utilize the CLAS standards as a tool to ensure that their strategic work plan for cultural competency encompasses all elements cited in the CLAS (Standard #8).

2. Anthem and MHS may want to consider making at least some materials available in English and Spanish upon release like MDwise does (Standard #7).

3. Now that race/ethnicity data has become more readily available from the OMPP, B&A recommends that the MCOs utilize this data more proactively in conjunction with claims data to better target health disparities within HHW and HIP populations (Standard #10).

4. MCOs may consider sharing the primary language spoken by the member as soon as they are aware of it with the member's primary medical provider (Standard #11).

5. Use the credentialing and recredentialing process to assist in tracking languages spoken by providers since they may appear on the application (Standard #11).

6. MCOs should run a random sample audit of physician offices that self-report that they speak non-English languages to ensure that this is true (Standard #11).

7. MCOs should conduct ongoing assessments of CLAS-related activities (Standard #9) and grievance processes (Standard #13) with an eye for cultural competency.

# SECTION IV: REVIEW OF MCO EFFORTS TO ADDRESS PROGRAM INTEGRITY

## Introduction

Another component of this year's external quality review (EQR) related to efforts by contracted managed care organizations (MCOs) is to ensure the integrity of the Hoosier Healthwise (HHW) program and the Healthy Indiana Plan (HIP). Specifically, Burns & Associates, Inc. (B&A) reviewed policies and procedures related to the credentialing and recredentialing of providers as well as procedures to detect member, provider or employee fraud and abuse. For each topic, the EQR team interviewed the appropriate staff at each MCO that are responsible for these program integrity efforts as well as reviewed credentialing case files and fraud or abuse case files.

B&A utilized federal regulations and Office of Medicaid Policy and Planning (OMPP) contractual requirements to guide our review of these topics.

Related to credentialing and recredentialing

> 42 CFR §438.214 (b) *Credentialing and recredentialing requirements.*
> (1) Each State must establish a uniform credentialing and recredentialing policy that each MCO… must follow.
> (2) Each MCO… must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO...
>
> 42 CFR §438.214 (d) *Excluded providers.* MCOs… may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. [see also 42 CFR §438.610 *Prohibited affiliations with individuals debarred by Federal agencies.*]
>
> *From the Hoosier Healthwise Scope of Work, Section 4.5 and the Healthy Indiana Plan Scope of Work, Section 5.5 Provider Credentialing*
> The MCO must have written credentialing and re-credentialing policies and procedures for ensuring quality of care is maintained or improved and assuring that all contracted providers hold current State licensure and enrollment in the IHCP [Indiana Health Coverage Programs]. The MCO's credentialing and re-credentialing process for all contracted providers must meet the National Committee for Quality Assurance (NCQA) guidelines.
>
> The MCO must ensure that providers agree to meet all of OMPP's and MCO's standards for credentialing PMPs and specialists, including compliance with State record keeping requirements, OMPP's access and availability standards, and other quality improvement program standards.

Related to detecting fraud and abuse

> 42 CFR §438.608 *Program integrity requirements.*
> (a) General requirement. The MCO… must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

(b) Specific requirements. The arrangements or procedures must include the following:
(1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.
(2) The designation of a compliance officer and a compliance committee that are accountable to senior management.
(3) Effective training and education for the compliance officer and the organization's employees.
(4) Effective lines of communication between the compliance officer and the organization's employees.
(5) Enforcement of standards through well-publicized disciplinary guidelines.
(6) Provision for internal monitoring and auditing.
(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's or PIHP's contract.

In the HHW and HIP Scope of Work, the program integrity requirements stated in 42 CFR §438.608 are repeated along with the following:

*From the Hoosier Healthwise Scope of Work, Section 5.3 and Healthy Indiana Plan Scope of Work, Section 6.3 Program Integrity Plan*
As part of the annual Quality Management and Improvement Work Plan Report, the MCO must include program integrity activities. The work plan must detail program integrity-related goals, objectives and planned activities for the upcoming year. This plan must be updated annually and submitted to OMPP as part of the MCO's Quality Management and Improvement Work Plan.

The MCO must immediately report any suspicion or knowledge of fraud and abuse including, but not limited to the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent. The MCO must report provider fraud to OMPP, the Indiana Medicaid Fraud Control Unit (IMFCU) and the Surveillance and Utilization Review Unit (SUR). The MCO must report member fraud to OMPP, the SUR, the Indiana Bureau of Investigation and the Office of the Inspector General.

The MCO must not attempt to investigate or resolve the reported suspicion, knowledge or action without informing the IMFCU and OMPP and must cooperate fully in any investigation by the IMFCU or subsequent legal action that may result from such an investigation.

## Review of Credentialing and Recredentialing Activities

The credentialing and recredentialing function of contracted providers is a coordinated effort at each of the HHW and HIP MCOs. The actual activity of conducting the verifications for credentialing or recredentialing is completed by delegated entities (for MDwise and MHS) or other subsidiaries of the organization (Anthem). But the final decision to accept the recommendation to credential or recredential providers is completed by a credentialing committee housed at the MCO's headquarters.

Process Utilized at Anthem
For Anthem, many verification functions are completed by a unit within Anthem located in Massachusetts. Another team located in Ohio and Indiana conducts additional research for those

providers that meet a Level 2 review. A third unit housed within Anthem's HHW and HIP operations monitors providers against federal exclusions lists maintained by the National Practitioner Data Bank (NPDB), the Office of Inspector General (OIG) and the Drug Enforcement Administration (DEA). These lists are continually monitored based on the periodicity of the updates to the list.

In Indiana, Anthem reported approximately 300 files are reviewed each month (includes commercial and Medicaid products). Recredentialing is done on every provider once every three years. Anthem follows NCQA standards with respect to which individual and institutional providers are required to be credentialed or recredentialed. Because state law prohibits nurse practitioners and physician assistants from practicing independently, these providers are not credentialed.

Anthem stated that there is no real difference between the process conducted for credentialing and recredentialing, with two exceptions. An individual provider's educational background is only verified at the time of credentialing. Likewise, office site visits are only done at credentialing, and even then only for primary medical providers, OB/GYNs, and high level behavioral health providers (per NCQA guidelines).

All providers must be approved by the MCO's Chief Medical Officer (CMO). Level 1 (also referred to as "clean") credential and recredential files are those in which all required elements are met and the scoring within the credential file merits approval. These are given to the CMO once a week to approve. Level 2 (also referred to as "unclean") files are those that are presented to the credentialing committee. Anthem reported that some items that may merit a Level 2 assignment include sanctions against the provider, hospital actions, or the volume or type of member complaints reported against the provider. There are occasions where a provider is reviewed by the committee "off cycle", i.e., not when their three-year recredentialing anniversary is due. This is typically when member issues reported about the provider are elevated.

The Anthem credentialing committee is chaired by the CMO but consists of multiple specialists that presently include a family practitioner, OB/GYN, general surgeon, and a behavioral health specialist. Membership rotates on a periodic basis.

<u>Process Utilized at MHS</u>
MHS shares credentialing and recredentialing activities for its 7,000 practitioners with six delegated entities. MHS retains responsibility internally for approximately 90 percent of the primary medical providers and two-thirds of the specialists. MHS has developed a delegated oversight protocol in line with NCQA standards in which each delegate is reviewed no less frequently than every 14 months. Within MHS, two full time staff handle the credentialing and recredentialing efforts. MHS reported that the provider's use of the Council for Affordable Quality Healthcare's (CAQH's) and the internet have streamlined the verification processes in credentialing activities significantly. The internal staff is responsible for checking the federal exclusion lists (NPDB, OIG and DEA). These are checked monthly for all credentialed providers as well as the Indiana License Bureau and CAQH.

MHS estimated that at least 2,500 recredentials are completed each year but that this fluctuates based on historical contracting efforts. Recredentialing is completed once every three years. They start the process six months prior to the three-year anniversary with a stronger push 90 days prior to the anniversary to achieve compliance.

Similar to Anthem, MHS reported that the process for recredentialing individual and institutional providers is the same as the credentialing process. One additional piece of information brought forward to the credentialing committee on recredentialing cases is any exceptions noted in a practitioner's file related to standards of care.

MHS follows NCQA with respect to the requirements for credentialing as well as the providers that must be credentialed. Like Anthem, they do not credential nurse practitioners or physician assistants. Office site visits are conducted upon initial credentialing for PMPs, OB/GYNs and high-volume behavioral health providers. Additionally, they are done at recredentialing even though this is not required by NCQA.

The credentialing committee at MHS meets monthly to review cases. Their portfolio includes all cases reviewed by the delegated entities, all internal cases that did not meet a targeted scoring threshold to be determined "clean", plus any case that deviated from the usual standard of care. There are five to six standing members on the committee which rotate periodically. Although the MHS CMO sits on the committee, an external physician chairs the committee.

Process Utilized at MDwise

MDwise delegates all credentialing functions to its delivery systems, including the activities of the credentialing committee and maintaining review of the federal exclusion lists. A delegation audit is completed on an annual basis of each delivery system and any subdelegates that they use related to credentialing providers. Part of the audit includes reviewing the minutes of each delivery system's credentialing committee meetings and reviewing each case that was determined "unclean" that required review by the committee. Attention is paid to any case where a delivery system may have approved credentialing or recredentialing that was in conflict with MDwise's Medical Advisory Committee policies. The audit also verifies that ongoing monitoring is occurring to check the NPDB, OIG, and DEA lists as well as the minutes of meetings of the state licensing agencies.

MDwise and its delivery systems follow NCQA with respect to elements required for credentialing as well as which providers must be credentialed. Although nurse practitioners are not credentialed in Indiana as a matter of course, some delivery systems choose to list them in their provider directories. When this is done, the delivery system will credential the nurse practitioner. Office site visits are only done on those providers that NCQA requires site reviews at initial credentialing.

Each delivery system recredentials its providers at least once every three years, although some are on an every other year cycle. The delivery system provides a list to MDwise each quarter of the providers that were credentialed or recredentialed in that quarter.

Outcomes from the Credentialing Process

Each of the MCOs reported that there are some providers who are denied recredentialing for administrative reasons each year, but most all are quickly recredentialed once their paperwork is complete. Anthem reported that some providers (possibly up to 20 per year) are not recredentialed, usually because they do not meet the criteria of having Board certification within five years after graduation. MDwise reported four recredentialing denials for non-administrative reasons last year and MHS was unaware of any for this reason last year.

Each MCO takes a different approach to handling providers involved in a drug or alcohol abuse incident. Anthem stated there would be immediate suspension if a provider was brought to a licensing board. If there is a perceived threat, then the behavioral health provider on the credentialing committee will assist with this assessment. The provider is always provided an opportunity to appeal for reconsideration in the case of an adverse decision.

MHS stated that a provider would be terminated automatically in the case of conviction of a felony. If the provider is suspended from a hospital, that would warrant further investigation by the credentialing committee.

MDwise indicated that prior drug or alcohol abuse may be one exception to continue participation in the program, but only if the provider is in compliance with the Indiana Impaired Practitioner Program.

All three MCOs stated that their credentialing policies and procedures are reviewed each year and that there are usually some small modifications, mostly to comply with NCQA requirements.

B&A's Review of the Credentialing Process

B&A found that all three MCOs had thorough written policies and procedures related to credentialing. Through interviews, we determined that the staff responsible for following these procedures have a clear understanding of them and follow the procedures as written.

B&A reviewed individual provider case files for completeness and conformity to written policies. Twenty cases were identified for each of the HHW MCOs and 20 cases were identified for each HIP MCO. Evidence of the following items was reviewed in each file:

1. Copy of valid and current licensure
2. Evidence of clinical privileges at a hospital
3. Copy of a valid Drug Enforcement Agency or Controlled Dangerous Substance certificate
4. Copy of Board certification (including education and training)
5. Copy of Certificate of Insurance for malpractice insurance
6. Completed application form
7. Attestation from the physician that they can perform the essential functions for which they are being credentialed and that they don't use illegal drugs
8. History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (NPDB database)
9. Copy of the physician site visit (only for initial credentialing and only for certain providers)
10. Verification that the OIG and EPLS (Excluded Party List System) lists were checked
11. Indication by the MCO's Chief Medical Officer or Committee that the provider is approved

The results of our review are as follows:

| MCO | | Total Reviewed | Total Fully Compliant | Total Not Fully Compliant |
|---|---|---|---|---|
| Anthem | | 40 | 33 | 7 |
| | Initial Credentialing | 17 | 14 | 3 |
| | Recredentialing | 23 | 19 | 4 |
| | | | | |
| MDwise | | 40 | 40 | 0 |
| | Initial Credentialing | 14 | 14 | 0 |
| | Recredentialing | 26 | 26 | 0 |
| | | | | |
| MHS | | 20 | 20 | 0 |
| | Initial Credentialing | 4 | 4 | 0 |
| | Recredentialing | 16 | 16 | 0 |

Anthem was the only MCO not found fully compliant in every case reviewed. In six of the seven cases, one of the ten items was missing. In one of the cases, two items were missing. Anthem had a checklist in the front of each case file. Usually, it was the case that the items we found incomplete were actually checked as being reviewed by the staff member. We did not consider the file complete, however, because we did not see evidence of the item (e.g., verification that a federal list was checked) documented in the file.

## Review of Activities to Detect Fraud and Abuse

The Special Investigations Unit (SIU) at all of the HHW/HIP MCOs in CY 2009 was fairly stagnant. Prior to the initiation of this external quality review, however, a renewed emphasis was placed at each MCO on examining potential fraud and abuse. This included an expansion of staff assigned to these activities as well as the number of actual investigations. For example, Anthem had 17 cases (HHW and HIP) investigated in CY 2009 and has already exceeded this number through the first eight months of 2010. MDwise had nine cases in CY 2009 and has already had 24 through August 2010. MHS had 14 cases last year investigated and have 14 opened so far through September 2010.

As a result, B&A's review of the SIUs at the MCO depicts activities that better represent the current year than CY 2009.

Staffing and Training of the Special Investigations Unit at Each MCO

Anthem has a Director of Program Integrity and two Senior Investigators each with many years of experience at Anthem in non-Medicaid products. In 2010, each was assigned to focus on the HHW and HIP, among other products. Anthem also leverages a team of 60 investigators throughout WellPoint. All program integrity activities and tests that are run through WellPoint's commercial lines of business are also run through the state-sponsored business unit.

Specific training for the HHW and HIP investigators includes 40 hours per year. Last year, they received training at the National Health Care Anti Fraud Association (NHCAF) convention as well as training through an FBI task force and a Blue Cross-specific fraud training group.

Ongoing training occurs at weekly meetings as well as monthly meetings among WellPoint investigators.

Whereas in CY 2009 all program integrity efforts were housed at the delivery systems, MDwise developed a new SIU team at the corporate office in January 2010 which is led by a former Medicaid Fraud and Control Unit (MFCU) four-year staff member. Prior to this, she was General Counsel for a hospital system. The unit includes an analyst who is an epidemiologist specialist and an investigator who is a claims specialist with 12 years experience in health care and a focus in high-cost pharmacy claims. The MDwise delivery systems serve in a support role to this unit as specific cases warrant assistance. The delivery systems also meet monthly and are each required to bring a case under investigation to serve as an educational tool.

Training for the new team has been limited thus far, but the Manager has had training at the NHCAF convention and the investigator will be attending this year.

MHS's SIU consists of three Senior Investigators, two analysts and two nurses which serve multiple plans owned by Centene. Four team members are certified coders, one analyst is a pharmacy technician and the other is a paramedic. This group is responsible for referrals, data mining and investigations. Training for the team includes NHCAF annual training, monthly webinar training, certified coder classes, and internet research on specific topics. All training for each staff member is documented.

Process to Investigate Fraud and Abuse Cases

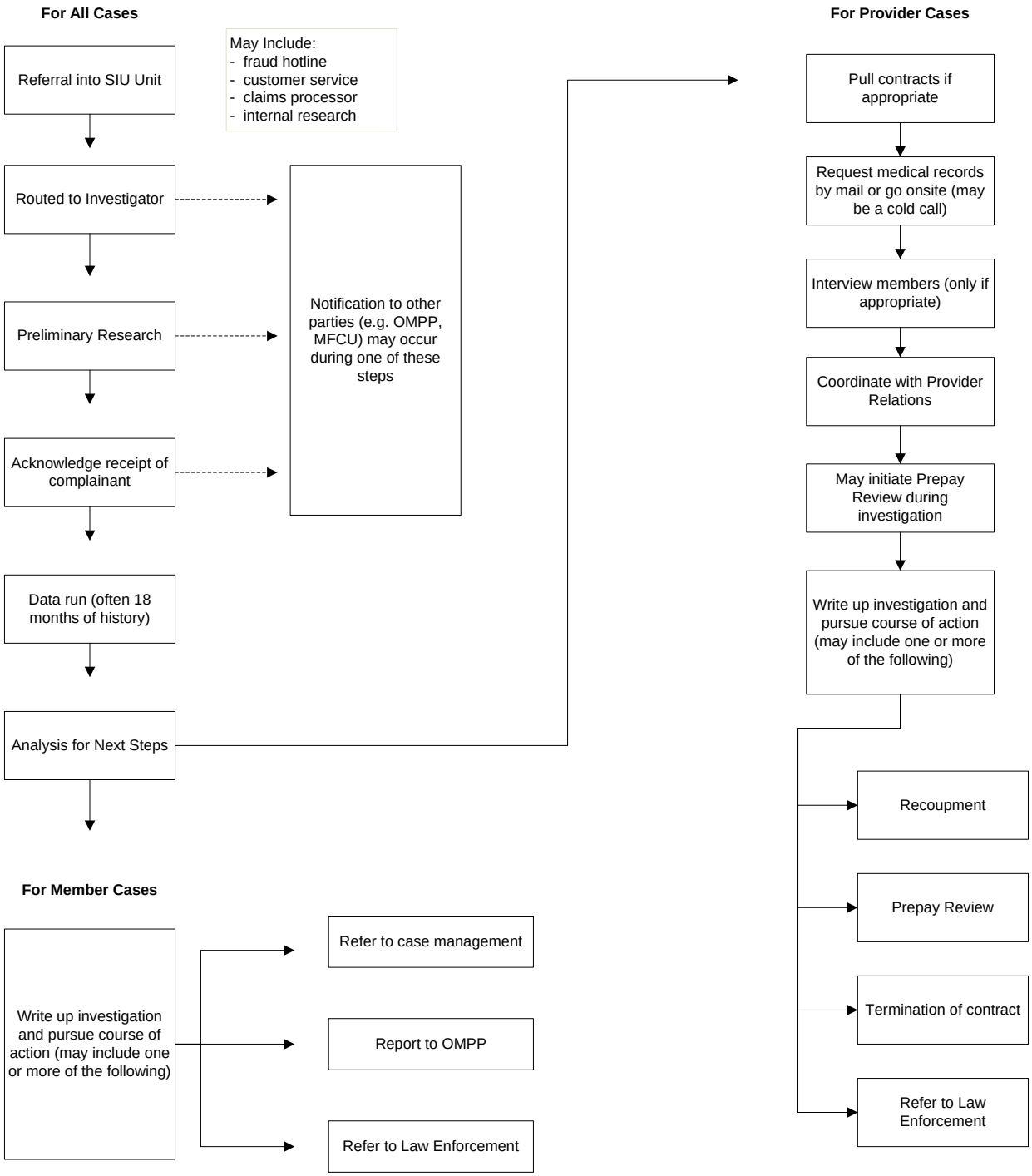
The exhibit on the next page depicts, in general, the process steps completed by the MCO's SIUs. Anthem reported taking all of the steps shown in their investigations whereas MHS and MDwise identified most of these activities in their protocols. All three MCOs indicated that they notify the OMPP of new cases and that many of these cases are also shared at monthly meetings attended by representatives from the OMPP, the MCOs and the MFCU.

With respect to the sources for referrals, Anthem reported that they obtain a fair amount of referrals from their fraud and abuse hotline but the other two MCOs stated that their hotline is not used much. Former employees and former spouses of providers are often sources for referrals. Each MCO cited other internal staff (e.g. customer service) as well as internal data mining as common leads for new cases.

Although the investigation of each case is unique, each MCO stated that there is always an initial research period followed by a more comprehensive analysis of claims experience (for both provider and member cases). There are times when the claims analysis for an investigation of a provider can lead to an investigation of a member, or vice versa.

The level of additional research depends upon the outcome of the analysis of claims. In the example of provider upcoding, for example, Anthem in particular indicated that there may be a need to review provider's medical records of specific individuals to substantiate if there is a case for provider upcoding. These records may be requested via mail or through an onsite visit to the office. The provider being investigated is never told the reason for the medical record review other than that it is part of a periodic audit of providers.

## MCO Process Within Special Investigations Unit




Other actions may be required by the SIU unit based upon how the MCO will be handling the case. In situations of member drug seeking, for example, the SIU may refer the member to case

management or to the OMPP's Right Choices Program (which limits the number of scripts and the pharmacies that members can obtain scripts). In the case of recoupment of monies from a provider, the SIU may coordinate with the provider relations staff to make them aware that a notice of action will be occurring. In more extreme cases, the provider relations staff may be instructed to terminate the provider's contract with the MCO.

For investigations where action was taken, Anthem and MHS reported maintaining continued follow-up on the case for six months to one year after the initial action was taken. MDwise did not report a specific follow-up protocol.

Types of Cases Investigated

The three MCOs stated that the majority of investigations that are made are related to providers. Specific examples relate to upcoding, unbundling of services, mutually exclusive codes billed together, services billed but not rendered, and billing for new technologies not covered by Medicaid. Among the investigations completed on members, the vast majority are related to drug seeking activities such as doctor shopping, pharmacy shopping, hospital ER shopping, or Medicaid card sharing.

On rare occasions, an MCO staff member is also investigated. Each of the three MCOs conducts annual training on ethics and program integrity. MHS (through its parent Centene) also runs reports on the internet usage of its employees. The MCOs ensured that employees are only informed of cases involving members and providers on a need-to-know basis. Often, they are given only the information on a case that they need to help supplement the SIU's research.

Outcomes from the Review of Fraud and Abuse Cases

As the exhibit on the previous page illustrates, there are a number of outcomes that may occur in an investigation of a member or provider. The SIU staff cited a number of variables that may help in determining the ultimate outcome that may be pursued. These include:

- The amount of proof (e.g., Was the action taken "knowingly and intentionally"?)
- The pattern of behavior (e.g., Did the provider continually upcode for an extended period or was it more isolated?)
- In the case of a provider, the amount of funds expected to be recouped
- If this is a one-time or a repeat offense
- Whether the action was a contractual offense or a felonious offense
- If the individual is also being investigated by other entities (e.g., the MFCU or the FBI)

One outcome that is always possible is that nothing is done. This is when it is determined that there is insufficient proof to seek corrective action.

The MCOs all reported that it is rare to seek prosecution against a member or to terminate them from the MCO. Because most cases involve drug seeking, the usual outcome is to refer the member to the Right Choices Program and/or to case management. For providers, an auto recoupment may occur through a future billing cycle. Another tactic used is a demand letter to the provider for the amount of funds that are sought for recoupment. For large dollar amounts, it

is customary to seek a settlement with the provider on the final payment. Extrapolation of a larger sample of claims beyond the initial investigation is also used as a negotiating tool with providers. There are times when an MCO will terminate the provider's contract after the recoupment payment is made. In other cases, the provider is put on a pre-pay review status.

In the situations where the MCO suggests seeking prosecution against the provider, the MCO will work with outside entities as to the manner in which the prosecution takes place.

Internal follow-up actions that are made on a global level can also occur as a result of a specific investigation. Anthem in particular cited this as a means for preventing future fraud or abuse. Two recent examples included putting in edits to check for specific CPT related to the treatment of varicose veins (typically cosmetic and not covered) and instituting a policy of appropriate billing for anti-nausea medication given during chemotherapy (generic versus brand name).

B&A's Review of Sample Cases

B&A requested a list from each MCO of the investigations opened in CY 2009 in the HHW and HIP. From this list, B&A selected five cases from each HHW MCO and five cases from each HIP MCO (Anthem-10, MDwise- 10, MHS- 5). The samples selected represented both member and provider investigations. B&A staff met with the investigators at each MCO to walk through the case file completed for each investigation. A set of 10 questions was asked in relation to each case:

1. What is the origin of how the case was brought to the MCO's attention?
2. Were any internal processes or triggers used that suggested that further research was warranted? If so, what?
3. Which staff or departments at the MCO were involved in research of the case?
4. What research was conducted to confirm or deny the validity of the suspected fraud or abuse?
5. Was the person/entity being investigated contacted during the investigation process?
6. Were other entities/individuals contacted during the investigation process? For what reason or information were they contacted?
7. What was the final determination of this case?
8. What evidence do you have to support this determination?
9. Once the internal investigation was completed, was the case closed, brought to OMPP, brought to the authorities, or some combination of the above?
10. Has there been final resolution on the case? If so, what is the resolution?

B&A reviewed the policies and procedures related to program integrity and then utilized these questions to ensure that the procedures were being followed. We found that the MCOs were adhering to the policies that they outlined, recognizing that each case is unique and may require more or less of specific procedural tasks.

Our review showed that, indeed, cases are brought forward and investigated from a variety of sources (refer to exhibit on the top of the next page).

| Referral Source | Anthem | MDwise | MHS |
|---|---|---|---|
| Internal | 3 | 3 | 5 |
| Member | 1 | 0 | 0 |
| Physician | 1 | 1 | 0 |
| Delivery system | 0 | 2 | 0 |
| OMPP (RCP) | 2 | 0 | 0 |
| MFCU | 1 | 3 | 0 |
| OIG | 1 | 0 | 0 |
| FBI | 1 | 1 | 0 |
| | 10 | 10 | 5 |

Triggers that led to an investigation included: members pretending to be a provider to secure scripts, information obtained by a case manager regarding services delivered to a member, member verbal abuse reported by a provider, member violating a pain management regimen agreed to with the provider, internal reports of the number of controlled substances issued by each prescriber, system edits flagging unusually high number of units billed, and analysis of claims for duplicate billing for vaccines.

Depending upon the referral source, other entities may have been involved with the investigation or informed of its status as needed. For example, Anthem and MDwise reported their discussions with MFCU and the FBI related to the cases brought to them from these parties and the coordinated effort that was mapped out.

The cases reviewed by B&A indicated to us that multiple actions are considered to resolve the case given the circumstances of the investigation. In these cases, it appeared that the MCOs were utilizing the most appropriate action given the evidence that was compiled. The resolutions from the sample of cases reviewed from CY 2009 are as follows:

| Resolution | Anthem | MDwise | MHS |
|---|---|---|---|
| Recoupment/pre-pay review | 1 | 0 | 4 |
| Provider termination | 0 | 0 | 1 |
| Refer to legal authorities (provider) | 6 | 4 | 0 |
| Refer to case management/ RCP (member) | 1 | 0 | 0 |
| Refer to OMPP | 0 | 1 | 0 |
| Refer to legal authorities (member) | 0 | 0 | 0 |
| No action but may include follow-up review | 1 | 4 | 1 |
| Case still open | 1 | 1 | 0 |

## Best Practices

1. Anthem's new staff within the HHW and HIP SIU has a very strong process for handling investigations. Among the three MCOs, Anthem's group best illustrated to B&A how the results from SIU investigations often get fed back as improved processes on the front end to other parts of the organization to prevent fraud and abuse.

2. MHS has a solid cross section of talent performing the SIU function and also has a rigorous continuing education for its staff.

3. The monthly meeting of MCO SIU staff with the OMPP and the MFCU provides an excellent way to share information about items detected in cases and to alert other entities of member or provider practices that may need to be investigated. This work group is especially important given that providers can contract with multiple MCOs and with both the HHW and HIP programs.

## Areas of Opportunity

1. Recognizing that the SIU team is new at MDwise and that some training is being planned for 2010, B&A suggests that the MDwise staff adopt an ongoing training schedule in line with the other MCOs.

2. There were a number of investigations reviewed by B&A with the MCOs that were excellent examples of inappropriate provider billing that were properly handled by the MCO. B&A encourages when these cases are resolved that the MCOs take more of the issues identified in a single case and, when appropriate, expand the review globally to all providers in the peer group of the provider being investigated. This may lead to further investigations or may identify opportunities to proactively address issues.

# SECTION V: REVIEW OF ACCESS AND AVAILABILITY OF PROVIDERS

## Introduction

Federal regulations mandate that managed care organizations (MCOs) participating in the Medicaid program must adhere to requirements related to its service delivery network.

> 42 CFR §438.206 *Availability of services*
> (b) *Delivery network.* The State must ensure, through its contracts, that each MCO…meets the following requirements:
> (1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the MCO must consider the following:
> (i) The anticipated Medicaid enrollment.
> (ii) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO
> (iii) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.
> (iv) The number of network providers who are not accepting new Medicaid patients.
> (v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities
>
> (c) *Furnishing of services.*
> (1) Timely access. Each MCO must--
> (i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services;
> (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
> (iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.
> (iv) Establish mechanisms to ensure compliance by providers.
> (v) Monitor providers regularly to determine compliance.
> (vi) Take corrective action if there is failure to comply.

The Office of Medicaid Policy and Planning (OMPP) placed additional requirements on the MCOs serving the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP).

- For both HHW and HIP, members must have access to a Primary Medical Provider (PMP) within 30 miles of their residence.

- In HHW, for particular specialty providers there must be two of each specialty type within 60 miles of the member's residence. These include cardiologist, orthopedic surgeon, otologist or otolaryngologist, psychiatrist, urologist, durable medical equipment provider, home health provider and pharmacy. For HIP, there must be just one of each specialty type within 60 miles but the list is expanded to 30 different types of specialty providers (to be shown in the analysis on page V-4).

The OMPP is also more specific about its requirements for accessibility of providers beyond the federal definition.

> *Section 4.2.2 of the Hoosier Healthwise Scope of Work and*
> *Section 5.2.2 of the Healthy Indiana Plan Scope of Work*
> The MCO must ensure that the PMP provide "live voice" coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The MCO must ensure that members have telephone access to their PMP (or appropriate designate such as a covering physician) in English and Spanish 24-hours-a-day, seven-days-a-week.

As another focus study area for this year's external quality review (EQR), Burns & Associates, Inc. (B&A) examined the accessibility and availability of providers to Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) members. Accessibility was examined in multiple dimensions:

- B&A reviewed the results of GeoAccess reports submitted annually to the OMPP by each MCO in HHW and HIP.
- Using encounter data, B&A examined HHW and HIP member's visits to primary care and specialist physicians within their county of residence, in a contiguous county of their residence, or in a non-contiguous county.
- A random sample of HHW and HIP members were selected to test the actual distance traveled between their residence and the PMP or specialist office they visited.

B&A also examined the availability of providers both in seeking appointments and in seeking access on a 24x7 basis.

- B&A measured the availability of PMPs and specialists in both the HHW and HIP for members to make appointments for urgent care, well care, and consultation visits.
- A separate analysis was conducted on a sample of the physicians contacted by the HHW and HIP MCOs in their 24-hour availability audits to confirm the results they reported to the OMPP.

Our findings from each of these studies are discussed in the remainder of this chapter.

## GeoAccess Analysis

The OMPP requires that the HHW MCOs submit a GeoAccess map annually showing which members have the desired access of 30 miles from each member's residence to a PMP. Although the HHW MCO contract also requires access of within 60 miles to certain specialists, these maps are not required to be submitted. The HIP MCOs must provide GeoAccess maps annually that show desired access to PMPs, specialists, behavioral health providers and pharmacies.

B&A reviewed the reports submitted in January 2010 to the OMPP for the period covering CY 2009. We asked the MCOs for supplemental maps on certain specialists for this review when they were not submitted to the OMPP.

Exhibit V.1 shows the results for desired access for each specialty type in the HHW program. The MCOs plotted the location of their providers as well as documenting the location of members without desired access. B&A classified "counties w/o desired access" if *any* members in the county do not have the desired access; however, in each of these counties at least *some* of the members do have desired access.

For HHW primary care, there is full compliance of the 30 mile requirement. Among the HHW specialists where there must be at least two of the specialty within 60 miles, there is desired access among all MCOs for orthopedic surgeons and psychiatrists or other behavioral health providers. In all but a few counties, there is also desired access for cardiologists and urologists. Both Anthem and MDwise did not report on the accessibility of DME or home health providers. For MHS, these are two areas where access can be enhanced.

**Exhibit V.1**
**MCO Reported Network Access for Hoosier Healthwise Members in Indiana's 92 Counties**
**Source: GeoAccess reports provided by the MCOs to the OMPP or to B&A**

| | | Anthem | | MDwise | | MHS | |
|---|---|---|---|---|---|---|---|
| Provider Specialty | Standard | # Counties w/ Desired Access | # Counties w/o Desired Access | # Counties w/ Desired Access | # Counties w/o Desired Access | # Counties w/ Desired Access | # Counties w/o Desired Access |
| Primary Medical Provider | 1 within 30 miles | 92 | 0 | 92 | 0 | 92 | 0 |
| | | | | | | | |
| Cardiologists | 2 within 60 miles | 92 | 0 | 92 | 0 | 88 | 4 |
| Orthopedic Surgeon | 2 within 60 miles | 92 | 0 | 92 | 0 | 92 | 0 |
| Otolaryngologist | 2 within 60 miles | at least 79[2] | | 90 | 2 | Not Reported | |
| Psychiatrists[1] | 2 within 60 miles | 92 | 0 | 92 | 0 | 92 | 0 |
| Urologist | 2 within 60 miles | 92 | 0 | 92 | 0 | 86 | 6 |
| | | | | | | | |
| DME | 2 within 60 miles | Not Reported | | Not Reported | | 74 | 18 |
| Home Health | 2 within 60 miles | Not Reported | | Not Reported | | 35 | 57 |

[1] Anthem reported "Behavioral Health Providers" and not psychiatrists specifically.

[2] Anthem reported desired access of otolaryngologists in all regions of the state except for the West Central Region. In this region that includes 13 counties, 62% of members have desired access, but this was not reported at a county level.

Exhibit V.2 on the next page shows the counties where there is desired access for members to see HIP PMPs and the 30 specialists for which the MCOs must have access within 60 miles. In the HIP, the MCOs only plotted the locations of the providers, but did not indicate if specific members had desired access. Therefore, B&A classified "counties w/o desired access" if there was at least some portion of the county that was not served within a 60 mile radius of a provider. We are not certain if there are HIP members living in these locations.

For HIP, both MCOs have desired access for PMPs. In most cases, the MCOs are meeting the desired access among the 30 specialties where they are required to have one provider in the specialty within 60 miles (not counting seven specialties where one or more of the MCOs did

not report data). There is one specialty (speech pathologist) where both Anthem and MDwise do not meet the desired access in many counties and two other specialties (neurological surgery and pathology) where Anthem does not meet desired access in 10-15 counties.

**Exhibit V.2**
**MCO Reported Network Access for Healthy Indiana Plan Members in Indiana's 92 Counties**
**Source: GeoAccess reports provided by the MCOs to the OMPP or to B&A**

| | | Anthem | | MDwise | |
|---|---|---|---|---|---|
| Provider Specialty | Standard | # Counties w/ Desired Access | # Counties w/o Desired Access | # Counties w/ Desired Access | # Counties w/o Desired Access |
| Primary Medical Provider | 1 within 30 miles | 92 | 0 | 92 | 0 |
| | | | | | |
| Anesthesiologists | 1 within 60 miles | 92 | 0 | 92 | 0 |
| Cardiologists | 1 within 60 miles | 92 | 0 | 92 | 0 |
| Clinical Psychologists | 1 within 60 miles | 92 | 0 | 91 | 1 |
| Dermatologists | 1 within 60 miles | 87 | 5 | 89 | 3 |
| Diagnostic Radiologists | 1 within 60 miles | 92 | 0 | Not Reported | |
| DME | 1 within 60 miles | Not Reported | | Not Reported | |
| Endocrinologists | 1 within 60 miles | 87 | 5 | Not Reported | |
| Gastroenterologists | 1 within 60 miles | 92 | 0 | 92 | 0 |
| General Surgeons | 1 within 60 miles | 92 | 0 | 92 | 0 |
| Hematologists | 1 within 60 miles | 90 | 2 | Not Reported | |
| Home Health | 1 within 60 miles | Not Reported | | Not Reported | |
| Infectious Disease Specialists | 1 within 60 miles | 83 | 9 | Not Reported | |
| Medical Oncologists | 1 within 60 miles | 92 | 0 | 92 | 0 |
| Nephrologists | 1 within 60 miles | 92 | 0 | 86 | 6 |
| Neurological Surgeons | 1 within 60 miles | 77 | 15 | 92 | 0 |
| Neurologists | 1 within 60 miles | 92 | 0 | 92 | 0 |
| Occupational Therapists | 1 within 60 miles | 92 | 0 | 89 | 3 |
| Ophthalmologists | 1 within 60 miles | 92 | 0 | 92 | 0 |
| Orthopedic Surgeons | 1 within 60 miles | 92 | 0 | 92 | 0 |
| Optometrists | 1 within 60 miles | 92 | 0 | 92 | 0 |
| Otolaryngologists | 1 within 60 miles | 92 | 0 | 90 | 2 |
| Pathologists | 1 within 60 miles | 82 | 10 | 92 | 0 |
| Physical Therapists | 1 within 60 miles | 92 | 0 | 92 | 0 |
| Psychiatrists[1] | 1 within 60 miles | 92 | 0 | 92 | 0 |
| Pulmonary Diseases Specialists | 1 within 60 miles | 92 | 0 | 92 | 0 |
| Radiation Oncologists | 1 within 60 miles | 92 | 0 | 92 | 0 |
| Rheumatologists | 1 within 60 miles | 89 | 3 | Not Reported | |
| Speech Pathologists | 1 within 60 miles | 41 | 51 | 73 | 19 |
| Urologists | 1 within 60 miles | 92 | 0 | 92 | 0 |

[1] Anthem reported "Behavioral Health Providers" and not psychiatrists specifically.

| | | | | | |
|---|---|---|---|---|---|
| Advanced Nurse Practitioner | 1 within 60 miles | 92 | 0 | Not Reported | |
| Dentist | 1 within 60 miles | Not Reported | | 89 | 3 |

## Location of Actual Services

Although the GeoAccess reports provide assurances of provider accessibility, they do not factor in if particular providers in an MCO network have full panels or other limitations. As an additional way to measure provider accessibility, B&A examined the location of the actual providers that HHW and HIP members visited.

Methodology

B&A aggregated all of the encounters that the MCOs submitted to the OMPP for primary care and specialist visits in CY 2009. In our study, primary care includes physicians identified as general practitioners, family practitioners, pediatricians, internists, and OB/GYNs. Specialists include non-primary physicians and other practitioners that members would visit in an office setting. It should be noted that providers self-identify their specialty to the OMPP and providers can have more than one specialty but only one is stored in the database used for this analysis.

The encounters were then stratified between children (age <19) enrolled in HHW, adults enrolled in HHW, and adults enrolled in HIP. Specialties where there was no or low volume (e.g. pediatricians or neonatologists for the adult population) were removed from the analysis.

For each encounter, the member's county was identified. This was mapped to the county on file for where the physician practices. For each specialty group, the encounters were categorized as follows:

- Member saw a provider in the county where they reside
- Member saw a provider in a county contiguous to the one where they reside
- Member saw a provider in a county not contiguous to the one where they reside

This stratification did not measure the actual distance to the provider seen, but it serves as an arbiter for member's proximity to their provider. It should be noted that, based on the land area of Indiana's counties, any member who saw a physician in their home county most likely travelled less than 30 miles. There are also cases where traveling to a contiguous county would also be within 30 miles.

Results

Exhibits V.3 through V.5 on the pages V-7 through V-9 show the results for members accessing PMPs and specialists as it relates to the county where they reside. Some key findings related to PMP visits include:

- 75 percent of the HHW children visits were in their home county and 93 percent were in their home county or a contiguous county

- Similar results were found for HHW adults—73 percent of visits in the member's home county and 93 percent in their home county or a contiguous county

- Accessibility was not as high for HIP members. Only 51 percent of the PMP visits were in the member's home county. One third (34%) of the visits were in a non-contiguous county to the member's home county.

- One-third of HHW children visits to pediatricians were to providers that were in offices that were in a non-contiguous county from where the member resides.

The location of specialists visited by HHW and HIP members varied significantly by the type of specialist seen. Some key findings from the review of specialist visits showed that:

- More than half of all specialist visits for both HHW children (52% overall) and HHW adults (58% overall) were in the member's home county and three-quarters were in the home county or a contiguous county (74% for HHW children and 80% for HHW adults).

- Some of the specialists seen most often by HHW children and adults (cardiologists, general surgeons, oncologists and orthopedic surgeons) were also the specialists in closest proximity to where the members live.

- Specialists most seen in non-contiguous counties to the HHW members' residence were also the specialists used infrequently (cardiovascular surgeon, neurological surgeon, pediatric surgeon and thoracic surgeon).

- Only one specialist (thoracic surgeon) was seen by HHW adults at least half the time in a non-contiguous county.

- There were a number of specialists seen by HIP members where the majority of the time they saw a provider in a non-contiguous county (cardiovascular surgeon, hand surgeon, nephrologist, neurological surgeon, otologist, physical medicine, plastic surgeon and psychiatrist), but collectively these only represented 12 percent of all HIP specialist encounters.

**Exhibit V.3**
**Matching of Actual Provider Visits in CY 2009 to the Member's Home County**
**Hoosier Healthwise Children**

| Provider Specialty | Total Encounters | In Home County | Contiguous County | Non-Contiguous County |
|---|---|---|---|---|
| General Practitioner | 72,666 | 78% | 18% | 4% |
| Family Practitioner | 787,932 | 83% | 14% | 4% |
| Pediatrician | 77,095 | 49% | 15% | **36%** |
| General Pediatrician | 990,808 | 72% | 21% | 6% |
| General Internist | 95,415 | 70% | 19% | 11% |
| Internist | 410 | 86% | 11% | 3% |
| Obstetrician/Gynecologist | 87,777 | 71% | 21% | 8% |
| **PMPs** | **2,112,103** | **75%** | **18%** | **7%** |
| Allergist | 28,033 | 45% | 26% | 29% |
| Cardiologist | 10,162 | 60% | 16% | 24% |
| Cardiovascular Surgeon | 3,437 | 43% | 4% | **53%** |
| Dermatologist | 15,194 | 40% | 25% | 36% |
| Gastroenterologist | 1,524 | 51% | 18% | 31% |
| General Surgeon | 7,822 | 64% | 26% | 10% |
| Geriatric Practitioner | 8,137 | 98% | 1% | 2% |
| Hand Surgeon | 2,945 | 36% | 18% | 46% |
| Neonatologist | 27,751 | 44% | 15% | 42% |
| Nephrologist | 144 | 38% | 32% | 30% |
| Neurological Surgeon | 3,179 | 23% | 12% | **65%** |
| Neurologist | 12,814 | 36% | 15% | 49% |
| Oncologist | 5,379 | 61% | 21% | 18% |
| Opthamologist | 68,275 | 56% | 23% | 21% |
| Orthopedic Surgeon | 76,613 | 62% | 25% | 13% |
| Otologist | 74,721 | 50% | 26% | 24% |
| Pathologist | 32,541 | 56% | 13% | 31% |
| Pediatric Surgeon | 2,603 | 47% | 0% | **53%** |
| Physical Medicine and Rehabilitation | 5,432 | 62% | 29% | 10% |
| Plastic Surgeon | 5,533 | 56% | 8% | 35% |
| Proctologist | 63 | 56% | 30% | 14% |
| Psychiatrist | 37,813 | 55% | 18% | 27% |
| Pulmonary Disease Specialist | 2,047 | 43% | 15% | 42% |
| Radiologist | 295,338 | 51% | 23% | 26% |
| Thoracic Surgeon | 10,914 | 32% | 17% | **51%** |
| Urologist | 16,393 | 40% | 18% | 42% |
| **Specialists** | **754,807** | **52%** | **22%** | **26%** |

**Exhibit V.4**
**Matching of Actual Provider Visits in CY 2009 to the Member's Home County**
**Hoosier Healthwise Adults**

| Provider Specialty | Total Encounters | In Home County | Contiguous County | Non-Contiguous |
|---|---|---|---|---|
| General Practitioner | 36,581 | 73% | 21% | 5% |
| Family Practitioner | 343,140 | 80% | 15% | 5% |
| General Pediatrician | 22,627 | 72% | 17% | 11% |
| General Internist | 58,092 | 69% | 23% | 8% |
| Internist | 1,686 | 77% | 16% | 7% |
| Obstetrician/Gynecologist | 473,178 | 70% | 22% | 8% |
| **PMPs** | **935,304** | **74%** | **19%** | **7%** |
| Allergist | 2,905 | 57% | 23% | 21% |
| Cardiologist | 28,208 | 59% | 20% | 21% |
| Cardiovascular Surgeon | 4,517 | 38% | 26% | 36% |
| Dermatologist | 4,250 | 46% | 23% | 31% |
| Gastroenterologist | 7,416 | 65% | 24% | 11% |
| General Surgeon | 20,156 | 63% | 26% | 11% |
| Geriatric Practitioner | 104 | 46% | 17% | 37% |
| Hand Surgeon | 1,900 | 43% | 20% | 37% |
| Nephrologist | 2,572 | 56% | 19% | 25% |
| Neurological Surgeon | 2,744 | 42% | 16% | 42% |
| Neurologist | 16,548 | 43% | 23% | 34% |
| Oncologist | 29,596 | 52% | 33% | 15% |
| Opthamologist | 17,362 | 63% | 21% | 15% |
| Orthopedic Surgeon | 38,171 | 60% | 27% | 13% |
| Otologist | 10,717 | 56% | 23% | 21% |
| Pathologist | 62,782 | 62% | 12% | 25% |
| Physical Medicine and Rehabilitation | 23,095 | 51% | 19% | 30% |
| Plastic Surgeon | 1,620 | 67% | 8% | 24% |
| Proctologist | 475 | 60% | 31% | 8% |
| Psychiatrist | 14,412 | 58% | 16% | 26% |
| Pulmonary Disease Specialist | 7,665 | 61% | 17% | 21% |
| Radiologist | 234,063 | 59% | 22% | 19% |
| Thoracic Surgeon | 1,465 | 27% | 23% | **50%** |
| Urologist | 12,878 | 44% | 34% | 23% |
| **Specialists** | **545,621** | **58%** | **22%** | **21%** |

**Exhibit V.5**
**Matching of Actual Provider Visits in CY 2009 to the Member's Home County**
**Healthy Indiana Plan Adults**

| Provider Specialty | Total Encounters | In Home County | Contiguous County | Non-Contiguous |
|---|---|---|---|---|
| General Practitioner | 8,678 | 59% | 20% | 22% |
| Family Practitioner | 96,507 | 52% | 13% | **36%** |
| General Pediatrician | 2,582 | 89% | 4% | 7% |
| General Internist | 38,173 | 45% | 18% | **36%** |
| Internist | 447 | 66% | 5% | 29% |
| Obstetrician/Gynecologist | 13,044 | 54% | 21% | 25% |
| **PMPs** | **159,431** | **51%** | **15%** | **34%** |
| Allergist | 2,680 | 41% | 15% | 44% |
| Cardiologist | 12,782 | 42% | 18% | 40% |
| Cardiovascular Surgeon | 2,089 | 19% | 2% | **79%** |
| Dermatologist | 4,155 | 26% | 26% | 48% |
| Gastroenterologist | 6,959 | 55% | 16% | 29% |
| General Surgeon | 8,246 | 45% | 21% | 34% |
| Geriatric Practitioner | low volume | | | |
| Hand Surgeon | 727 | 30% | 11% | **59%** |
| Nephrologist | 580 | 23% | 10% | **67%** |
| Neurological Surgeon | 2,488 | 18% | 16% | **66%** |
| Neurologist | 8,074 | 39% | 22% | 39% |
| Oncologist | 14,435 | 31% | 20% | 48% |
| Opthamologist | 5,670 | 44% | 22% | 35% |
| Orthopedic Surgeon | 23,359 | 33% | 20% | 47% |
| Otologist | 5,669 | 23% | 15% | **62%** |
| Pathologist | 15,287 | 45% | 15% | 40% |
| Physical Medicine and Rehabilitation | 7,286 | 27% | 20% | **54%** |
| Plastic Surgeon | 625 | 25% | 8% | **67%** |
| Proctologist | 376 | 25% | 27% | 48% |
| Psychiatrist | 5,059 | 32% | 16% | **52%** |
| Pulmonary Disease Specialist | 3,998 | 43% | 12% | 45% |
| Radiologist | 71,163 | 36% | 14% | 49% |
| Thoracic Surgeon | 275 | 40% | 13% | 47% |
| Urologist | 6,058 | 45% | 21% | 34% |
| **Specialists** | **208,075** | **37%** | **17%** | **46%** |

## Distance Test in a Sample of Cases

As an additional review of provider accessibility, B&A selected two encounters from CY 2009 within each county for each of the three MCOs in HHW and the two MCOs in HIP. One encounter was among member visits to PMPs while the other was among member visits to specialists. The sample selection was randomized to obtain an assortment of specialties within the PMP and specialist group.

For each encounter, the member's home address and the attending provider's office address were used to measure the distance traveled by the member to the visit. Mileage was computed using MapQuest. Visits to PMPs were considered within desired access if the visit was 30 miles or less from the member's home. Visits to specialists were considered within desired access if the visit was 60 miles or less from the member's home.

In the sample reviewed, about 90 percent of the PMP visits for each MCO were within 30 miles, with an average distance traveled between 11.0 and 13.2 miles. The percentage of members that travelled more than 30 miles was small, but the average distance ranged from 50.1 miles for MDwise members to 79.3 miles for Anthem members.

B&A found more variation among the MCOs for distance traveled to specialists. About 80 percent of both Anthem's and MHS's sample traveled under 60 miles to see a specialist, with an average distance between 22.9 and 25.4 miles. MDwise had fewer members within the 60 mile threshold (63.7% of the sample) and their average distance was slightly higher at 28.0 miles.

**Exhibit V.6**
**Test of Distance Traveled for a Sample of HHW Members, by MCO**

**Primary Providers**

| MCO | N = | Percent of Members within 30 miles | Avg Distance | Percent of Members > 30 miles | Avg Distance |
|---|---|---|---|---|---|
| Anthem | 85 | 92.9% | 11.9 | 7.1% | 79.3 |
| MDwise | 90 | 87.8% | 11.0 | 12.2% | 50.1 |
| MHS | 90 | 87.8% | 13.2 | 12.2% | 59.3 |

**Specialists**

| MCO | N = | Percent of Members within 60 miles | Avg Distance | Percent of Members > 60 miles | Avg Distance |
|---|---|---|---|---|---|
| Anthem | 87 | 81.6% | 25.4 | 18.4% | 129.5 |
| MDwise | 91 | 63.7% | 28.0 | 25.3% | 124.9 |
| MHS | 83 | 79.5% | 22.9 | 20.5% | 93.6 |

Findings among HIP members were similar to those found for HHW members. More than nine in ten members in both health plans had a PMP visit within 30 miles in our sample. (Refer to Exhibit V.7 on the next page.) The average distance traveled was 15.5 miles for Anthem members and 10.9 miles for MDwise members.

Access to specialists was similar between the two MCOs. Both of the MCO samples had more than 90 percent of members travel less than 60 miles to see their specialist, with an average distance traveled of 26 miles.

**Exhibit V.7**
**Test of Distance Traveled for a Sample of HIP Members, by MCO**

**Primary Providers**

| MCO | N = | Percent of Members within 30 miles | Avg Distance | Percent of Members > 30 miles | Avg Distance |
|---|---|---|---|---|---|
| Anthem | 90 | 91.1% | 15.5 | 8.9% | 45.6 |
| MDwise | 90 | 93.3% | 10.9 | 6.7% | 74.2 |

**Specialists**

| MCO | N = | Percent of Members within 60 miles | Avg Distance | Percent of Members > 60 miles | Avg Distance |
|---|---|---|---|---|---|
| Anthem | 88 | 92.0% | 26.7 | 8.0% | 89.7 |
| MDwise | 92 | 90.2% | 25.9 | 9.8% | 93.6 |

## Appointment Availability

In addition to measuring the accessibility of providers, B&A also tested for the availability of providers in the HHW and HIP networks. Using the same encounters that were drawn to sample distance in the previous section, B&A created a separate sample of PMPs and specialists contracted with the MCOs within each program to measure the availability of members to make an appointment.

Phone calls were placed by EQR team members in the month of September 2010 during normal business hours to providers that had actually seen a HHW or HIP member in CY 2009. The EQR reviewer identified themselves and asked the doctor's office questions about seeing the doctor for either urgent care, a routine checkup, or for a consultation. The questions asked varied based on the provider specialty.

*Asked of Pediatricians, Family Practitioners and General Practitioners in HHW*

- How long would it take to see the doctor if my child broke out with a fever of 101 degrees this morning?
- What would be the next available date to set an appointment for a routine physical exam for my child?

*Asked of General Internists and Gynecologists in HHW and HIP, Family Practitioners and General Practitioners in HIP*

- If I was a patient in your panel, what would be the next available date to set an appointment for a routine exam?

*Asked of Specialists in both HHW and HIP*

- If I was a patient in Hoosier Healthwise [or Healthy Indiana Plan] that had a referral from my primary care doctor, what would be the next available date to set an appointment for a consultation?

The results were stratified by MCO and by the type of question asked. Exhibit V.8 shows that almost every PMP in HHW would be available to see their patient for a same day appointment if it was an urgent situation. Between 87.2 and 92.5 percent would be available to see their doctor within two weeks for a routine exam. The rate of obtaining a consultation within two weeks varied by MCO, but at least two-thirds of providers could see the HHW member within two weeks.

**Exhibit V.8**
**Test of Appointment Availability for a Sample of HHW Members, by MCO**

**Primary Providers (Urgent Appt)**

| MCO | N = | Percent Offering Same Day Appt | Percent Offering Appt > 1 Day |
|---|---|---|---|
| Anthem | 33 | 100.0% | 0.0% |
| MDwise | 30 | 96.7% | 3.3% |
| MHS | 32 | 100.0% | 0.0% |

**Primary Providers (Routine Appt)**

| MCO | N = | Pct Offering Appt in 2 weeks | Pct Offering Appt > 2 weeks |
|---|---|---|---|
| Anthem | 40 | 92.5% | 7.5% |
| MDwise | 40 | 92.5% | 7.5% |
| MHS | 39 | 87.2% | 12.8% |

**Specialists (Consultation)**

| MCO | N = | Pct Offering Appt in 2 weeks | Pct Offering Appt > 2 weeks |
|---|---|---|---|
| Anthem | 23 | 65.2% | 34.8% |
| MDwise | 22 | 81.8% | 18.2% |
| MHS | 22 | 72.7% | 27.3% |

The rates for obtaining a primary care routine visit within two weeks were slightly higher among HIP providers than HHW providers. The ability to obtain a consultation from a specialist within two weeks was also higher among HIP providers than what was found among HHW providers. (Refer to Exhibit V.9 on the next page.)

**Exhibit V.9**
**Test of Appointment Availability for a Sample of HIP Members, by MCO**

**Primary Providers (Routine Appt)**

| MCO | N = | Pct Offering Appt in 2 weeks | Pct Offering Appt > 2 weeks |
|---|---|---|---|
| Anthem | 51 | 94.1% | 5.9% |
| MDwise | 53 | 92.5% | 7.5% |

**Specialists (Routine Appt)**

| MCO | N = | Pct Offering Appt in 2 weeks | Pct Offering Appt > 2 weeks |
|---|---|---|---|
| Anthem | 19 | 84.2% | 15.8% |
| MDwise | 22 | 90.9% | 9.1% |

## 24 Hour Availability

As stated in the introduction to this section, HHW and HIP providers must be available to respond to members 24 hours per day, seven days per week. This can be achieved by answering the phone themselves after hours, coordinating with another provider, hiring a nurse line, or utilizing an outbound answering machine that instructs the member how to contact the physician. The OMPP sets a goal of 100 percent compliance.

The OMPP requires each MCO to conduct an annual audit on at least a sample of providers for 24/7 availability each year. The annual report submitted by each MCO for the CY 2009 audits is one of the measures being validated this year in Chapter VII: *Validating Performance Measures* and will be discussed more in that section. Briefly, the percentage of providers that each MCO found compliant with the standards is as follows:

- Anthem: 58.0% compliant in HHW, 62.6% compliant in HIP
- MDwise: 98.8% compliant in HHW, 98.8% compliant in HIP
- MHS: 91.3% compliant in HHW

B&A obtained the listing of all providers contacted by each MCO in their 24 hour availability audit in CY 2009. From this list, we selected a subset that included at least one physician from each county for each MCO. Calls were made at different after-office hours to providers in July through September 2010.

The results of our calls to HHW providers are shown in Exhibit V.10 on the next page. More than 90 percent of the time, the doctors in our sample had an outbound message on their office answering machine. This is an acceptable method for OMPP so long as the message includes information as to how the member can get in contact with the doctor. Our audit shows that among the calls where an outbound answering machine was provided, MDwise physicians provided another phone number to patients more than 91 percent of the time, but this was only true of Anthem providers 78 percent of the time and MHS providers 74 percent of the time.

The OMPP does not explicitly state that MCOs must ensure that providers also give out information if the patient calling has an emergency. In fact, this is not being included in outbound messages at a number of physician offices in the HHW program. About 68 percent of Anthem and MHS providers sampled have a message with instructions if there is an emergency and 80 percent of MDwise providers had it. Interestingly, about three-quarters of MDwise providers had both types of messages yet just over half of Anthem and MHS providers had it.

B&A's results for Anthem (56%) are about the same as the MCO's audit (58%). But B&A's pass results for MDwise and MHS (69% and 55%) are much lower than what the MCOs reported to OMPP (99% and 91%, respectively).

**Exhibit V.10**
**Test of 24 Hour Availability for a Sample of HHW Members, by MCO**

**When Live Answering Service or the Doctor was Reached**

| | | Ability to Contact the Doctor | |
|---|---|---|---|
| MCO | N = | PASS = Yes, before next business day | FAIL = Don't know or Refused |
| Anthem | 17 | 53% | 47% |
| MDwise | 10 | 40% | 60% |
| MHS | 12 | 67% | 33% |

**When a Recorded Answering Machine was Reached**

| | | Completeness of Outbound Message | | |
|---|---|---|---|---|
| MCO | N = | If Urgent or Nonurgent, call doctor at [phone #] | If Emergency, hang up and call 911 or go to the ER | PASS = Both Messages Included |
| Anthem | 100 | 78% | 68% | 57% |
| MDwise | 101 | 91% | 80% | 72% |
| MHS | 110 | 74% | 67% | 54% |

**Pass Score Under Either Provision**

| MCO | N = | PASS | FAIL |
|---|---|---|---|
| Anthem | 117 | 56% | 44% |
| MDwise | 111 | 69% | 31% |
| MHS | 122 | 55% | 45% |

For the 24 hour availability audit for HIP providers, Anthem did better than the results found for their providers in HHW. MDwise scored slightly worse. Once again, near 90 percent of providers utilize an answering machine to fulfill the 24 hour availability requirement in HIP. Whereas a similar percentage of HIP providers indicated how a patient could access the doctor on their answering machine as the HHW providers, more Anthem and MDwise providers also had language related to what to do in an emergency.

B&A's results for Anthem (68%) are about the same as the MCO's audit (63%). But B&A's pass results for MDwise (66%) are much lower than what the MCO reported to OMPP (99%).

**Exhibit V.11**
**Test of 24 Hour Availability for a Sample of HIP Members, by MCO**

**When Live Answering Service or the Doctor was Reached**

| | | Ability to Contact the Doctor | |
|---|---|---|---|
| MCO | N = | PASS = Yes, before next business day | FAIL = Don't know or Refused |
| Anthem | 11 | 82% | 18% |
| MDwise | 11 | 55% | 45% |

**When a Recorded Answering Machine was Reached**

| | | Completeness of Outbound Message | | |
|---|---|---|---|---|
| MCO | N = | If Urgent or Nonurgent, call doctor at [phone #] | If Emergency, hang up and call 911 or go to the ER | PASS = Both Messages Included |
| Anthem | 91 | 79% | 84% | 66% |
| MDwise | 84 | 88% | 75% | 68% |

**Pass Score Under Either Provision**

| MCO | N = | PASS | FAIL |
|---|---|---|---|
| Anthem | 102 | 68% | 32% |
| MDwise | 95 | 66% | 34% |

## Conclusion

Through our review of GeoAccess reports, locations for obtaining services within and across counties, and our sample of actual distances traveled by members, B&A believes that each of the MCOs in HHW and HIP exceed both the federal standards and the OMPP contractual requirements for member's access to primary care. This holds true in almost all cases for specialists as well when examined using the GeoAccess reports. The analysis of actual encounters, however, reveals that there are some specialists where access could be improved in HHW. This is less of an issue in HIP.

Our availability appointment audit revealed that members are ensured access to getting appointments for urgent and routine care within acceptable standards. B&A suggests that the OMPP research further our 24-hour availability audit results when compared to the MCO's self-reported results. We believe that an area that may need the most improvement can be easily fixed by having the MCOs work with their physician's office on the outbound message that is conveyed when members call in after hours.

# SECTION VI: ANALYSIS OF RETROSPECTIVE AUTHORIZATIONS, CLAIM DENIALS AND CLAIM DISPUTES

## Introduction

In last year's external quality reviews (EQRs) of the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP), Burns & Associates, Inc. (B&A) conducted an extensive review of the managed care organizations' (MCOs') policies and procedures related to the authorization of services and utilization management. This, in part, was to assist the Office of Medicaid Policy and Planning (OMPP) give feedback to a legislative oversight committee to:

1. Report on the similarities and differences across the MCOs with respect to authorization policies and procedures,

2. Compile the results of authorizations completed in Calendar Year (CY) 2008 to understand differences in timeliness in decision making, denial rates, and appeals rates, and

3. Identify recommendations for improving the authorization processes in OMPP's managed care programs

The results of this review were shared with the oversight committee and B&A delivered a report to the OMPP on this focus study as part of our annual EQR. Actions were taken to provide improvement both at the OMPP and at the individual MCOs, but these actions did not begin to be enacted until CY 2010.

Although all policies and procedures related to authorizations were reviewed by the B&A Clinical Review team last year, specific cases that were reviewed focused on prior authorizations and concurrent reviews. In an effort to round out our review, this year B&A examined a sample of retrospective authorizations as well as claims denials that were denied for clinical reasons in CY 2009. An examination of policies and procedures was not conducted this year since the MCOs indicated that no substantive changes were made to the policies and procedures in CY 2009 since our last review.

Separately, B&A non-clinical staff reviewed the process for handling provider claims disputes with claims processing staff at each MCO. In addition to a review of policies and procedures, we examined a sample of cases with the MCO staff during our onsite visits.

## Methodology

<u>Understanding MCO Processes</u>

The first step in B&A's approach to examining a sample of retrospective authorizations and claims denials was to determine how each MCO identified them in their system. As we learned last year, each MCO in the HHW and HIP use various tracking systems and, in some cases,

multiple vendors to conduct authorization reviews and to adjudicate claims. Therefore, before drawing a sample, B&A asked each MCO the following questions:

1. How do you flag retrospective reviews in your system to distinguish them from pre-service or concurrent reviews?

2. To best stratify a sample of retrospective reviews for our study, we are interested in the reasons that the plans conduct retrospective reviews.
    a. Do you retain a 'reason code' on file for each retrospective review conducted?
    b. If yes, is there a finite list of reasons? Please list them.

3. With respect to the volume of retrospective reviews specifically related to provider claims disputes, can you track the amount of a cutback on a claim?

4. *For HHW MCOs*: Report QR-S3 (Claims Denial Reasons) is only required to be submitted when an MCO's denial rate exceeds 15% in a quarter.
    a. As a matter of policy, does the MCO store a denial reason for every denial even if this report is not required to be submitted?
    b. If yes, is there a finite list of reasons? Please list them.
    c. Would the MCO be able to provide (in the aggregate) a frequency of claims denied by denial reason for all claims reported denied on the QR-S1 reports in submitted for CY 2009?

    *For HIP health plans*: Report 1-S3 requires that you submit information on the top 10 denial reasons using standardized HIPAA claims adjudication reasons.
    a. Would you be able to provide (in the aggregate) a frequency of claims denied by denial reason for all claims reported denied and not just those in the top 10 denial reasons for CY 2009?

B&A learned that Anthem and some of the MDwise delivery systems separately flag authorizations made or denied as retrospective while MHS and some of the MDwise delivery systems do not. The latter group can identify such reviews by comparing the authorization review date to the date of service.

With the exception of the Hoosier Alliance and Select Health delivery systems at MDwise, specific reason codes for retrospective reviews are not stored within the utilization management department. If a claim was disputed by a provider and the dispute required clinical review, the reason for the objection would be stored by the claims processing staff. All of the MCOs track when cutbacks are made on a claim that was paid to help inform a clinical reviewer if a provider is disputing a claim.

The three MCOs also reported that they track specific denial reasons for each claim. Often, more than one reason code is stored with the claim history.

Developing a Sample

Once this information was provided, B&A requested a list of all claim denial reason codes from each MCO (or subdelegate) that adjudicates claims. The B&A team identified claim denial reasons that would appear to involve clinical review before making the decision to deny. One exclusion from this was emergency room cases that were reviewed for "prudent layperson" (PLP) criteria. The OMPP had conducted an extensive study of PLP cases in the prior year. From this subset list, B&A requested a list of all claims in CY 2009 that had clinically-related denial reasons to draw a sample of cases for our review. Separately, we asked for a list of all authorizations tagged as retrospective reviews in CY 2009.

Our intent was to review cases where utilization management staff would be participating in the ultimate decision on the case. Therefore, we sampled cases from both the retrospective authorization lists provided as well as the claims denial lists provided. Because MHS reported that they did not classify retrospective authorizations separately, we oversampled MHS on claims denials made based on clinical reasons.

Our sample selection for both Anthem and MDwise included cases in the HHW and HIP. Because the MCOs reported that the processes used were the same for both programs, we report our findings among the cases reviewed for both programs combined throughout this section.

Separately, B&A gathered information to develop a sample of claims that had been disputed by providers. The OMPP requires the HHW MCOs to submit a quarterly report that itemizes the total count of claim disputes received. For HIP MCOs, a monthly report submission is required. One of the desk review items requested in the EQR Guide was for the MCOs to submit to B&A an Excel table itemizing all of the claims disputes counted on these reports for the period covering CY 2009. B&A requested items such as the provider name and ID, the date of the objection, the nature of the objection, and the service that was rendered on the disputed claim.

Sample Drawn

The Clinical Review Team examined 289 cases in all—84 retrospective authorizations and 204 claim denials (refer to Exhibit VI.1 on the next page). Forty-five percent of the retrospective authorizations were related to inpatient care, and more than 75 percent of the cases were either inpatient, outpatient or emergency room-related. There was a greater portion of Anthem's cases related to inpatient care than MDwise, but in both cases the majority of the cases reviewed were hospital-related.

There were differences, however, in the types of claims denials reviewed by MCO. Sixty-four percent of MHS's cases were related to inpatient care, but the B&A reviewers found that many of these could have been classified as retrospective authorizations as well. For Anthem and MDwise, just over one quarter of the claim denials reviewed were related to office visits and consultations. A sizeable portion of MDwise's cases were related to ER visits which resulted in the fact that upon initial review these cases were not clearly marked to the reviewers as PLP cases.

**Exhibit VI.1**
**Retrospective Authorizations and Claims Denials Samples Reviewed by the EQR Clinical Review Team**

| | Anthem | | MDwise | | MHS | | TOTAL | |
|---|---|---|---|---|---|---|---|---|
| | Sample | Pct of Total in Sample | Sample | Pct of Total in Sample | Sample | Pct of Total in Sample | Sample | Pct of Total in Sample |
| **Total Retrospective Auths** | 50 | 60% | 34 | 40% | 0 | 0% | 84 | 100% |
| **By Service Category** | Number | Percent in MCO Sample | Number | Percent in MCO Sample | Number | Percent in MCO Sample | Number | Percent in MCO Sample |
| Ambulatory or Outpatient Surgical | 4 | 8% | 0 | 0% | | | 4 | 5% |
| OP Diagnostic, Radiology, Pathology | 6 | 12% | 8 | 24% | | | 14 | 17% |
| Inpatient--Med/Surg or Observation | 28 | 56% | 10 | 29% | | | 38 | 45% |
| Office Visits, Consults, Specialty Referral | 3 | 6% | 5 | 15% | | | 8 | 10% |
| Physical, Occupational or Speech Therapy | 1 | 2% | 2 | 6% | | | 3 | 4% |
| Durable Medical Equipment | 2 | 4% | 2 | 6% | | | 4 | 5% |
| Home Health Visits | 1 | 2% | 2 | 6% | | | 3 | 4% |
| ER & Other | 5 | 10% | 5 | 15% | | | 10 | 12% |
| **Total** | **50** | | **34** | | | | **84** | |

| | Anthem | | MDwise | | MHS | | TOTAL | |
|---|---|---|---|---|---|---|---|---|
| | Sample | Pct of Total in Sample | Sample | Pct of Total in Sample | Sample | Pct of Total in Sample | Sample | Pct of Total in Sample |
| **Total Claims Denials** | 63 | 31% | 67 | 33% | 75 | 37% | 205 | 100% |
| **By Service Category** | Number | Percent in MCO Sample | Number | Percent in MCO Sample | Number | Percent in MCO Sample | Number | Percent in MCO Sample |
| Ambulatory or Outpatient Surgical | 9 | 14% | 6 | 9% | 3 | 4% | 18 | 9% |
| OP Diagnostic, Radiology, Pathology | 11 | 17% | 9 | 13% | 3 | 4% | 23 | 11% |
| Inpatient--Med/Surg or Observation | 12 | 19% | 3 | 4% | 48 | 64% | 63 | 31% |
| Office Visits, Consults, Specialty Referral | 18 | 29% | 19 | 28% | 1 | 1% | 38 | 19% |
| Physical, Occupational or Speech Therapy | 1 | 2% | 0 | 0% | 2 | 3% | 3 | 1% |
| Durable Medical Equipment | 9 | 14% | 2 | 3% | 3 | 4% | 14 | 7% |
| Home Health Visits | 0 | 0% | 1 | 1% | 1 | 1% | 2 | 1% |
| ER & Other | 3 | 5% | 27 | 40% | 14 | 19% | 44 | 21% |
| **Total** | **63** | | **67** | | **75** | | **205** | |

B&A also selected 20 claim disputes from each of the three MCOs to be reviewed with MCO representatives in the onsite meetings. B&A ensured that a representative sample was selected from each MCO. In the case of Anthem and MDwise, 10 HHW dispute cases were selected and 10 HIP dispute cases were selected. Our sample was selected factoring in variation that included:

- Disputes adjusted in favor of the provider and disputes where the denial was upheld
- A variety of reasons cited for the nature of the dispute
- A variety of provider types and specialties

B&A's Process

Once the study sample was selected, the case list was given to each MCO. The MCOs were asked to provide all data, including any medical records, which were used in determining the disposition of the authorization or claim denial. This data was transmitted to B&A via CDs. The two MDs and RN on the Clinical Review Team then reviewed the materials provided for each case. The RN completed a review tool for each case which was passed on to the medical doctors for further review. A copy of the review tools appears in Appendix B.

The physicians reviewed all sample cases with specific focus on possible clinical issues that may have occurred during the course of the retrospective review by the MCOs. This was for both retro authorizations and for claim denials. One of the medical doctors on the team is a Certified Professional Coder and assisted in clarifying when questions arose as to what specific treatment event was being disputed by reviewing the CPT codes where it was otherwise not clear in the documentation.

There was also an Inter-Rater Reliability (IRR) process used to assure confidence in the concurrence and consistency with each team member's answers to the tool questions. Approximately 20 percent of the entire sample was put through the IRR process. This was accomplished by the Clinical Team leader reviewing the RN and other physician team member's answers after independently reviewing the cases selected for IRR. If discrepancies were found, these were communicated to the entire team to assure consistency in answering the questions.

Once the review of all sample files was completed, the responses on the tool were entered into a Microsoft Access database designed specifically for this project to allow for ease of query and analysis. The reviewers separately maintained notes on specific cases that illustrated some of the findings tabulated from the tool. Many of these observations appear in the next section.

## Findings and Observations from the Review of Retrospective Authorizations and Claim Denials

It is important to note at the outset that the clinical aspect of this review was not done on a statistically valid sampling technique. It was, however, done on a representative sample from each MCO. Observations and findings are not intended to represent statistically valid conclusions. They are intended to convey reviewer impressions and possible trends. The OMPP and the MCOs can use these observations in a manner to support continuous quality improvement of their own processes.

Many of the issues or observations mentioned in this section were also identified in last year's EQR where the focus was on prior authorizations. B&A recognizes that these issues have already been communicated to the MCOs but were not communicated until January 2010. As such, this review for the look-back period of CY 2009 was not during a time when the MCOs may have been able to take action on any of the suggestions presented here. The MCOs have already communicated to B&A and the OMPP that some changes have already been implemented in 2010. B&A looks forward to a follow-up review in a future EQR after the MCOs have had an opportunity to make policy and procedure changes.

Findings

Exhibits VI.2 and VI.3 on pages VI-7 and VI-8 present the results of B&A's review of retrospective authorizations and claim disputes, respectively.

Exhibit VI.2 shows that within our sample of retrospective authorizations reviewed, the records showed in almost every case that clinical staff reviewed these authorizations and that physicians reviewed the authorizations which were denied. In the case of Anthem, 24 percent of the cases were denied and B&A could determine the reason for all but one of these cases. Usually, the reason cited was that the service was not medically necessary. In the case of MDwise, 82 percent of the cases reviewed were denied, but in 19 of the 28 cases it was not evident from the records provided why the MCO denied the authorization.

Among just the denied authorizations reviewed, the B&A Review Team was not able to provide an opinion if the denial was appropriate in eight out of 12 cases. This was due to the fact that, among all of the authorizations reviewed, we found that the medical records provided to support the determination (approved or denied) were not appropriate or adequate in most of Anthem's cases.

For MDwise, our team was able to provide an opinion in 89 percent of the retrospective authorization cases reviewed. In all but two of these cases, we believe that the determination was appropriate.

Exhibit VI.3 shows our findings from the review of claim denials. Among these cases, MHS clinical staff (both nurse and doctor) reviewed two-thirds of the cases. B&A believes that many of these cases, in effect, were similar to retrospective authorizations but in the form of a claim submission. For Anthem, we could not determine who reviewed the case the majority of the time.

Interestingly, although all of the claims in our sample had been denied at some point by the MCOs, 27 percent of them were ultimately overturned, just over half upheld the denial status, and it could not be determined for sure in 21 percent of the cases. Among the cases that remained denied (106 total), in half of these cases the MCO cited that the service was not medically necessary.

There were issues with the lack of documentation provided in half of the cases reviewed. This meant that the B&A team could not give an informed opinion on the appropriateness of denied claims 57 percent of the time.

Our review of the individual cases led to some observations that illustrate some of our findings about MCO processes. These observations appear beginning on page VI-9.

## Exhibit VI.2
## Findings from B&A's Review of Retrospective Authorizations

| | Anthem | | MDwise | | TOTAL | |
|---|---|---|---|---|---|---|
| | Sample | Pct of Total in Sample | Sample | Pct of Total in Sample | Sample | Pct of Total in Sample |
| **Total Retrospective Auths** | **50** | **60%** | **34** | **40%** | **84** | **100%** |
| | Number | Percent in MCO Sample | Number | Percent in MCO Sample | Number | Percent in MCO Sample |
| **MCO Reviewer (may be more than one)** | | | | | | |
| Nurse (RN or LVN) | 44 | 57% | 25 | 46% | 69 | 53% |
| Physician | 29 | 38% | 23 | 43% | 52 | 40% |
| Non-Clinical Staff | 1 | 1% | 3 | 6% | 4 | 3% |
| Cannot be determined from file | 3 | 4% | 3 | 6% | 6 | 5% |
| **Total** | **77** | | **54** | | **131** | |
| **Final Determination** | | | | | | |
| Approved | 23 | 46% | 3 | 9% | 26 | 31% |
| Approved with Change | 12 | 24% | 2 | 6% | 14 | 17% |
| Denied | 12 | 24% | 28 | 82% | 40 | 48% |
| Cannot be determined from file | 3 | 6% | 1 | 3% | 4 | 5% |
| **Total** | **50** | | **34** | | **84** | |
| **Reason for Denial** | | | | | | |
| Insufficient Provider Documentation | 1 | 8% | 1 | 4% | 2 | 5% |
| Investigational or Experimental | 2 | 17% | 0 | 0% | 2 | 5% |
| Equally Effective, Less Costly | 1 | 8% | 2 | 7% | 3 | 8% |
| No Prior Authorization on File | 0 | 0% | 1 | 4% | 1 | 3% |
| Not Medically Necessary | 7 | 58% | 5 | 18% | 12 | 30% |
| Cannot be determined from file | 1 | 2% | 19 | 56% | 20 | 24% |
| **Total** | **12** | | **28** | | **40** | |
| **In B&A's Opinion, Was Auth Denial Appropriate?** | | | | | | |
| Yes | 4 | 33% | 23 | 82% | 27 | 68% |
| No | 0 | 0% | 2 | 7% | 2 | 5% |
| Unable to Determine | 8 | 67% | 3 | 11% | 11 | 28% |
| **Total** | **12** | | **28** | | **40** | |
| **Appropriate and/or Adequate Medical Records Provided for Review?** | | | | | | |
| Yes | 6 | 12% | 23 | 68% | 29 | 35% |
| No | 44 | 88% | 11 | 32% | 55 | 65% |
| **Total** | **50** | | **34** | | **84** | |

## Exhibit VI.3
## Findings from B&A's Review of Claim Denials

| | Anthem | | MDwise | | MHS | | TOTAL | |
|---|---|---|---|---|---|---|---|---|
| | Sample | Pct of Total in Sample | Sample | Pct of Total in Sample | Sample | Pct of Total in Sample | Sample | Pct of Total in Sample |
| **Total Claim Denials** | **63** | **31%** | **67** | **33%** | **75** | **37%** | **205** | **100%** |
| | Number | Percent in MCO Sample | Number | Percent in MCO Sample | Number | Percent in MCO Sample | Number | Percent in MCO Sample |
| **MCO Reviewer (may be more than one)** | | | | | | | | |
| Nurse (RN or LVN) | 20 | 31% | 28 | 38% | 51 | 40% | 99 | 38% |
| Physician | 4 | 6% | 22 | 30% | 52 | 41% | 78 | 30% |
| Non-Clinical Staff | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Cannot be determined from file | 40 | 63% | 24 | 32% | 23 | 18% | 87 | 33% |
| **Total** | **64** | | **74** | | **126** | | **264** | |
| **Final Disposition** | | | | | | | | |
| Claim Denial Overturned | 30 | 48% | 16 | 24% | 9 | 12% | 55 | 27% |
| Claim Denial Upheld | 16 | 25% | 30 | 45% | 60 | 80% | 106 | 52% |
| Cannot be determined from file | 17 | 27% | 21 | 31% | 6 | 8% | 44 | 21% |
| **Total** | **63** | | **67** | | **75** | | **205** | |
| **Reason for Continued Denial** | | | | | | | | |
| Insufficient Documentation | 0 | 0% | 0 | 0% | 1 | 2% | 1 | 1% |
| Investigational or Experimental | 1 | 6% | 0 | 0% | 0 | 0% | 1 | 1% |
| Equally Effective, Less Costly | 0 | 0% | 13 | 43% | 0 | 0% | 13 | 12% |
| No Prior Authorization on File | 2 | 13% | 2 | 7% | 1 | 2% | 5 | 5% |
| Not Medically Necessary | 9 | 56% | 2 | 7% | 42 | 70% | 53 | 50% |
| Cannot be determined from file | 4 | 25% | 13 | 43% | 16 | 27% | 33 | 31% |
| **Total** | **16** | | **30** | | **60** | | **106** | |
| **In B&A's Opinion, Was Claim Denial Appropriate?** | | | | | | | | |
| Yes | 6 | 38% | 17 | 57% | 21 | 35% | 44 | 42% |
| No | 0 | 0% | 1 | 3% | 1 | 2% | 2 | 2% |
| Unable to Determine | 10 | 63% | 12 | 40% | 38 | 63% | 60 | 57% |
| **Total** | **16** | | **30** | | **60** | | **106** | |
| **Appropriate and/or Adequate Medical Records Provided for Review?** | | | | | | | | |
| Yes | 37 | 59% | 22 | 33% | 41 | 55% | 100 | 49% |
| No | 26 | 41% | 45 | 67% | 34 | 45% | 105 | 51% |
| **Total** | **63** | | **67** | | **75** | | **205** | |

Observations Pertaining to All Three MCOs

1. As noted in last year's EQR which reviewed the prior authorization process and procedures, definitions of terms remains a challenge. The terms *retro authorization*, *claim appeal*, *claim dispute* and *grievance* mean different things to each MCO. There are other definition issues, but these terms are the most pertinent to this clinical review.

2. Format differences of how the MCOs collect and manage authorizations and claims data remains so distinctly different from each other that it significantly impairs a reviewer's (whether an EQRO, the OMPP or CMS) ability to easily collect and compare data and information. This observation is above and beyond the definition issue cited above.

3. It appeared that the MCOs did a better job providing clinical documentation for this year's EQR study. There were certain exceptions to this observation which will be noted later.

4. Overall, the clinical review team found very few actual clinical issues that were disputed in either retro-authorization or claims disputes. The exception to this is the ER visits where the PLP rule was cited (see #6 below). Most cases in the sample were denied for administrative reasons. It is our opinion that certain administrative rules appear to be used to deny the opportunity to adjudicate based on the clinical merits of the case.

   One example is the "60 day" rule for timely filing a claims dispute. We understand this is an administrative rule (405 IAC 1-1.6) that sets time limits for out-of-network (OON) providers to submit claim disputes. Each MCO has established a 60-day limit for in-network providers to file claims disputes as well. It is our opinion that 60 days is an unusually short turnaround time to demand of a large institution, such as a hospital, or even of a private physician's office. The operational reality of dealing with multiple payers, multiple sets of rules, and the high volume of third party payers is that this short time period prevents many otherwise legitimate claims to even get a review at all. They are simply denied for being untimely, even if evidence was provided that merited a re-review by the MCO.

5. The other administrative reason for claim denials that is often cited is "OON". Although we agree that this is a key issue in a managed care model of health care delivery, the fact that it is so often referenced in our very small sample raises the question of how effectively the MCOs are educating both the members and providers about this issue. We agree with the legitimacy of denying a claim for OON; however, it can be an ongoing reason why there is animosity and/or lack of participation by providers. It deserves to be looked at to see what more can be done to reduce the frequency of OON denials.

6. Although ER visits were not supposed to be included in the sample because of the previous PLP study already mentioned, a large percentage of retrospective authorization review cases included ER visits. It was our finding that not meeting the PLP rule was the main reason for denial. Our clinical review agreed that these denials were appropriately made by the MCO, at least when adequate records were included. B&A recognizes that a new policy was put in place in mid-2009 to pay at least a $25 triage fee every ER case. The PLP test is now done to determine if the case was emergent and merits a higher payment than the triage fee.

Observations Pertaining to MDwise

1. There were multiple ER visits initially denied due to "PLP." Subsequently, they were overturned for the treating ER physician after his/her appeal for reimbursement of their professional fees. There was no information if the hospital (ER facility) was included in this overturned denial.

2. As noted last year, certain MDwise delivery systems did not maintain, or send for review, adequate clinical records for the cases selected. In fact, there was a significant lack of MCO documentation to explain what, if any, retro review process took place. For example:

    a. CMCS (St Francis) provided many cases for this review. Those that included copies of MCO denial letters were not signed by any individual, but by the "Medical Management Department." Thus, it was often impossible to know what level of clinical review, if any, took place. One case was the denial of an out-of-state delivery of a normal healthy infant girl. The reason for denial was it was out of state, even after it was appealed. There were many other examples of OON denials.

    b. ProHealth provided six cases for review. The records were unclear and/or inadequate. We were unable to determine if an appeal/dispute was requested or accomplished.

    c. For Hoosier Alliance, there were several examples of a clinical review citing the wrong Milliman guideline to deny an inpatient stay. This problem was extensively discussed in last year's EQR study. Issues such as staff training and certification in how to properly use these and other nationally recognized guidelines were identified. It is our assumption that any improvements in this particular issue will require a year or two of intensive training and policy revision at the MCO level.

Observations Pertaining to Anthem

1. The Anthem sample included many retro-authorizations for routine vaginal births. They were all approved and there was no evidence of a clinical review.

2. In the Anthem HHW sample of 25 cases, three had records of other members included in the sample case. This is a problem identified in last year's EQR prior authorization study.

3. Many files received from the sample of HIP cases were extremely disorganized. There was a separate file of documents for clinical information, a separate file for claims information and a third file for any appeal/dispute information. There was no cross reference or link to allow ease for the reviewer to find the correct information for each file. For example, there were many denials for inpatient stays or reduction in payment according to fee schedules, but it was unclear from the lack of MCO records as to what the appeal was based on, or even if there was an appeal.

4. Anthem sent documentation to support their determinations which were as small as two pages and as large as 753 pages. This large file was actually two separate inpatient stays by the same member. There were no MCO notes or records; therefore, the clinical reviewers had no idea what the issue was, or even if there was a denial. This sort of inconsistency in documentation was seen frequently in the Anthem cases.

5. There were several examples of a hospital provider having clear documentation that they attempted to call Anthem for pre-certification (PA), but had to leave a voice mail. Anthem never attempted to call them back, even with multiple calls by the provider. Anthem then denied the claim for lack of PA. (One example of this is HIP case #3655142).

6. There were several examples in the Anthem sample where a provider was caught in a "Catch-22" about member eligibility. One example was a member who was in HIP at the outset of a care event but lost that coverage at the end of a certain month. The MCO called OMPP and was assured the member would fall to HHW coverage which would cover the cost of care. Ultimately, neither HIP nor HHW covered the care and the provider was left without any payment. (One example is HIP case #37326691).

7. Many of the Anthem cases for review had copies of denial letters (form letters) included but none of them had any date on the letter other than the date of service. Reviewers could not tell if this was the initial denial that was being appealed or the final letter after adjudication of the appeal. Thus, we don't know for sure what the outcome of the appeal was.

8. There was one example of a claim dispute for an ER bill sent to Anthem. They sent back a denial letter for an inpatient stay of different dates.

9. Anthem used its own set of jargon and abbreviations, many of which were not understood by the clinical review team. One example was multiple cases in which the denial reason was "DNREC."

10. A number of Anthem cases had records of the wrong member included in files. One example is Case #0214066204 in which all the clinical notes are for a different member than the claim/denial information.

<u>Observations Pertaining to MHS</u>

1. MHS had a large number of cases in the sample which were ER visit disputes based on the PLP rule.

2. MHS also had a relatively large number of denials to hospitals based on the 60-day time limit to file an appeal. Several of these included sufficient clinical records that clearly showed that the MCO had made a mistake in the initial denial, but the denial was sustained due to this rule without even reviewing the clinical issue.

3. MHS had several instances where clinical information from a different member was embedded within the clinical records sent for this review.

4. MHS has no identification of the staff member who is reviewing the case; the EQR reviewer cannot tell if it is a RN, physician, or support staff.

5. MHS had several examples of the wrong Milliman guideline being cited as support for a denial. One example is a 24 year old inpatient with gastrointestinal symptoms diagnosed as acute cholecystitis. MHS denied the stay based on the Milliman guideline for acute "gastritis". This problem was extensively discussed in last year's EQR study. Issues such as staff training and certification in how to properly use these and other nationally recognized guidelines were identified. It is our assumption that any improvements in this particular issue will require a year or two of intensive training and policy revision at the MCO level.

6. One finding from last year's EQR study was also seen in this year's sample. This is where the MHS Medical Director denied inpatient days but included a statement in the denial letter that they will approve observation days. There was no information included in this sample as to whether the facility accepted the observation day payment or not.

7. There is documentation in case #015 that during a peer-to-peer conversation, the MCO Medical Director told the providing physician who was questioning a denial and providing additional information that he (the MCO Medical Director) "cannot change the determination based on peer-to-peer, but he (the provider) must file a formal appeal." This raises the question what of what then is the point of a peer-to-peer. This position is also quite different from the other MCOs as far as allowing additional information from a peer-to-peer be taken into consideration to reverse a previous denial.

8. Interestingly, case #044 documents a situation where a denial was overturned after a peer-to-peer conversation.

## Findings and Observations from the Review of Claim Disputes

The total number of disputes in both HHW and HIP is low as compared to the total number of claims denied. In HHW in CY 2009, there were 17,797 claim disputes reported across the three MCOs; in HIP, the total was only 1,147. On average, 3.0 percent of the claims denied in HHW were disputed by providers in CY 2009. This did not vary much between the MCOs (Anthem- 3.0%; MDwise- 2.0%; MHS- 3.8%). In HIP, 0.2 percent of Anthem's denied claims were disputed and 4.7 percent of MDwise's claims were disputed by providers.

For our onsite meetings, B&A requested that the MCOs prepare a case file for each of the sample of 20 dispute cases to be reviewed by B&A. We walked through each case with the MCO representative responsible for the final disposition of the dispute. For some MCOs, we reviewed paper documentation related to the case; for other MCOs, we reviewed the screens within the MCO's claims processing system and reviewed the notes written by the claim reviewer that addressed the dispute. Our review considered the following for each case:

- Was the process used to review the dispute valid?
- Were the notes taken to justify the final disposition complete?
- Did B&A concur with the MCO's disposition of the dispute?

In Section VII, *Validating Performance Measures*, our review of the process and accounting of claims disputes is addressed in depth. With respect to the specific cases reviewed in our sample:

1. Each MCO had a systematic process to intake, record and research the disputes received from providers.

2. Although each MCO had a specific form for providers to complete related to disputes, they each accepted any type of written communication (by fax or mail) that represented the provider's dispute.

3. The notes in the dispute file were complete enough to provide justification as to why the dispute was either upheld or overturned by the MCO.

4. There were situations where the MCO overturned its original denial and B&A concurred with this change. This was usually due to the MCO's error in how it processed the claim originally. In other cases where the denial was upheld, B&A also concurred with the MCO's rationale.

5. This being said, there was a preponderance of cases reviewed where the denial was upheld due to untimely filing of the dispute by the provider. It was often the case that the provider gave the MCO additional information to support overturning the denial, but this information was not considered by the MCO because the provider submitted the information past the 60 day filing limit post-adjudication. Although each MCO does allow for a few additional days to address mailing time (e.g., 65 to 67 days), it appears that additional provider education may be warranted as to their rights to dispute claims that are denied.

# SECTION VII: VALIDATING PERFORMANCE MEASURES

## Introduction

The validation of performance measures is one of the three mandatory activities cited by the Centers for Medicare and Medicaid (CMS) in its protocol *"Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al."* published in February 2003. In cooperation with the Office of Medicaid Policy and Planning (OMPP), Burns & Associates, Inc. (B&A) selected performance measures that are required to be reported by Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) managed care organizations (MCOs) as part of their contractual requirements.

This chapter includes the results of this review. B&A utilized Attachment I from *"Validating Performance Measures: A protocol for use in conducting Medicaid External Quality Review activities" (May 2002)* as the template for assessing the validity of performance measure results reported by the HHW and HIP MCOs. The tool was customized based on the performance measure. For this year's EQR, some performance measures selected for validation are required to be reported in both HHW and HIP while others are unique to one of the programs.

1. Claims Disputes
   Data elements on the HHW Reports QR-P1 for CY 2009
   Data elements on the HIP Reports 4-P2 for CY 2009

2. 24 Hour Availability
   Data elements and sampling methodology from the annual HHW Report AN-N3
   Data elements and sampling from the annual HIP Report 3-N4

3. Inpatient Utilization (Maternity)
   Data elements on the report QR-MNEW5 for the period 3rd Quarter 2009 (HHW only)

4. Emergency Room Utilization
   Data elements on the report QR-CA7 for the period 4th Quarter 2009 (HHW only)

5. Member Pregnancy Identification
   Data elements on the report 10-P1 for activity reported for the months of July, August and September 2009 (HIP only)

6. POWER Employer Participation
   Data elements on the annual report 8-P2 (HIP only)

B&A reviewed the actual reports submitted to the OMPP from each MCO as part of a desk review. Onsite visits were held with MCO representatives familiar with each Performance Measure listed above to discuss the methodology used to compile the data that was submitted on each report. The MCO representatives were instructed to be prepared to present to the reviewers a step-by-step methodology utilized to tabulate the results of the measure.

The purpose of the review was to ascertain the validity of the processes utilized within the reporting structures more so than the actual numbers on the reports. Specifically, B&A asked about how the data is accumulated and counted to determine if the MCOs were complying with reporting standards and definitions set forth by the OMPP. To the degree that the process was consistent at each MCO, then the results of each measure can be compared across MCOs.

The remainder of this chapter describes the approach used by B&A for this validation for each performance measure that was reviewed including:

- An overview of the measure,
- Findings from the review of MCO processes, and
- Recommendations to the MCO and/or to the OMPP.

## Performance Measure #1- Provider Claim Disputes

The reports QR-P1 (for HHW) and 4-P2 (for HIP) monitor the volume of MCO provider claims disputes received each month from all providers (i.e., in-network and out-of-network). The MCO must submit the report to the OMPP by the last day of the month following the end of the calendar quarter (for HHW) or calendar month (for HIP). The report data elements include:

- Total number of disputes received
- Total number of disputes pending from previous reporting period (HIP report only)
- Number of disputes resolved
- Number of disputes pending resolution (HIP report only)
- Average number of days to resolve disputes
- Number of disputes aged over 30 days (HIP report only)

Additionally, the HIP report requires the MCOs to identify the most frequent reasons for informal and formal claims disputes.

Findings from the Review of MCO Processes

Per the instructions from the OMPP, MCOs are required to include all verbal and written disputes received on Reports QR-P1 and 4-P2. A difference between the two reports is that the HIP Report 4-P2 requires the MCOs to distinguish between informal and formal disputes whereas the HHW Report QR-P1 is silent on this requirement. The report instructions do provide guidance on how an informal and formal dispute is defined. B&A found that the MCOs are inconsistent in how they report verbal and written disputes and informal and formal disputes.

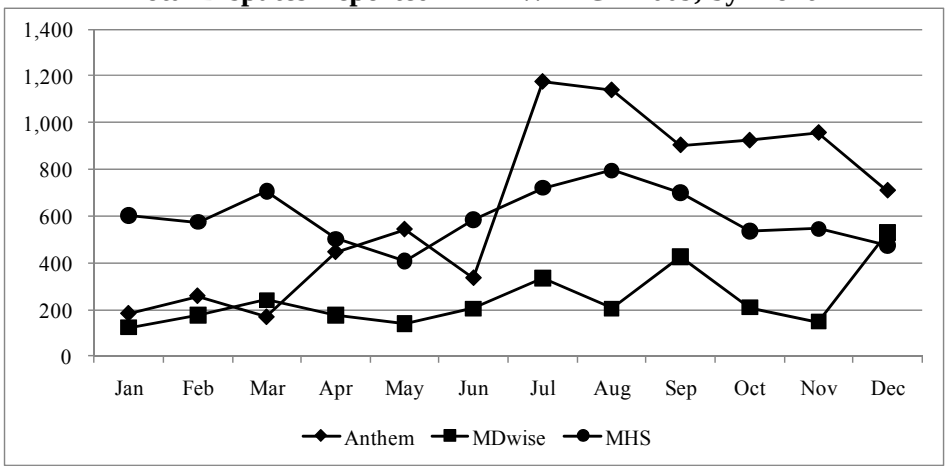
**Summary of How MCOs Classify and Report Provider Claims Disputes**

| MCO/Program | Verbal Disputes (Inquiries) | Written Disputes | Informal Disputes | Formal Disputes |
|---|---|---|---|---|
| Anthem/HHW | Included | Included | Included | Not Included |
| MDwise/HHW | Not included | Included | Included | Not Included |
| MHS/HHW | Not included | Included | Included | Not Included |
| Anthem/HIP | Not included | Included | Included | Not Included |
| MDwise/HIP | Not included | Included | Included | Not Included |

In our interviews with MCO staff, the following was discovered:

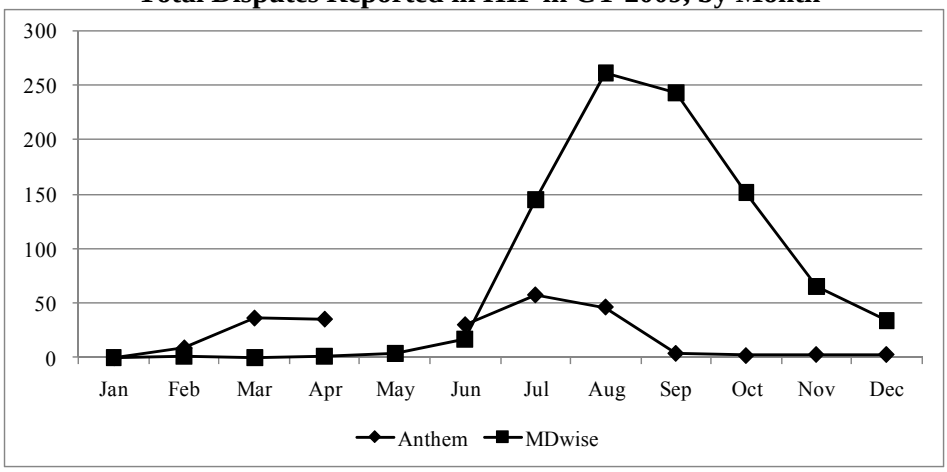
1. All MCOs characterize verbal claims disputes as calls into the provider relations or claims processing staff. Anthem records these verbal inquiries on the HHW Report QR-P1 while MDwise and MHS record these calls on the Provider Helpline statistics report. As a result, the number of disputes varies greatly between Anthem and the other two HHW MCOs (refer to Exhibit VII.1).

**Exhibit VII.1**
**Total Disputes Reported in HHW in CY 2009, by Month**




2. Whereas Anthem's HHW counts verbal inquiries on the QR-P1 report, in the HIP Anthem is not counting verbal inquiries on its 4-P2 report. The number of written disputes in the HIP was very low for Anthem in CY 2009. For MDwise, there was a spike in disputes as a result of a change in claims processors (refer to Exhibit VII.2).

**Exhibit VII.2**
**Total Disputes Reported in HIP in CY 2009, by Month**




3. The written disputes reported by all HHW and HIP MCOs are considered informal disputes as defined in the OMPP Reporting Manual and Indiana Administrative Code. Providers have 60 calendar days from the receipt of a claim determination to file a

written dispute. All MCOs reported allowing for an additional five to seven days beyond the 60 days to allow for mail delivery. Although each MCO has a form specific to filing claims disputes, they each reported that they accept fax or mail disputes not filled out on the MCO form.

4. All of the MCOs defined formal disputes as appeals when the provider is not satisfied with the outcome of their informal claims dispute. In this case, the three MCOs report these on OMPP-required grievance and appeals reports, not on the claims dispute reports. Therefore, no HHW or HIP MCO reported formal claims disputes on Reports QR-P1 or 4-P2.

5. If a provider is disputing a claim payment where a clinical determination needs to be made, these cases are automatically tagged as appeals and not counted on the claims dispute report. Each MCO described the process where these disputes flow to a nurse and/or a physician and are not reviewed by the claims processing staff.

6. The average number of days to resolve a dispute is being calculated consistently by all of the MCOs and in accordance with the reporting manual instructions.

7. The OMPP considers a provider claims dispute to be resolved when the provider has been notified of the resolution decision. The MCOs vary on this notification process. All three MCOs send a letter to providers when the written claims disputes claim is not in favor of the provider. When the dispute is overturned in favor of the provider, MHS also sends a letter in this case. Anthem and MDwise notify the provider through a remittance advice.

8. All three MCOs stated that it is common for some provider groups to go through a large batch of claims at one time and to submit a "dump" of written disputes all at the same time. This may explain some of the swings in the count of total disputes received on a month-by-month basis.

<u>Recommendations to the MCO and/or the OMPP</u>

1. Anthem should remove provider claim inquiries from its dispute report to be consistent with the other MCOs.

2. B&A recommends that only written informal claims disputes should be counted on the claims dispute report and not verbal informal claims disputes.

3. The OMPP should decide if it wants to require the MCOs to report formal claims disputes on the claims dispute report or the grievance and appeals report, or both. Clear guidance should be given as to the final decision in this matter.

4. The OMPP should give guidance as to how the MCOs should treat provider disputes that involve a clinical review. Options include:
    a. Always count as formal claims disputes and report in the manner that will be specified (see item #3 above).

b. Treat as informal disputes but count on the appeals report and not on the claims dispute report.
c. Treat as informal disputes but count on the claims dispute report with an indicator that the dispute involved clinical review.

## Performance Measure #2- 24 Hour Availability Audit

The reports AN-N3 (for HHW) and 3-N4 (for HIP) monitor the members' access to primary medical providers (PMPs) outside regular business hours. MCOs/health plans are required to ensure that members have access to PMPs 24 hours a day, seven days a week, for urgent/emergent health care needs. Therefore, PMPs must have a mechanism in place to ensure that members are able to either (a) speak to their PMP directly, (b) be in contact with a designated clinical staff person, (c) be in contact with a contracted answering service, or (d) to receive instructions on how to access emergency care or to page a doctor through an outbound message on the PMP office answering machine.

To monitor the PMPs availability, the MCOs are required to conduct an annual test of provider availability among a sample of PMPs. For both HHW and HIP, a sample of at least five percent of the MCO's PMPs must be included each year that reflects a representation of each county served in the state. MCOs are required to submit the audit by January 31st of each year.

OMPP specifies a target of 100% compliance among the PMPs surveyed in the audit. For PMPs found non-compliant, the OMPP requires that MCOs put corrective actions in place with the PMP within 30 days of notification.

The format of the report in HHW AN-N3 is not defined by the OMPP. There is a specified format for the HIP 3-N4 report. The specific data elements required to be submitted in each report are as follows:

- Description of the methodology used to draw the sample (HHW and HIP)
- Total number of PMPs called (HHW and HIP)
  - By county and by specialty (HIP report only)
- Total number of PMPs called that met availability standards (HIP report only)
- Percentage of PMPs called that met availability standards (HHW and HIP)

Findings from the Review of MCO Processes

**Exhibit VII.3**
**Provider Availability Audit Statistics**

| | HHW | | | HIP | |
|---|---|---|---|---|---|
| | **Anthem** | **MDwise** | **MHS** | **Anthem** | **MDwise** |
| Sample Size | 100.0% | 30.0% | 100.0% | 8.2% | 20.0% |
| PMPs Called | 1,031 | 412 | 1,020 | 174 | 248 |
| % that Met Standard | 58.0% | 98.8% | 91.3% | 62.6% | 98.8% |

In our interviews with MCO staff, the following was discovered:

1. The three MCOs each use a subcontractor to conduct the availability audits. The firms used by Anthem and MDwise conduct the audit all at one time during the year while MHS's subcontractor conducts them on a rolling basis throughout the year.

2. The sampling methodologies used by Anthem and MDwise differed but both appeared to be appropriate for what was required by the OMPP.

3. All of the MCOs stated that non-compliant PMPs are subsequently re-audited. MHS reported that the re-audit is conducted within the following calendar quarter after the initial audit. Anthem and MDwise reported conducted that re-audit as part of the following year audit.

4. All MCOs stated that a PMP can only achieve full compliance or non-compliance and not "partial compliance".

5. Anthem's results are much lower than the other MCOs. Some of this may be due to the fact that, in addition to the definition of compliance stated in the OMPP instructions, Anthem requires that the PMP's outbound answering machine message includes language about instructions for accessing both urgent and emergent (e.g. call 911) care. Anthem reported that there were situations where PMPs had language related to one situation but not the other.

<u>Recommendations to the MCO and/or the OMPP</u>

1. The OMPP may want to consider requiring more detail on the sampling methodology used by each MCO for those that do not audit 100% of their PMPs. Although the MCO's verbal descriptions to B&A of their methodology appeared appropriate, this information was not conveyed to the OMPP on Report AN-N3 or 3-N4.

2. The OMPP should provide a template to the HHW MCOs for reporting results to ensure consistency in the data points collected.

3. The OMPP may want to provide more clarity around the definition of "deemed available" in the report instructions. In particular, if an outbound answering machine is considered acceptable, what language must be used in the outbound message?

4. The OMPP should require MCOs to follow-up with non-compliant PMPs sooner than the re-audit in the following year. Although the MCOs are including all non-compliant PMPs in the next audit, the OMPP should require this.

5. The OMPP should have the MCOs indicate on their report how many PMPs were surveyed initially and how many are being re-audited.

6. The OMPP may want to consider that each PMP be audited at least once every three years, potentially to coincide with the re-credentialing of the individual provider.

## Performance Measure #3- Inpatient Utilization (Maternity)

The HHW reports QR-MN4 through QR-MN7 summarize the utilization of maternity inpatient services by age and delivery type. The report is generated quarterly and displays quarterly totals as well as totals for the prior rolling 12 months. Each HHW MCO is required to submit the report to OMPP on the last day of the month following a 90-day claims lag period following the close of the reporting quarter.

MCOs must identify the number and average length of stay (ALOS) for total maternity discharges, vaginal delivery discharges, cesarean delivery discharges and discharges identified as complex. For complex deliveries, the number of deliveries is reported on a per 1,000 member month basis whereas the numbers for the other delivery types are a straight count of cases. All discharge types are defined and identified utilizing standard HEDIS definitions.

Findings from the Review of MCO Processes

1. Each MCO is following the HEDIS specifications for identifying vaginal deliveries and cesarean deliveries. All of the MCOs commented, however, that the OMPP definition to account for claims lag is shorter than the HEDIS definition; therefore, it would not be appropriate to compare the HHW MCO results on these measures against HEDIS benchmarks.

2. Complex deliveries, however, are being defined differently by the MCOs. In the reporting manual instructions provided to the MCOs by the OMPP, the DRGs identified for neonate cases appears on the same page as the list of DRGs identified for complex deliveries. In the count of complex deliveries, MDwise is including neonate deliveries in the count of complex deliveries. MHS, however, is appropriately only counting cases related to the complex delivery DRGs. It was not clear what Anthem was including.

3. In addition to this issue, the number of complex deliveries per 1,000 member months reported by MDwise is significantly higher than what was reported by Anthem or MHS. This appears to be related to the fact that MDwise is counting the neonate cases in with complex delivery cases. (Refer to Exhibit VII.4 below) What is not clear is that if MDwise is counting more cases in the complex category, then both the number per 1,000 member months and the percentage of total should be higher than the other two MCOs. In fact, only the number per 1,000 member months value is higher for MDwise.

**Exhibit VII.4**
**Totals Complex Delivery Discharges, 3rd Quarter 2009**

| | Anthem | MDwise | MHS |
|---|---|---|---|
| Percentage of Total | 28.3% | 30.8% | 28.6% |
| Number per 1,000 Member Months | 1.39 | 26.79 | 3.59 |
| ALOS | 3.1 | 3.0 | 7.3 |

4. The report requirements from OMPP on these performance measures changed during CY 2009. Whereas the instructions originally requested counts of discharges per 1,000 member months, later it was changed to total number of discharges (except for complex

deliveries). This appears to have caused confusion in reporting each quarter. B&A questions the utility of reporting absolute discharge numbers instead of the per 1,000 member month figures since the HHW MCOs have varying levels of the total HHW enrollment.

5. As a result of the statements above, B&A has low confidence in the consistent accuracy of the figures reported for these measures throughout CY 2009.

Recommendations to the MCO and/or the OMPP

1. The OMPP should ensure that a standardized definition of complex deliveries is used which does not count neonate cases. Instead of reporting these cases as a separate group, it may be more meaningful to separate the counts for vaginal and cesarean deliveries between complex and non-complex.

2. Since there is a column showing the 12-month rolling average, B&A recommends eliminating the quarter-specific data elements on this report.

3. B&A suggests that the OMPP revert back to requiring the MCOs to report delivery counts on a per 1,000 member month basis instead of actual total discharge counts.

**Performance Measure #4- Emergency Room Utilization**

The HHW report QR-CA7 measures the number of children and adolescents (per 1,000 member months) using emergency room services. Three groups are reported separately: children ages 0-12 months, children ages 13 months-9 years, and children ages 10-19 years. This report is submitted on a quarterly basis to the OMPP and contains quarterly totals and the prior 12 month totals. The MCO must submit the report to the OMPP on the last day of the month following a 90-day claims lag period following the close of the reporting quarter.

Data is accumulated based upon place of service (ER) from the general claims files for each MCO. Data is compiled and reported quarterly and includes data for the current quarter and the prior 12-month period.

Findings from the Review of MCO Processes

1. The MCOs are counting different sets of claims in the totals reported. MHS counts paid and denied claims to determine the data for the report, but Anthem and MDwise only count paid claims. This is apparent in the results reported for each MCO. (Refer to Exhibit VII.5 on the next page.) There are different assumptions from the MCOs on what is required. Two of the MCOs believe that they are to follow HEDIS guidelines as to which types of claims to include (HEDIS excludes denied claims) while MHS believes that they are to include denied claims per OMPP's original reporting manual instructions.

2. There is no distinction between identifying emergent and non-emergent ER visits. If the purpose of the report is to potentially identify and track inappropriate ER utilization, the report as currently designed is inadequate.

**Exhibit VII.5**
**Emergency Room Utilization per 1,000 Member Months, 4th Quarter 2009**

| Age Group | Anthem | | MDwise | | MHS | |
|---|---|---|---|---|---|---|
| | Q4 Value | 12 mo | Q4 Value | 12 mo | Q4 Value | 12 mo |
| Children, Ages 0-12 months | 93 | 104 | 86 | 100 | 211 | 376 |
| Children, Ages 13 months - 9 years | 56 | 57 | 53 | 56 | 134 | 259 |
| Children, Ages 10-19 years | 56 | 53 | 50 | 49 | 129 | 289 |

Recommendations to the MCO and/or the OMPP

1. The issue of whether or not denied ER claims should be included in the totals may be moot given the fact that mid-way through CY 2009 the OMPP began to require MCOs to make a $25 triage fee to hospitals instead of denying ER claims when the visit appeared to be non-emergent. Therefore, B&A would recommend that the OMPP require that only paid claims be included on the report (to conform with HEDIS specifications) but to require the MCOs to separately report emergent and non-emergent claims. This will provide the OMPP with more meaningful data that is being measured.

## Performance Measure #5- Member Pregnancy Identification

Pregnancies are not covered in the HIP, but most all pregnant women enrolled in HIP will be eligible for HHW upon determination of pregnancy. The HIP report 10-P1 is a monthly report that tracks the individuals enrolled with the MCO that have been identified as pregnant. The MCO is required to submit the report to OMPP within 30 days of the last day of the reporting month. The report includes all members that the MCO has been notified of a pregnancy during the reporting month. The MCO is responsible for continuing to report the pregnant member(s) in subsequent reporting periods until the Enrollment Roster indicates that they have been disenrolled from HIP.

This report accumulates information on a member (client) specific level. Information tracked within the report includes:

- The member's identification number,
- The date the health plan was notified of the pregnancy,
- Notification method,
- Status of follow-up,
- HHW coverage effective date, and
- An indicator as to whether the member was identified in a prior month.

Findings from the Review of MCO Processes

1. The primary method of identification reported by the MCOs is an initial claim processed by the MCO that identifies the member as having a pregnancy-related diagnosis and/or procedure (e.g. pregnancy test).

2. Once the member has been identified as pregnant, the process for tracking appears to be unclear. Due to the fact that the HIP does not cover pregnancy related services (other

than the initial claim), the member is required to obtain eligibility for HHW. However, the process for transitioning members is not controlled by the health plan.

3. The average time to transfer to HHW is not tracked in Report 10-P1. Therefore, it is unclear how the report can measure if there is meaningful improvement in the transfer process from HIP to HHW.

4. The health plans asserted that members are dropped from the report after they appear for nine consecutive months and no resolution is made to transfer to HHW.

Recommendations to the MCO and/or the OMPP

1. B&A recommends that the OMPP revise the report to easily flag HIP members that have more than a 30-day, 60-day, or 90-day lapse from notification of pregnancy to enrollment in HHW to better determine the effectiveness of this transition process. This may help to identify high-priority transfers as well as opportunities for improvement and process changes with the enrollment broker.

**Performance Measure #6- POWER Account Employer Participation**

The HIP report 8-P2 is an annual report that tracks the total number of employers and corresponding employees that the employer made POWER Account contributions on behalf of to the MCO. The MCO must submit the report on an annual basis to OMPP by January 31st of each year for the prior year.

Findings from the Review of MCO Processes

1. Anthem reported 76 participating employers and $25,185 contributed in CY 2009 while MDwise reported only three participating employers and $275 contributed.

2. Because both MCOs reported very low participation by employers in CY 2009, they both continue to use a manual process to track the information submitted in this report. Each MCO defined to B&A a clear process for tracking and tabulating this information.

Recommendations to the MCO and/or the OMPP

1. The OMPP may want to consider the utility of continuing to require this report to be submitted.

# SECTION VIII: VALIDATING PERFORMANCE IMPROVEMENT PROJECTS

## Introduction

The validation of performance improvement projects (PIPs) is another mandatory activity specified in the Centers for Medicare and Medicaid's (CMS's) protocol for conducting external quality reviews.

Burns & Associates, Inc. (B&A) utilized the document "*Validating Performance Improvement Projects: A protocol for use in conducting Medicaid External Quality Review activities*" (May 2002) as the foundation for assessing the validity of PIP results reported by the managed care organizations (MCOs) serving members in Hoosier Healthwise (HHW). This tool focuses on the validity of the data reported rather than a critique of actual performance improvement, although Step 9 does request the external quality review organization to assess whether there was any "real" improvement in the measure.

In late 2008, the OMPP requested that the HHW MCOs select one topic from each of three groups—behavioral health, preventive health, and other disease/condition-specific care. This was the first year that OMPP directed MCOs to perform specific PIPs, so the OMPP mostly provided options that tie to HEDIS measures since these already had baseline information. The MCOs were instructed to use the NCQA's Quality Improvement Projects form (effective July 2008) to report findings. The HIP MCOs were not required to complete any PIPs in CY 2009.

A similar process for validating PIPs was used as was described for the validation of performance measures. During the onsite visits, B&A met with the MCO representatives familiar with each PIP to walk through the NCQA form that was completed. In addition to a review of the data sources and methodology used to compile the results, B&A discussed with the MCO the activities described in the Section IV: Interventions Table portion of the NCQA form.

Performance Improvement Projects that were validated include the following (numbers shown below are for tracking purposes within this document):

*Anthem*

1. Planning for follow-up care after hospitalization with a behavioral health diagnosis
2. Breast cancer screening rate
3. Lead screening in children

*MDwise*

1. Follow-up care for children prescribed ADHD medication, initiation phase
2. Adolescent well care visits
3. Comprehensive diabetes care LCL-C screening

*MHS*

1. Follow-up care after hospitalization with a behavioral health diagnosis
2. Breast cancer screening rate
3. Timely prenatal and post-partum visits

## Anthem Performance Improvement Project #1
## Planning for Follow-up Care after Hospitalization with a Behavioral Health Diagnosis

The period between discharge from an inpatient setting and engagement in community services is a critical and vulnerable time for the continuity of care of persons with behavioral health disorders. Anthem's results indicated the care coordination rates were consistently below the performance goal of 90% for appointments within seven days. In addition, results of the 2007 Member Satisfaction Survey, received at the end of the first quarter 2007, indicated that members were dissatisfied with facility efforts at care coordination.

Measures

Anthem uses the following measures to determine the efficacy of the PIP activities:

1. The percentage of members in the HHW program hospitalized with a behavioral health diagnosis who have a care coordination plan established prior to discharge that includes an aftercare appointment scheduled to occur within seven days post hospitalization. (This is not a HEDIS measure, but is similar to a HEDIS measure- refer to MHS's PIP.)

2. The percentage of members in the HHW program who responded positively to the following question on the Member Satisfaction Survey: *"Did the hospital facility work with you and/or your family to develop an after-discharge treatment plan?"*

Source Data and Formulas

Data for Measure 1 is obtained from administrative (appointment/access) data. Data elements required to support data analysis is maintained for 100% of acute inpatient discharges. Acute inpatient admissions that are transferred to sub-acute level of inpatient care, such as residential treatment skilled nursing facility, or transferred to a medical bed are excluded from the data set.

- *Numerator specifications:* The number of eligible members discharged from acute inpatient behavioral health treatment that have a care coordination plan established prior to discharge that includes an aftercare appointment scheduled to occur within 7 days post hospitalization.
- *Denominator specifications:* The number of eligible members discharged from acute inpatient behavioral health treatment during the measurement period.

Data for Measure 2 is the Magellan Medicaid Member Satisfaction Survey. The survey instrument contains items assessing clients' perceptions on access to services and care, care provider and treatment, cultural competency, health status, inpatient or residential treatment, and complaints and grievances. Additionally, clients are given the opportunity to answer items to ascertain socio-demographic information. Evaluations are based on Likert type scales. The majority of the items are rated on a scale ranging from "Poor" to "Excellent".

- *Numerator specifications:* The number of members responding positively to the question about how well the staff worked with the member to develop an after-discharge treatment plan.
- *Denominator specifications:* The total number of respondents to the question.

Results

| Measure | Benchmark (Internal Goal) | Base Line CY 2007 | Re-Measure CY2008 | Re-Measure CY2009 | Notes |
|---|---|---|---|---|---|
| #1 | ≥90% | 52.4% | 57.2% | 77.7% | Both statistically significant |
| #2 | ≥85% | 78.2% | 72.6% | 79.4% | Both not statistically significant |

MCO Interventions

1. *Concurrent Review Team:* Realigned Concurrent Review team so that care managers are assigned by facility, not product. Facilitated care managers becoming thoroughly familiar with a specified group of facilities and resources in the area, establishing relationships, and reinforcing care coordination expectations.
2. *Bridge Plan Intervention:* Anthem implemented an intensive "Bridge" plan with 11 high-volume facilities (comprising approximately 75% of cases) to address the development of the discharge plan for this population. The plan includes a review of the discharge plan with the member prior to discharge to address any barriers to care that may exist beyond the inpatient hospitalization. Included in the review is the information about the follow-up care provider (including a list of other providers within a 5 mile location of the member) and the importance of the visit.
3. *Staff Report Care Project:* Redesigned and implemented to reinforce care coordination process with staff. Disseminated monthly report cards to Care Managers and Follow-up Specialists with their individual care coordination rates. Results are discussed in clinical staff meetings. Supervisor works with individual staff to identify barriers to individual performance.
4. *Facility Report Card Project:* Report cards are disseminated to facilities quarterly. The Care Management Center Medical Director, Clinical Director and/or Clinical Supervisor meet with high volume facilities to educate on the importance of care coordination and to review their individual performance data which includes rates of care coordination.
5. *Admission Packet:* The MCO implemented a process to provide a comprehensive admissions packet for individuals that require behavioral health follow up. These packets incorporate information and processes for authorization of follow up care after discharge.

Anthem indicated that the interventions of particular success included the introduction of the Bridge Plan and the admissions packet.

Conclusions and Recommendations

Overall, B&A has confidence in the reported results. Many interventions indicated by Anthem to be most successful were implemented during the latter half of 2009 and direct results from these interventions may not be realized until the next measurement year. Nevertheless, real improvement was shown for Measure 1 and the improvement was tested for statistical significance. Although no real improvement was found for Measure 2, B&A has confidence in the reported results since the tests for statistical significance were completed. B&A encourages Anthem to drill down into the 23 percent that did not have a post-hospitalization appointment scheduled to see if it can be determined if it is specific facilities, specific case managers, locations in the state where provider access may be an issue, or specific types of diagnoses.

## MHS Performance Improvement Project #1
## Follow-up Care after Hospitalization with a Behavioral Health Diagnosis

The MHS PIP differs from Anthem's PIP in that MHS's PIP addresses tracking of those who actually had a visit after a behavioral health hospitalization. The historical results for MHS members enrolled in the HHW program for 7-day and 30-day follow up appointments were consistently below the performance goal of the HEDIS 50th percentile.

Measures

MHS uses the following measures to determine the efficacy of the PIP activities:

1. The percentage of members in the HHW program hospitalized with a behavioral health diagnosis who receive aftercare within 7 days post-hospitalization.
2. The percentage of members in the HHW program hospitalized with a behavioral health diagnosis who receive aftercare within 30 days post-hospitalization.

Source Data and Formulas

Data for Measure 1 is obtained from administrative data. Data elements required to support data analysis is maintained for 100% of acute inpatient discharges. Acute inpatient admissions that are transferred to sub-acute level of inpatient care are excluded from the data set as are hospital readmissions within three days of discharge.

- *Numerator specifications:* The number of discharges in the denominator calculation that have documentation of an aftercare appointment with a mental health professional within 7 days of discharge.
- *Denominator specifications:* The denominator will include 100% of members discharged following an inpatient admission with a mental health diagnosis. To be eligible for inclusion in the denominator, the member must have been continuously enrolled without breaks for at least 30 days prior to discharge and for at least 30 days after discharge.

Data for Measure 2 is also obtained from administrative data and follows the same specifications as Measure 1.

- *Numerator specifications:* The number of discharges in the denominator calculation that have documentation of an aftercare appointment with a mental health professional within 30 days of discharge.
- *Denominator specifications:* Same as denominator for Measure 1.

Results

The first re-measure of Measure 1 exceeded the benchmark of the HEDIS 50th percentile so the benchmark was increased to the HEDIS 75th percentile in the second re-measure. Likewise, the first re-measure of Measure 2 exceeded the benchmark of the HEDIS 75th percentile so the benchmark was increased to the HEDIS 90th percentile in the second re-measure.

| Measure | Benchmark (HEDIS Percentile) | Base Line HEDIS RY2008 | Re-Measure HEDIS RY2009 | Re-Measure HEDIS RY2010 | Notes |
|---|---|---|---|---|---|
| #1 | 43.0% (50th) | 45.7% | 55.0% | | No statistical test performed |
| #1 | 56.6% (75th) | | | 60.1% | No statistical test performed |
| #2 | 64.3% (75th) | 61.1% | 77.4% | | No statistical test performed |
| #2 | 81.5% (90th) | | | 79.4% | No statistical test performed |

MCO Interventions

1. *Intensive Case Management:* MHS implemented an intensive case management program that contacts the member and discharge planning personnel prior to discharge to assist as needed with discharge planning and aftercare appointments. Barriers to care are identified and addressed during the process. Additionally, all eligible individuals are contacted and offered the service of intensive case management prior to discharge.
2. *Member Outreach:* MHS attempted to contact all members within two to three days of discharge from an inpatient setting to remind them of their scheduled appointment within seven days. Barriers to keeping the appointment were identified on these calls and action was taken to address these barriers.
3. *Continuity of Care:* Upon admission, MHS obtained previous outpatient provider contact information and provided this information to the hospital. If there is no evidence of an established outpatient mental health provider, care coordination staff offered to assist the discharge planner with locating a network provider in the member's area.
4. *Provider Outreach:* MHS made contact with the behavioral health professional after the scheduled follow-up appointment to assure the member kept the appointment. If not, the member is re-contacted and assistance is offered to re-schedule the appointment.
5. *Provider Education:* Inpatient facilities accounting for the top 50% of discharges across markets were identified. Network management and clinical teams began to identify key discharge planners in these facilities. Plans were made to meet face to face and provide a "Stay Healthy" brochure to be included in discharge instructions provided to members as they leave the hospital.
6. *Caring Voice Program:* The MCO provided a preprogrammed cell phone with key supports of medical and behavioral provider contacts to members with no or unstable phone access.
7. *Member Incentive:* Follow-up after discharge incentive offered to children and parents to encourage compliance with the aftercare appointment within 7 days of discharge. Upon confirmation that this follow up appointment occurred timely, children receive a gift certificate to "Build-A-Bear" and a book about feelings. Parents receive a Wal-Mart gift card.

MHS indicated to B&A that the most successful intervention was the introduction of intensive case management, although the cross-cutting interventions are what provided the most improvement.

Conclusions and Recommendations

B&A has confidence in the reported results. The data utilized for this PIP are based upon annually audited HEDIS data. Although no tests for statistical significance were conducted, the improved results for both measures have face validity that there was real improvement. It should

be noted that HEDIS allows for the Bridge appointment to be counted as a follow-up appointment within seven days, even if it just hours after discharge and occurs on the hospital campus. B&A recommends that MHS analyze the members in the number to understand if their follow-up visit was this Bridge appointment or truly an appointment after re-entering the community. Stratifying the analyses by region or ethnicity may also lead to better understanding between the relationship of interventions and changes within the measure(s).

### Anthem and MHS Performance Improvement Project #2
### Breast Cancer Screening

Both Anthem's and MHS's percentage of breast cancer screenings have historically been below 40 percent of eligible members. While the population of HHW members fitting the HEDIS age range for this measure is limited, it remains an important tool used to successfully detect early breast cancer when it is at the most curable stage.

Measure

Anthem and MHS both utilize the HEDIS measure to determine the efficacy of the PIP activities:

> The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer in either the current or prior calendar year. This measure is compiled annually.

MHS also reported to B&A that they utilize quarterly data that is submitted to the OMPP related to this measure internally to validate and monitor activities. However, the quarterly data does not mimic the HEDIS specifications.

Source Data and Formulas

Data for the measure is obtained from administrative data by both Anthem and MHS. Data elements required to support data analysis is maintained for 100% of the eligible population. Members that have received a bilateral mastectomy or two unilateral mastectomies are excluded from the measurement population.

- *Numerator specifications:* One or more mammograms during the measurement year or the year prior to the measurement year. A woman had a mammogram if a submitted claim/encounter contains one of the appropriate pre-defined codes.
- *Denominator specifications:* Women 42–69 years as of December 31 of the measurement year. Continuous enrollment is required, which is defined as the measurement year and the year prior to the measurement year with no more than a one-month gap in coverage.

Results for Anthem

| Benchmark (HEDIS Percentile) | Base Line HEDIS RY2009 | Re-Measure HEDIS RY2010 | Notes |
|---|---|---|---|
| 44.4% (25th) | 37.8% | 38.0% | Not statistically significant |

Results for MHS

| Benchmark | Base Line | Re-Measure | | |
|---|---|---|---|---|
| (HEDIS Percentile) | HEDIS RY2008 | HEDIS RY2009 | HEDIS RY2010 | Notes |
| 54.7% (50th) | 36.0% | | | No statistical test performed |
| 61.2% (75th) | | 38.2% | | No statistical test performed |
| 50.4% (50th) | | | 47.7% | No statistical test performed |

MCO Interventions- Anthem

1. *Member Education:* Materials provided to members lists annual mammogram as a covered benefit. Preventive Health Guidelines posted on the member web site includes the recommendations for breast cancer screening.
2. *Provider Education:* The Provider Operations Manual (POM) includes information on the Plan's well women program which includes primary medical provider's responsibility to inform and refer members for breast cancer screening. Preventive health guidelines posted on the provider website includes links to guidelines for breast cancer screening recommendations.
3. *Semi-Annual Phone Reminder:* Automated calls reminding women about both breast and cervical cancer screening to non-compliant members. In 2009, there were 27,969 females who received the well women reminder calls.
4. *Annual Reminder:* Anthem implemented a reminder and incentive program for a member that includes a $15 gift card for those members that complete an annual screening. To date, this program has not been linked to outcomes data.
5. *Provider Profile:* Anthem implemented a reporting process listing non-compliant members (gap in care reports) to primary care providers. The listing has been well received by the provider community.

Anthem indicated that the interventions they consider most successful are the introduction of the Annual Reminder and the Provider Profiles.

Conclusions and Recommendations- Anthem

Overall B&A has confidence with the results reported overall but other drill downs did not appear to be meaningful. The data utilized for this PIP is based upon annually audited HEDIS data and the results were tested for statistical significance. Although there was no real improvement found, Anthem stated that many interventions were implemented during the latter half of the initial year of the study and direct results from these interventions may not be realized until the second re-measurement year.

A stratified analysis was performed that provided results by region and age. There appeared to be an issue in not counting all members in the numerator but they were counted in the denominator. B&A agrees that this stratified analysis may be helpful to further identify successful interventions but stresses the need for comparable data in the calculations. Anthem may also want to consider expanding the stratified analysis by race and ethnicity to provide additional insight as to potential barriers to delivery of care.

MCO Interventions- MHS

1. *Member Education:* The MHS telephone on-hold messages are updated quarterly to include educational messages, including the topic of women's health and mammograms. Mailings of brochures regarding women's health to all female members aged 16 and older. The brochures included information on mammography, human papilloma virus (HPV), chlamydia and cervical cancer. Brochures are available for distribution at events and by Network Managers, Case Managers, and Connections representatives. The brochure has been posted on the website.
2. *Access to Mobile Mammography:* MHS provides for members to have access to mobile mammography screenings.
3. *Provider Profile:* MHS implemented a reporting process listing non-compliant members to primary care providers. The listing has been well received by the provider community. MHS also pays providers to do their own outreach to non-compliant members.
4. *Community Outreach:* Media messaging encouraging annual exams via media, billboards, shopping carts, and interior and exterior mass transit signs. Also working to diffuse cultural issues about not getting screened.
5. *Member Outreach:* Phone calls to members receiving targeted mailings by the quality outreach team. Assisted members in scheduling appointments, arranging transportation and how to use the CentAccount Healthy Rewards card.

The MCO indicated that the interventions of particular success included the introduction of the Access to Mobile Mammography and the Provider Profile.

Conclusions and Recommendations- MHS

B&A has confidence in the reported results. The data utilized for this PIP is based upon annually audited HEDIS data. Although tests were not completed to assess if there was statistically significant improvement, the improvement since the baseline period has face validity that there has been real improvement. In the future, B&A encourages MHS to run tests for statistical significance to support if "real" improvement has occurred.

## Anthem Performance Improvement Project #3
## Lead Screening

CMS requires that Medicaid children have a blood lead level test between 12 and 24 months of age. Anthem's percentage of lead screenings has historically been below the HEDIS 25$^{th}$ percentile benchmark.

Measure

Anthem utilizes the HEDIS measure to determine the efficacy of their PIP activities:

The percentage of HHW children two years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

Source Data and Formulas

Data for is obtained through the hybrid methodology, a combination of administrative data and medical records. Data elements required to support data analysis is maintained for a selected sample of the eligible population.

- *Numerator specifications:* Sampled HHW children who have received a lead screening test by their second birthday.
- *Denominator specifications:* A systematic sample of 411 Medicaid children continuously enrolled prior to their 2nd birthday who turned two years of age during the measurement year.

Results

| Benchmark | Base Line | Re-Measure | | |
|---|---|---|---|---|
| (HEDIS Percentile) | HEDIS RY2008 | HEDIS RY2009 | HEDIS RY2010 | Notes |
| 49.3% (25th) | 41.2% | 43.5% | 53.0% | RY2009 results not statistically significant<br>RY2010 results are statistically significant |

Based upon their improvement, Anthem has increased their benchmark to the HEDIS 50th percentile (70.2%) beginning in HEDIS RY2011 for continuous quality improvement.

MCO Interventions

1. *Member Education:* Anthem's Member Handbook lists blood lead screening in the EPSDT section. Blood lead testing is included in the healthy children section of Anthem's Preventive Health Care Guidelines which are posted on the Plan's website.
2. *Introduction of MEDTOX services:* Anthem entered into a relationship with MEDTOX, a laboratory service. Intensive training and informational materials were distributed to the provider community to increase awareness of the proper testing and coding for lead screenings (as well as other required testing).
3. *Member Reminders:* Lead screening reminder calls are part of monthly automated immunization calls made to children ages 3, 6, 9, 12, 15 and 18 months of age and one month before their birthday.

Anthem indicated that the most successful intervention was the introduction of the MEDTOX Service.

Conclusions and Recommendations

B&A has confidence in the reported results since the data utilized for this PIP are based upon annually audited HEDIS data and a test for statistical significance was completed to assess if "real" improvement occurred. B&A recommends that Anthem expand its data analysis to assess if the improvement is directly tied to those providers participating with MEDTOX to see if expanding this program would add value to future outcomes. To date, this analysis has not been done by Anthem.

### MHS Performance Improvement Project #3
### Timely Prenatal and Postpartum Care

Timely prenatal visits during pregnancy and postpartum visits after delivery lead to better outcomes for members. MHS's percentage of timely prenatal visits and rate of postpartum care have historically been below the HEDIS 75th percentile.

Measures

MHS uses the following measures to determine the efficacy of the PIP activities:

1. The percentage of members in the HHW program that receive a timely prenatal visit during pregnancy.
2. The percentage of members in the HHW program that receive a timely postpartum visit following a pregnancy.

Source Data and Formulas

Measure 1 uses the standard HEDIS definition for prenatal visits. MHS obtains data through the hybrid methodology, a combination of administrative data and medical records.

- *Numerator specifications:* The number of individuals that receive a timely (defined within HEDIS standards) prenatal visits.
- *Denominator specifications:* The total number of individuals that receive an initial prenatal visit.

Measure 2 also uses the standard HEDIS definition for postpartum visits. MHS uses the hybrid methodology for this measure as well.

- *Numerator specifications:* The number of individuals that receive a postpartum visit.
- *Denominator specifications:* The total number of individuals that delivered a live birth during a pre-defined time period of the measurement year (defined within HEDIS standards).

Results

| Measure | Benchmark (HEDIS Percentile) | Base Line HEDIS RY2007 | Re-Measure HEDIS RY2008 | Re-Measure HEDIS RY2009 | Re-Measure HEDIS RY2010 | Notes |
|---|---|---|---|---|---|---|
| #1 | 88.6% (75th) | 87.5% | 89.8% | 92.7% | 90.8% | Not statistically significant |
| #2 | 65.7% (75th) | 63.5% | 66.4% | 70.1% | 72.7% | Statistically significant increase in RY2009 |

The initial re-measures have exceeded the goal of the HEDIS 75th percentile and have been increased to the HEDIS 90th percentile for both measures beginning in RY2011 to support the continuous improvement.

MCO Interventions

1. *Prenatal 17P Program:* This program coordinates administration of injections and provides Case Management support to members. The program is for members to help prevent pre-term labor and delivery in members who have had this history.
2. *High Risk OB Case Management:* Case management services for pregnant members to assist with health coaching, coordination of care, collaboration with providers and home and hospital visits to high risk members.

3. *Start Smart for Your Baby:* MHS implemented a program to identify pregnant members as early as possible in pregnancy. This has enabled them to assist members with access to prenatal medical care, education and coordination of referrals. The program extends throughout the first 15 months of the child's life, offering ongoing education and reminders related to the importance of regular well-child appointments and immunizations.
4. *Smart Step:* MHS developed an exercise and walking program for members involved in Start Smart for Your Baby. The member receives a brochure on the benefits of exercise during pregnancy as well as how to set up her walking program before and after delivery and a log to keep track of progress. She will also get a pedometer and survey to complete after the baby is born.
5. *Member Education:* MHS encourages smoking cessation for all pregnant members who smoke during pregnancy. This program encourages member engagement with trained cessation counselors who provide support, education and smoking cessation tools to MHS members with the goal of total cessation of smoking during pregnancy to promote improved birth outcomes.
6. *CONNECTION PLUS:* MHS implemented a phone program that issues limited-use cellular phones to members who are identified by an OB case manager or provider as high-risk without dependable access to a phone. The cell phone allows outgoing calls to pre-programmed numbers such as to the member's medical provider; case manager, 24 hour nurse line, and 911.
7. *Member Education Packets:* Packet of educational information including need to complete post partum follow-up care as part of the prenatal process.
8. *Provider Scorecard:* Quarterly scorecard providing providers who provide prenatal and postpartum care with the percentage of compliant members in the previous 12 month rolling period. Provides MHS with another educational opportunity regarding appointment availability for early prenatal care and post partum visit between 21 and 56 days after delivery.

The MCO indicated that the interventions of particular success included the introduction of the Start Smart and CONNECTION PLUS programs. One barrier to additional success cited by MHS was the fact that the American Congress of Obstetricians and Gynecologists recommends a post-partum visit within one week of delivery and also 6-8 weeks post delivery for mothers who have a cesarean delivery. Both of these visits are outside the parameters of the time for a post-partum visit in the HEDIS definition.

Conclusions and Recommendations

B&A has confidence in the reported results since the data utilized for this PIP is based upon annually audited HEDIS data. B&A encourages MHS to expand its data analysis to include stratification (e.g. region, ethnicity) to potentially improve outcomes. Although not part of the HEDIS definition, it may be of interest to quantify the number of cesarean mothers who did have a post-partum visit but just not within the HEDIS timeframes.

## MDwise Performance Improvement Project #1
## Follow-up Care for Children Prescribed ADHD Medication, Initiation Phase

The diagnosis of attention deficit/hyperactivity disorder (ADHD) is the most common disorder of childhood, affecting three to five percent of school aged children. MDwise chose this measure due to its large pediatric population in HHW and because the initial period to monitor a child's response is an important contributor to the successful treatment of the child. MDwise believes this is an opportunity to work with the parent/guardian, the PMP and/or the behavioral health specialist who prescribed the medication to closely monitor the child's response to the medication.

Measure

MDwise uses the following measure to determine the efficacy of the PIP activities:

The percentage of HHW children ages 6-12 who have been identified as eligible for the population (ADHD diagnosis and within the initiation phase of medication) receiving the appropriate face-to-face follow up care.

Source Data and Formulas

The source data is obtained from administrative (claims and pharmacy) data. Data elements required to support data analysis is maintained for 100% of the eligible population.

- *Numerator specifications:* All members in the denominator who had a face-to-face follow up visit with a practitioner, with prescribing authority, during the 30 day Initiation Phase.
- *Denominator specifications:* All members age 6 – 12 years old on the anchor date and continuously enrolled 120 days prior to ADHD index prescription start date through 30 days after index prescription start date.

Results

| Benchmark (HEDIS Percentile) | Base Line Measurement Period Ending 8/31/08 | Re-Measure Measurement Period Ending 8/31/09 | Notes |
|---|---|---|---|
| 47.3% ($90^{th}$) | 44.1% | 45.3% | No statistical testing |

MCO Interventions

1. *Real Time Reporting:* MDwise established a weekly report identifying children with newly prescribed ADHD medication from its pharmacy benefit manager (PBM) PerformRX and reviewed it to determine the eligibility of the member for the measure.
2. *Phone Outreach:* MDwise implemented a phone outreach program targeting the parent/guardian of the child who is identified with newly prescribed ADHD medication. Processes were implemented to identify if a follow up office appointment was scheduled or aid in scheduling appointment was required. The process proved to be resource intensive and provided little impact to the results. Barriers to an improved results included existing appointments outside of the HEDIS timeframe and timely receipt of information to identify the population.

3. *Provider Outreach:* Publish in MDwise Provider Link newsletter the Clinical Practice Guideline "Attention Deficient Hyperactivity Disorder" and make available on the MDwise web page.
4. *Provider Mailing:* Provider mailing to PMP and behavioral health prescribing providers promoting follow up visits for children with newly prescribed ADHD medication.

MDwise did not characterize any of the initiatives as being very successful. This, in conjunction with the fact that the pharmacy benefit has been carved out of HHW in CY 2010 and will make real time data even harder to capture, were the reasons that MDwise decided to eliminate this PIP at the end of 2009.

Conclusions and Recommendations

B&A has confidence in the reported results since the data used for this PIP is based upon annually audited HEDIS data. We have no additional recommendations since the PIP was discontinued.

**MDwise Performance Improvement Project #2**
**Adolescent Well Care Visits**

Thirty-eight percent of MDwise's HHW is between 12 and 21 years old. MDwise chose this measure since their results on this HEDIS measure have been below the HEDIS 25$^{th}$ percentile.

Measures

MDwise utilizes two HEDIS measures to determine the efficacy of its PIP activities:

1. Adolescent Well Care: The percentage of HHW children ages 12-21 who have been identified as eligible for the population that had a well child visit.
2. Children's Access to Primary Care: The percentage of HHW children ages 12-19 who have been identified as eligible for the population that had a visit with a primary care provider.

Source Data and Formulas

Data for Measure 1 is obtained from administrative (claims/encounter) data. Data elements required to support data analysis is maintained for 100% of the eligible population.

- *Numerator specifications:* All members in the denominator who had a well child visit during the measurement year.
- *Denominator specifications:* All members age 12-21 years old on the anchor date and continuously enrolled in Medicaid for 12 months.

Data for Measure 2 is also obtained from administrative data. Data elements required to support data analysis is maintained for 100% of the eligible population.

- *Numerator specifications:* All members in the denominator who had a visit with a primary care provider during the measurement year.
- *Denominator specifications:* All members age 12-19 years old on the anchor date and continuously enrolled in Medicaid for 12 months.

Results

| Measure | Benchmark HEDIS Percentile | Base Line HEDIS RY2009 | Re-Measure HEDIS RY2010 | Notes |
|---|---|---|---|---|
| #1 | 56.7% (90th) | 36.2% | 48.6% | No statistical testing |
| #2 | 91.9% (90th) | 88.3% | 90.3% | No statistical testing |

MCO Interventions

1. *Provider Education:* Incorporated orientation on well child care into new provider orientation and ongoing provider trainings. Also provided guidance on how to incorporate an OB-related visit into the parameters of a well child visit.
2. *Provider Incentive:* These two measures are part of MDwise's Reach Out for Quality program, which pays incentive dollars to delivery systems that show improvement in a subset list of HEDIS measures.
3. *Network Improvement Program (NIP):* MDwise implemented a team that completed visits with all of its delivery systems and large provider offices. The team produced monthly reports, including non-compliant patient listings and missed opportunities. These reports fill an information gap that allows the providers to know what members to target for outreach.
4. *Member Education:* MDwise sent mailings to members promoting well child visits and nurse on-call services.
5. *Member Incentive:* MDwise implemented a $20 member incentive for members listed as non-compliant for a well-child visit for 2009. Letters were mailed to members outlining the incentive program in conjunction with the providers receiving their non-compliant patient lists. The program was not implemented until late 2009.
6. *Community Outreach:* A "Well-Child First" campaign was rolled out which focused on well-care visits. It included posters and mouse pads with the slogan "Seize every opportunity to provide well care".

The MCO indicated that the interventions of particular success included the introduction of the Network Improvement Program and the Member Incentive.

Conclusions and Recommendations

B&A has confidence in the reported results since the data utilized for this PIP is based upon annually audited HEDIS data. Although some interventions were not implemented until the latter half of CY 2009, there appears to be "real" improvement already in Measure 1. B&A recommends conducting a stratified analysis to measure the impact that the member incentive has been on the improved rate. We also recommend conducting a test for statistical significance to measure "real" improvement beyond face validity.

**MDwise Performance Improvement Project #3**
**Comprehensive Diabetes LDL-C Screening**

Diabetes is the dominant chronic disease among MDwise HHW members. The LDL-C testing rate is just below the 10th percentile of the NCQA Medicaid benchmark. Much of the burden of illness and cost of diabetes treatment is attributed to potentially preventable long-term

complications including heart disease, blindness, kidney disease and stroke. Appropriate and timely screening and treatment can significantly reduce the disease burden. There is a huge opportunity through care coordination to provide the needed support for both members and providers to get members the necessary testing to drive appropriate treatment and control.

Measure

MDwise uses the HEDIS measure to determine the efficacy of the PIP activities:

The percentage of HHW members, ages 18-75, who have been identified as eligible for the population that have been tested for LDL-C within the past year.

Source Data and Formulas

Data is obtained from administrative sources. Data elements required to support data analysis is maintained for 100% of the eligible population.

- *Numerator specifications:* All members aged 18-75 meeting the HEDIS definition of diabetes who have been tested for LDL-C in the past year.
- *Denominator specifications:* All members aged 18-75 meeting the HEDIS definition of diabetes.

Results

| Benchmark | Base Line | Re-Measure | |
|---|---|---|---|
| **HEDIS Percentile** | **HEDIS RY2009** | **HEDIS RY2010** | **Notes** |
| 81.8% (90th) | 57.9% | 69.4% | No statistical testing |

MCO Interventions

1. *Provider Education:* MDwise worked with its delivery system staff to identify disease management (or case management) activities to work with providers and members to improve LDL screenings. They provided quarterly results of LDL screenings of its members to each delivery system by Primary Medical Provider.
2. *Network Improvement Program (NIP):* MDwise implemented the team that completed visits with all delivery systems and multiple provider offices to promote LDL screenings.
3. *Best Practices:* MDwise implemented a forum for providers to showcase 'best practices' to allow for the provider community to share successes and processes that have produced a positive impact to regular testing.
4. *Provider Reporting:* A revised disease management process for diabetes was implemented, including reports for disease management staff to identify members with diabetes and services and/or screenings needed to promote good care.
5. *Community Outreach:* MDwise implemented a new approach to outreach by delivery system in arranging for home visits to collect specimens and to promote LDL screenings.

MDwise indicated that the interventions of particular success included the introduction of the Best Practices and the Network Improvement Program. MDwise reported that the home visit pilot was not successful.

Conclusions and Recommendations

B&A has confidence in the reported results since the data utilized for this PIP is based upon annually audited HEDIS data. Although there appears to be face validity that real improvement has occurred, B&A recommends that in future years a test of statistical significance be run on new re-measurement data.

## Summary

The HHW MCOs each developed PIPs that were appropriate to the populations that they serve and were meaningful in working to improve outcomes in areas where unmet need was identified. This was the first year that the MCOs submitted formalized PIPs to the OMPP. B&A encourages the MCOs to work cooperatively with the OMPP to share information that is most meaningful to measure "real" improvement in each PIP. To this end, the OMPP may want to consider utilizing a streamlined version of the NCQA tool that was used last year. A revised tool may focus on reporting the benchmark and measurement year totals but also provide more detailed information on the interventions that were used and a commentary from the MCOs on which interventions were most meaningful. This will encourage the sharing of best practices among the MCOs for use in all of HHW.

# APPENDIX A

# EQR GUIDE

# 2010 EXTERNAL QUALITY REVIEW GUIDE FOR THE HOOSIER HEALTHWISE AND HEALTHY INDIANA PLAN PROGRAMS (REVIEW OF CY 2009 OPERATIONS)

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## A. Overview of Process and Timeline

Overview

Burns & Associates, Inc. (B&A) was hired by Indiana's Office of Medicaid Policy and Planning to conduct an External Quality Review (EQR) for both Hoosier Healthwise (HHW) and the Healthy Indiana Plan (HIP). This review will encompass activities in Calendar Year (CY) 2009.

This year's EQR will utilize the CMS protocols as a guide for two of the three mandatory activities requested by CMS:

- "Validating Performance Improvement Projects: A protocol for use in conducting Medicaid External Quality Review activities" (May 2002) will be used to measure compliance with specific PIPs that are reported to the OMPP as stipulated in 42 CFR 438.240(b)

- "Validating Performance Measures: A protocol for use in conducting Medicaid External Quality Review activities" (May 2002) will be used to measure compliance with specific measures that are reported to the OMPP as stipulated in 42 CFR 438.240(c)

- Other specific items related to MCO/health plan operations will be reviewed in a qualitative manner to assess compliance with 42 CFR requirements. Refer to Section B for the listing of specific topics to be covered in this year's EQR.

Note that the validation of performance improvement projects (PIPs) will be completed for HHW MCOs only and not HIP health plans since no PIPs were required by the OMPP for the HIP in CY 2009.

Timeline

Although the topics are the same for this year's HHW and HIP EQRs, there will be a separate report for each program. The OMPP is requesting that B&A deliver the draft reports of both EQRs by September 30. The final reports are due October 31. Therefore, the schedule of activities will be compressed in the July-September time period.

The onsite reviews with each MCO/health plan are split into four segments:

- **Tuesday, August 3 – Thursday, August 5**: Interviews and onsite document reviews for the topics related to Cultural Competency, Fraud and Abuse, and Provider Credentialing (1 day each at Anthem, MDwise and MHS)

- **Monday, August 23 – Wednesday, August 25**: Interviews and onsite document reviews for the Validation of Performance Measures and review of a sample of provider claim disputes (1 day each at Anthem, MDwise and MHS)

- **Wednesday, September 8 – Friday, September 10**: Interviews and onsite document reviews for the Validation of Performance Improvement Projects. Additionally, to the extent it is necessary, a follow-up discussion on the retrospective authorization review process may occur this week. B&A will inform

each MCO/health plan in advance if we would like to schedule a session on retrospective reviews (not to exceed two hours). (1 day each at Anthem, MDwise and MHS)

- **Tuesday, July 27 through Friday, September 17**: B&A's contracted RN and MD will coordinate scheduled appointments with each MCO/health plan to come onsite to review documents related to specific retrospective reviews or claim disputes related to medical necessity determinations. The sample to be reviewed will be communicated in advance with each MCO/health plan.

B&A anticipates that the day-long sessions at Anthem and MDwise will take the entire day since we will be covering both the HHW and HIP programs in these sessions. The MHS sessions may be less than a full day since only HHW will be covered.

There will be an opportunity for the MCO/health plan to provide accessory information if B&A needs further clarification on a specific review item after the onsite meetings are concluded.

Debriefing sessions with the MCOs/health plans are yet to be determined. It is intended that a presentation will be given of findings from the EQR to each MCO/health plan. Each MCO/health plan will also receive a copy of the final EQR report that will be delivered to CMS.

<u>The B&A Review Team</u>

This year's EQR Review Teams consist of the following members:

- Mark Podrazik, Project Manager: Mark has previously conducted four EQRs of the HHW program, last year's EQR of the HIP and an external review of the Care Select program. He will participate in all onsite sessions and oversee both EQRs this year.

- Steven Abele, Senior Consultant, B&A: Steve will assist Mark in the validation of PIPs and performance measures as well as the review of provider claims disputes for both HHW and HIP.

- Jesse Eng, SAS Programmer, B&A: Jesse will complete analysis in SAS in the desk review of access to services for both HHW and HIP.

- Cindy Collier, Subcontractor: Cindy has assisted B&A on two previous HHW EQRs and the Care Select review. She will participate in the Cultural Competency and Program Integrity aspects of this year's HHW and HIP reviews.

- Dr. Linda Gunn, PhD, Subcontractor: Linda participated in last year's HIP EQR and the Care Select review. She will participate in the Cultural Competency and Program Integrity aspects of this year's HHW and HIP reviews.

- Dr. CJ Hindman, MD, Kachina Medical Consultants: Dr. Hindman is an independent contractor who served as the Clinical Team Lead of the HHW, HIP and Care Select reviews in 2009. He was previously the Medical Director for Arizona's Medicaid program and also served as Medical Director of a Medicaid managed care program. He will lead the retrospective authorization review and

clinical review of medical necessity-related claims disputes for both the HHW and HIP programs.

- Rae Bennett, RN, Brightstar Healthcare: Rae will assist Dr. Hindman in the retrospective authorization review and clinical review of medical necessity-related claims disputes for both the HHW and HIP programs. She will be coming onsite to each MCO/health plan to conduct these reviews.

- Other B&A staff will be conducting the PMP 24 hour availability audit.

## B. Measuring Compliance with Medicaid Managed Care Regulatory Provisions

There are six topics that will be addressed in this year's EQR related to measuring compliance with Medicaid managed care regulatory provisions. Each MCO/health plan will be measured qualitatively using a benchmark of "Fully Compliant", "Substantially Compliant", or "Non-Compliant". The EQR report will discuss each MCO's/health plan's efforts to address compliance in each topic. The six topics are discussed in turn below.

Cultural Competency
42 CFR Citations: 438.100(a), (b); 438.206(b)

The CFR is broad when it comes to addressing cultural competency. B&A will use the following provisions specifically to make our qualitative assessment in this area:

> An enrollee of an MCO…have the following rights: The right to be treated with respect and with due consideration for his or her dignity and privacy (438.100(b)(2)(ii))
>
> The State must ensure, through its contracts, that each MCO…meets the following requirements: (1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO must consider…(ii) The expected utilization of services, considering Medicaid enrollee characteristics and health care needs. (438.206(b)(1)(ii))

The US Department of Health and Human Services Office of Minority Health released a report in March 2001 titled "National Standards for Culturally and Linguistically Appropriate Services in Health Care". Fourteen standards were cited as CLAS standards in this report. http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

The MCOs/health plans will not be scored on each of these standards. Rather, this report will be used as a benchmark to compare and contrast each MCO's/health plan's approach to addressing cultural competency. B&A will request materials and ask interview questions about any initiatives that the MCOs/health plans think address some aspect of recognizing cultural competency. The following are some examples that may be discussed:

- Review of internal training documents on recognizing and addressing cultural competency
- Review of provider training documents and contractual obligations on this topic
- Inventory of specific outreach efforts conducted by the MCO/health plan

Based on the profile of its members, B&A may ask questions of each MCO/health plan during the onsite session as to how they are working to reduce disparities for particular services offered among race/ethnicities and specific age groups within these race/ethnicities.

Program Integrity
42 CFR Citations: 438.608, 438.214(b)

B&A will review each MCO's/health plan's current Program Integrity program that is in place to detect fraud and abuse as required by 42 CFR 438.608. During the onsite session, we will walk through a sample of cases that were identified by the MCO/health plan to illustrate the procedures

in place at the MCO/health plan. We will also conduct interviews covering topics such as edits and audits done in claims processing to identify potential fraud and abuse, staff training in this area, internal monitoring and auditing to detect fraud and abuse, and procedures in place with providers related to this function

Additionally, B&A will once again review examples of provider credentialing and recredentialing files to assess the MCO's/health plan's process as required by 42 CFR 438.214(b). Among the items to be reviewed in the credentialing files are the MCO's/health plan's diligence in documenting compliance with 42 CFR 438.610, 455.104, 455.105, 455.106, and 1002.203. Specific policies and procedures related to credentialing and recredentialing will be reviewed by B&A in the desk review.

PMP Availability and Provider Access
42 CFR Citations: 438.206(b) and (c)

B&A is independently conducting three reviews in this topic area:

1. We will be conducting a 24 hour availability audit of a sample of the providers that were surveyed in the latest HHW AN-N3 and HIP 3-N4 report.

2. We will be conducting an accessibility audit to track the average amount of time it takes HHW and HIP members to obtain an appointment under different scenarios (e.g. urgent, non-urgent, routine physical, routine gynecological exam).

3. Using actual encounters, we will be completing a study to measure distance/travel time of a sample of each MCO's/health plan's members to primary care providers and to selected specialists.

Other than providing some information as part of the initial information request for the desk review, B&A does not anticipate conducting any onsite interviews or file reviews on this topic.

Clinical Retrospective Authorizations and Provider Claim Disputes
42 CFR Citations: 438.210 and 438.406(a)

B&A's clinical team will conduct a review of clinical authorization decisions in a manner similar to what was completed last year where the focus was on prior authorizations. This year, the focus on three specific subgroups of authorizations:

- Retrospective reviews initiated by the utilization management department
- Clinical reviews completed as part of the initial adjudication of a claim
- Clinical reviews completed post-payment when providers file a formal dispute of the payment that they received for the service rendered

B&A has already received the listing of retrospective reviews identified by each MCO/health plan. Separately, we will ask for information on claim disputes to appropriately identify a sample where the clinical staff was responsible for researching the dispute filed. We will also review a sample of adjudicated claims where clinical staff participated in the ultimate adjudication.

From each subgroup, B&A will identify specific cases for which we will ask the MCO/health plan to compile all pertinent information pertaining to the case. Last year, we requested that all of this

information be compiled in PDF format and transmitted to us via CD. This year, we are offering MCOs/health plans two options to provide case files to B&A:

1. Provide all relevant information on the case and deliver via CD in the same manner as last year's EQR (including any medical record documentation stored).

2. Provide B&A's RN, Rae Bennett, a workstation onsite with limited access rights to the data repositories where the case information is stored electronically.

If Option #2 is selected, there may be some limited cases that we still ask for on electronic media. Or, you can train Ms. Bennett how to save the data out of your electronic repositories.

When considering which option you will select, please keep in mind the following:

- Last year, our total sample was 960 across the three HHW MCOs. This year, we anticipate a total HHW sample for all MCOs combined not to exceed 300 cases. For HIP, the total sample for both health plans combined will not exceed 100 cases.

- Regardless of which option is selected, B&A will provide each MCO/health plan their total sample at one time, but the supporting documents will be due to B&A in two deliveries—one will be due July 27th; the second will be due August 9th.

If either delivery method is acceptable to the MCO/health plan, B&A would prefer to once again receive the information on CD to avoid having to schedule separate onsite time for Ms. Bennett and Dr. Hindman.

Separate from the clinical review, B&A will review a sample of provider claim disputes that do not require clinical staff input. The sample will be identified in advance of our visits August 23-25. We anticipate sitting down with a team member from the claims department and just walking through the sample on their computer screen. No documentation will be required to be delivered to us before the onsite meeting.

## C. Validating Performance Measures

B&A will utilize Attachment I from "Validating Performance Measures: A protocol for use in conducting Medicaid External Quality Review activities" (May 2002) as the template for assessing the validity of performance measure results reported by the HHW MCOs and HIP plans. This generic tool will be customized to some degree based on the performance measure. For this year's EQR, the performance measures that have been selected for validation are as follows.

For both HHW and HIP

1. Data elements on the Provider Claims Disputes report (HHW Report QR-P1 for 4th Quarter 2009 and HIP Reports 4-P2 and 4-P2 Log for October, November and December 2009)

2. Data elements and sampling for the 24 Hour Availability Audit (HHW Report AN-N3 submitted in January 2010 and HIP Report 3-N4 submitted in January 2010)

For HHW only

3. Data elements on the Inpatient Utilization-General Hospital/Acute Care (Maternity Only) report QR-MNEW5 for the period 3rd Quarter 2009

4. Data elements on the Emergency Room Utilization report QR-CA7 for the period 4th Quarter 2009

For HIP Only

5. Data elements on the Member Pregnancy Identification Report 10-P1 for activity reported for the months of July, August and September 2009

6. Data elements on the Employer Participation Summary Report 8-P2 that was submitted to the OMPP on January 31, 2010

B&A has access to the actual reports submitted to the OMPP from each MCO/health plan. During the onsite visits held August 23-25, we ask that health plan representatives familiar with each PM listed above be available for an interview to discuss the methodology used to compile the data that is submitted on each report. The MCO/health plan representative should be prepared to present the step-by-step methodology utilized to the reviewers. Supporting documentation is always helpful where feasible, but this supporting documentation is not required to be delivered to B&A prior to the onsite meeting. Please contact Mark Podrazik, B&A's Project Manager for this EQR, if some of these personnel will be present by teleconference.

## D. Validating Performance Improvement Projects

**Please note that Section D applies to Hoosier Healthwise MCOs only.**

B&A will utilize Attachment B from "Validating Performance Improvement Projects: A protocol for use in conducting Medicaid External Quality Review activities" (May 2002) as the template for assessing the validity of PIP results reported by the HHW MCOs. It should be noted that this tool focuses on the validity of the data reported rather than a critique of actual performance improvement, although Step 9 does request the EQRO to assess whether there was any "real" improvement in the measure.

A similar process for validating PIPs will be used as was described for the validation of performance measures. During the onsite visits held September 8-10, we ask that MCO/health plan representatives familiar with each PIP be available to walk through the NCQA Quality Improvement Project Form completed for the PIPs listed below. In addition to a review of the data sources and methodology used to compile the results shown in the NCQA template, B&A is interested in hearing from staff members involved in the items shown in Section IV: Interventions Table. The MCO/health plan representatives should be prepared to discuss each intervention cited in the NCQA tool and provide findings or other supporting materials on specific interventions, where applicable. This supporting documentation is not required to be delivered to B&A prior to the onsite meeting.

<u>Performance Improvement Projects to be Validated</u>

Anthem

1. Follow-up care after hospitalization with a behavioral health diagnosis
2. Breast cancer screening rate
3. Lead screening in children

MDwise

1. Follow-up care for children prescribed ADHD medication, initiation phase
2. Adolescent well care visits
3. Comprehensive diabetes care LCL-C screening

MHS

1. Follow-up care after hospitalization with a behavioral health diagnosis
2. Breast cancer screening rate
3. Timely prenatal and post-partum visits

## E. Information Request for Desk Review

The information request has been segmented by the topic areas in this year's EQR. Information provided should reflect health plan operations in effect in CY 2009. If a particular item has been updated in 2010, MCOs/health plans are welcome to provide this update in addition to (but not instead of) the 2009 version.

In the table on the next page, B&A is requesting that most information for the desk review be delivered to us via the OMPP SharePoint site. Please upload your data under the \2010\EQR directory under your MCO/health plan name by the due date shown. *For Anthem and MDwise, information should be separated for the HHW program and the HIP program and both SharePoint EQR directories should be populated separately.* Each desk review item has been numbered to assist in navigation on the SharePoint site. Please include the item number, your MCO/health plan name, and program at the beginning of the electronic file(s) that you are submitting. For example, the training materials to staff on cultural competency provided by HHW Anthem should be titled "Item 3 Anthem HHW [xxxx].yyy" where the xxx is a brief description of the file contents and .yyy may be files in .doc, .xls, .ppt and .pdf format.

*If more than one file is required to satisfy a request item*: Please number the electronic files with the item number but put a consecutive letter after each document [e.g. Item 1a.. , Item 1b.., etc.].

*If there is no information to satisfy a request item*: Please email Mark Podrazik to this effect so that B&A can confirm that we have received all materials that we are expecting from you.

If some items are only available in hard copy format, please direct all submissions to:

Mark Podrazik
Burns & Associates, Inc.
104 Fallsgrove Blvd. #3201
Rockville, MD 20850
(703) 785-2371 phone
mpodrazik@burnshealthpolicy.com

The one exception to the instructions above is the case files for the retrospective reviews/claim disputes. Do not put this data on the SharePoint site. If you are submitting this documentation to B&A on CD, please send the CDs to:

Barry Smith
Burns & Associates, Inc.
3030 North Third Street, Suite 200
Phoenix, AZ 85012
(602) 241-8578 phone
bsmith@burnshealthpolicy.com

Please note that the clinical review sample this year will be drawn from within your own set of data rather than across all plans. The sample will be derived from a combination of cases from retrospective reviews (already provided to B&A), provider claim disputes (desk review item #16) and claims adjudicated that involved a clinical review component (desk review item #18). If it is possible for health plans to provide item #16 before July 13, we will provide a quicker turnaround to you to identify your plan's sample. This will give you more time to produce the first batch of cases by July 27.

| Desk Review Item Number | Study Topic Area | Information Requested | Submission Due Date |
|---|---|---|---|
| 1 | Cultural Competency | Any policy/procedure that specifically addresses cultural competency | 7/6/2010 |
| 2 | Cultural Competency | Any policy/procedure that specifically addresses offering materials to enrollees in non-standard formats (e.g. other languages, Braille, etc.) | 7/6/2010 |
| 3 | Cultural Competency | Any training materials given to health plan staff that address cultural competency | 7/6/2010 |
| 4 | Cultural Competency | The CY 2009 edition of your Member Handbook | 7/6/2010 |
| 5 | Cultural Competency | Any training materials or guidelines given to providers that address cultural competency, including the Provider Manual | 7/6/2010 |
| 6 | Cultural Competency | Any staffing plans in the Member Services department that are intended to reflect the needs of the MCO's/health plan's membership | 7/6/2010 |
| 7 | Cultural Competency | Any materials illustrating examples of community-based initiatives to support cultural competency | 7/6/2010 |
| 8 | Cultural Competency | Your CY 2009 QAPI self-evaluation | 7/6/2010 |
| 9 | Program Integrity | Any policies/procedures used by the MCO/health plan to detect fraud and abuse | 7/13/2010 |
| 10 | Program Integrity | Any procedures used by the MCO/health plan to address fraud and abuse | 7/13/2010 |
| 11 | Program Integrity | An Excel, Word, or PDF file that itemizes specific cases of actual or suspected fraud and abuse by in CY 2009 that were handled (i.e. for which a case file was created). Please ensure that the following data elements are included on the report: (1) Unique identifier of provider or member; (2) Date case was opened; (3) if it relates to a Provider or Member; (4) nature of the case; and (5) Ultimate Action Taken (which could include "ongoing investigation"). | 7/13/2010 |
| 12 | Program Integrity | Any policies/procedures on credentialing and recredentialing, including any credentialing committee or the outsourcing of the credentialing function to third parties | 7/13/2010 |
| 13 | Program Integrity | Any MCO/health plan minimum criteria for a provider to be able to contract with the HHW or HIP program (if not already specified in #12) | 7/13/2010 |
| 14 | Program Integrity and Provider Access | An Excel file listing of providers that includes demographic and credentialing information (See separate page for the file layout requested.) | 7/13/2010 |
| 15 | Clinical Retrospective Reviews | Any policies and procedures related to authorization reviews *only if they have not changed since last year's EQR*. If no change, please indicate. | 7/6/2010 |
| 16 | Provider Claim Disputes | An Excel file itemizing each written Informal Claim Dispute reported on the 4 HHW QR-P1 Reports covering the period of CY 2009 or the 12 HIP 4-P2 reports covering the period of CY 2009. (See separate page for the file layout requested.) | 7/13/2010 |
| 17 | Validating Performance Improvement Projects | Please submit the NCQA Quality Improvement Forms for the PIPs that will be validated for your MCO that include all results available to be reported in Section II: Data/Results Table through 6/30/10. | 7/13/2010 |

| Desk Review Item Number | Study Topic Area | Information Requested | Submission Due Date |
|---|---|---|---|
| 18 | Clinical Retrospective Reviews | Based on a review of all the Claim Adjudication Reasons provided in your response to "Preliminary Questions in Preparation for the 2010 EQR", we are interested in the number of claims that hit specific adjudication reasons related to clinical/medical necessity determinations. | 7/6/2010 |
| | | | |
| | | To achieve the counts we want, we would like to receive a report showing frequency counts in one of two ways: | |
| | | (1) The MCO/plan can provide us with a report showing the frequency count of all claims adjudicated in CY 2009 by adjudication code. OR | |
| | | (2) The MCO/plan can request from B&A a list of the specific codes that B&A is interested in and the MCO/plan can provide us with the frequencies of just the specific adjudication codes we are interested in. | |
| | | | |
| | | In order to assess the magnitude of the specific adjudication codes that we are interested in, we will use a Total Claims Adjudicated value submitted by the MCO/plan on the report below unless directed otherwise by the MCO/plan. | |
| | | (a) For HHW, the Total Claims Adjudicated count is the sum of the 12 fields reported on all quarterly QR-S1 reports for CY 2009 under "Clean Claims Adjudicated" (Paid On Time + Paid Late + Denied). | |
| | | (b) For HIP, it is these same 12 fields reported on all monthly 1-S1 reports for CY 2009 under "Clean Claims Adjudicated". | |
| 19 | Clinical Retrospective Reviews | First batch of cases for retrospective review. | 7/27/2010 |
| 20 | Clinical Retrospective Reviews | Second batch of cases for retrospective review. | 8/9/2010 |

**Sample Template for Information Request Item #14**

**Template for Excel file**

| Provider ID | Provider First Name | Provider Last Name | Provider Specialty | Street Address | County | Area Code | Phone Number | Date of Last Credential Update (or initial date if new Provider) |
|---|---|---|---|---|---|---|---|---|

Please note that this is the same format as the listing of providers for the 24 Hour Availability Audit except that the Credentialing column has been added.

**Variable definitions**

| | |
|---|---|
| Provider ID | The NPI or IHCP ID for the provider. |
| Provider First Name | If your data is stored in such a way that the First Name and Last Name are stored in the same field, it is permissable to include the First and Last Name in this field. |
| Provider Last Name | See above |
| Provider Specialty | Examples that will be populated here include: General Practitioner, Family Practitioner, Pediatrician, Internal Medicine, OB/GYN, or specific specialties (e.g., cardiology, ENT). |
| Street Address | Address where the physician sees Hoosier Healthwise or HIP patients. |
| County | Provide the county name where the physician's office is located. |
| Area Code | If your data is stored in such a way that the Area Code and Phone Number are stored in the same field, it is permissable to include both in this field. |
| Phone Number | See above |
| Date of Last Credential Update | Enter either the date that the provider was credentialed by the MCO/health plan if it is a new provider or the most recent date that the provider was recredentialed by the MCO/health plan if it is a long-standing provider. |

**Sample Template for Information Request Item #16**

**Template for Excel file**

| Provider ID | Provider First Name | Provider Last Name | Date of Objection | Method | Nature of the Objection | Disposition (Determination) | Service Being Disputed | Claim Paid Amount |
|---|---|---|---|---|---|---|---|---|

Note to HHW MCOs:

B&A is aware that the instructions for QR-P1 indicate that the count of all verbal and written disputes should be reported.

B&A is only interested in the written informal disputes. When itemizing each dispute, please provide us with whatever is easier for you to output--written disputes only or verbal plus written. See the instructions below for how to handle each situation in the "Method" column.

Note to HIP Health Plans:

B&A is aware that the same situation applies to you on the 4-P2 report that both verbal and written disputes are reported.

B&A is only interested in the written informal disputes. You do not need to report on this table the Formal Disputes.

**Variable definitions**

| | | | | | |
|---|---|---|---|---|---|
| Provider ID | The NPI or IHCP Billing ID of the provider that filed the informal written dispute. | | | | |
| Provider First Name | If your data is stored in such a way that the First Name and Last Name are stored in the same field, it is permissable to include the First and Last Name in this field. | | | | |
| Provider Last Name | See above | | | | |
| Date of Objection | The date that the informal written dispute was received. | | | | |
| Method | If you have provided both verbal and written informal disputes, then specify if the dispute was verbal or written. If you have provided only the written disputes, leave this field blank. | | | | |
| Nature of the Objection | Provide free-form text as to the nature of the objection. | | | | |
| Disposition | Please provide an indication of the final disposition/determination, e.g. disposition favored provider, disposition favored health plan, or formal appeal filed. | | | | |
| Service Being Disputed | Provide free-form text as to the category of service that the claim was submitted for. If possible, use these categories: | | | | |
| | Inpatient Hospital stays | Ambulatory/Outpatient surgical | Specialty Physician | Primary Care | Home Health |
| | Emergency Room | Observation | Therapies (PT,OT,ST) | DME | SNF |
| Claim Paid Amount | If readily available, please indicate the amount paid on the claim prior to the dispute being filed. | | | | |

## F. Information Request for Onsite Review and Proposed Interview Schedule

From some of the items requested, B&A will develop a sample of items for review while onsite at the MCO/health plan. The specific information that is required only at the onsite is:

1. Provider credentialing/recredentialing files. An estimated sample of 20 will be identified for review onsite from the Provider Directory provided in Desk Review Item #14. B&A expects to review hard copy files for this item.

2. Provider claims disputes. An estimated 20 cases will be identified from the report provided to B&A in Desk Review Item #16. B&A anticipates that this review will occur by reviewing data online and not in hard copy format.

3. Examples of fraud and abuse case files. An estimated 5 cases will be identified from the report provided to B&A in Desk Review Item #11. B&A expects to review hard copy files for this item with the understanding that some data may be reviewed online as well.

4. Supporting documentation for the validation of performance measures. Information to be compiled at the MCO/health plan's discretion to support the validation items in the CMS validation tool.

5. Supporting documentation for the validation of performance measures. Information to be compiled at the MCO's discretion to support the validation items in the CMS validation tool.

Where hard copies are specifically requested above, we request only one copy of the credentialing files but three copies available for fraud and abuse case files and two copies available for documents related to the validation of performance measures and PIPs.

B&A will give the health plan one week notice prior to the onsite reviews of the specific samples for items #1, #2 and #3 above.

Onsite Interviews

The schedule below is intended to serve as a template so that the MCO/health plan can anticipate the agenda for each day onsite. B&A is willing to reorganize certain aspects of the schedule within a day. Also, we have some flexibility as to which day we visit each MCO/health plan. Please let Mark Podrazik know as soon as possible if a specific day will not work for you in the schedule.

Unless specifically requested above, MCO/health plan personnel do not need to bring any materials to the interview sessions. Each session will be customized to this EQR and some health plan-specific questions may be asked to assist B&A in better understanding desk review items provided.

We request that a workspace be set up for the Review Team members separate from the location of the interview, if possible, to enable some team members to work on other aspects of the review when they are not in the interviews.

Please note that on the schedule below, if the staff in each meeting scheduled for Anthem and MDwise are responsible for both the HHW and HIP, we will conduct the interview for both

programs simultaneously. If the staff differs between the two programs, we may need to schedule additional time to accommodate both programs.

| Date | Health Plan | Schedule Each Day | Topic |
|---|---|---|---|
| Tues, Aug 3 - Thurs, Aug 5 | MHS 8/3 | 8:30 - 10:30 | Interview session on Cultural Competency |
| | Anthem 8/4 | 10:30 - 12:30 | Interview session on Fraud and Abuse |
| | MDwise 8/5 | 1:30 - 5:00 | Some Review Team members will walk through Fraud & Abuse individual cases with MCO staff while others will review credentialing files |
| Mon, Aug 23 - Wed, Aug 25 | MDwise 8/23 | 8:30 - 9:30 | Validation of Performance Measure #1 |
| | Anthem 8/24 | 9:30 - 10:30 | Validation of Performance Measure #2 |
| | MHS 8/25 | 10:30 - 11:30 | Validation of Performance Measure #3 |
| | | 11:30 - 12:30 | Validation of Performance Measure #4 |
| | | 1:30 - 5:00 | Review sample of claim dispute files with MCO/health plan staff |
| Wed, Sept 8 - Fri, Sept 10 | MDwise 9/8 | 8:30 - 10:00 | Validation of PIP #1 |
| | Anthem 9/9 | 10:30 - 12:00 | Validation of PIP #2 |
| | MHS 9/10 | 1:30 - 3:00 | Validation of PIP #3 |
| | | 3:00 - 4:30 | Interview with Medical Management staff on retrospective reviews (if needed) |

# APPENDIX B

# AUTHORIZATION/CLAIM DENIAL REVIEW TOOL USED BY THE B&A CLINICAL TEAM

# AUTHORIZATION/CLAIM DENIAL REVIEW TOOL FOR CY 2010 EQR

## BURNS & ASSOCIATES, INC.

Name of MCO (specify Delivery System for MDWise) _____

Name of Delegated Reviewer (if different from MCO) _____

Auth ID/Claim # Assigned by MCO _____ Member RID _____

Initials of RN Reviewer _____ Initials of MD Reviewer _____

1. Specify which sample category this case is from
   - Retrospective authorization ☐
   - Claim denial ☐
   - Claim dispute ☐

2. Confirm Date of the
   - Auth request ☐
   - Claim denial ☐
   - Claim dispute ☐

3. For Retrospective Auths, who reviewed the case?
   - Nurse (RN or LVN) ☐
   - Physician ☐
   - Non-Clinical Staff ☐
   - Cannot be determined from file ☐

4. For claim denials/disputes, who reviewed the case?
   - Nurse (RN or LVN) ☐
   - Physician ☐
   - Non-Clinical Staff ☐
   - Cannot be determined from file ☐

5. Is this a multiple request? (More than one service/item requested or billed on claim?) (Y/N) ☐

6. Was request modified after initial submission? (changed to different service or amount, etc.)(Y/N) ☐

7. Service Category (place X in the appropriate box)
   - A. Ambulatory or Outpatient Surgery ☐ Procedure _____
   - B. OP Diagnostic Proc.; Radiology; Path ☐ Specify _____
   - C. Inpatient--Med/Surg or Observation ☐ Specify _____
   - D. Office Visits, Consults, Specialty Referral ☐ Specialist? _____
   - E. Physical, Occup, Speech Therapy ☐ Which therapy _____
   - F. Durable Medical Equipment (DME) ☐ Type? _____
   - G. Home Health Visits ☐ # of Visits _____
   - H. Other ☐ Type? _____

8. Final Determination of retrospective authorization, claim denial or claim dispute (place an X)
   - Approved ☐
   - Denied ☐
   - Cannot be determined from file ☐
   - Claim Denial Upheld ☐
   - Claim Denial Overturned ☐
   - Approved with Change ☐

9. *Complete only for retrospective authorization cases that were appealed*:
   - Enter date of appeal ☐
   - Enter date of final action ☐
   - Upheld? (place an X) ☐
   - Overturned? (place an X) ☐

10. Who filed appeal?
    - Provider? (Y/N) ☐
    - If "Y", was it a hospital? (place an X) ☐
    - Or, other? ☐
    - Unable to determine (place an X) ☐
    - Or, was it a physician? ☐
    - If "Other," list type _____

11. *Complete for retrospective auth appeals and claim disputes*:
    The reason for the appeal or the dispute was because the MCO failed to pay... (Place X in the appropriate box)
    - anything for the claim? ☐
    - enough of the payment? ☐
    - Other? (list) ☐ _____

# AUTHORIZATION/CLAIM DENIAL REVIEW TOOL FOR CY 2010 EQR

12. ***If Denied***, Reason for Denial by MCO (Place "X" in appropriate box)

Reason Given by MCO

| | |
|---|---|
| Insufficient documentation to support request (e.g. medical records requested but not provided) | |
| Requested service is considered to be "investigational" or "experimental" | |
| There is an equally effective, but less costly alternative service/treatment | |
| No Prior Authorization on file | |
| Service is not medically necessary (go to Item #13, otherwise go to Item #14) | |

13. If "service is not medically necessary" was cited in Item #12,

Which criteria was used (and documented) to support MCO decision?

| | | | |
|---|---|---|---|
| Milliman | | IAC/OMPP Published Criteria | |
| InterQual | | Specialty Society Criteria | |
| MCO Proprietary Criteria | | Not documented | |

If it was an ***Inpatient Stay*** ...

14. Was the length of stay… (Select only one option; place X in box)

| | | | |
|---|---|---|---|
| Less than 48 hours? | | Between 48--72 hours? | |
| Greater than 72 hours? | | Unable to determine | |

15. What type of Inpatient days were denied? (place an X)

| | | | |
|---|---|---|---|
| Inpatient? | | Observation? | |
| Unable to determine | | | |

**The following questions are for Physician Review only**

16. Was the auth or claim denial appropriate? (Place X in Appropriate Box)

| | | | |
|---|---|---|---|
| Yes | | Comment | _____ |
| No | | Reason? | _____ |
| Unable to determine | | Reason? | _____ |

17. Were appropriate and/or adequate clinical records provided with the notes, etc. for this review?

| | | | |
|---|---|---|---|
| Yes | | No | |