



**External Quality Review of Indiana's
Hoosier Healthwise Program and
Healthy Indiana Plan for the
Review Year Calendar 2014**

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FINAL REPORT

2015 External Quality Review of Indiana's Hoosier Healthwise Program and Healthy Indiana Plan

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Abbreviation	Meaning	Abbreviation	Meaning
ACRG	Aggregated Clinical Risk Group	JIVA	The name of software used by MDwise
ALOS	Average Length of Stay	LCSW	Licensed Clinical Social Workers
AMB	Ambulatory Care	LMFT	Licensed Marriage and Family Therapist
APR-DRG	All Payer Refined Diagnosis Related Group	MCE	Managed Care Entity
ASAM	American Society of Addiction Medicine	MCG	Milliman Care Guidelines
B&A	Burns & Associates, Inc.	MCO	Managed Care Organization
BH	Behavioral Health	MHS	Managed Health Solutions
BHM	Name of a company that works with MHS	MS-DRG	Multiple Severity Diagnosis Related Group
CAHPS	Consumer Assessment of Healthcare Providers and Systems	NCQA	National Committee on Quality Assurance
CHIP	Children's Health Insurance Program	NICU	Neonatal Intensive Care Unit
CM	Care Management/Case Management	NRT	Nicotine Replacement Therapy
CMHC	Community Mental Health Center	OMPP	Office of Medicaid Policy and Planning
CMCS	An organization that is contracted to perform authorization reviews for MDwise and Anthem	P4O	Pay For Outcomes
CMS	Centers for Medicare and Medicaid Services	PCCM	Primary Care Case Management
COPD	Chronic Obstructive Pulmonary Disease	PE	Presumptive Eligibility
CPT	Current Procedural Terminology	PIHPs	Prepaid Inpatient Health Plans
CRG	Clinical Risk Group	PIPs	Performance Improvement Projects
CY	Calendar Year	PMP	Primary Medical Provider
DME	Durable Medical Equipment	PMPM	Per Member Per Month
EAPG	Enhanced Ambulatory Patient Grouping	POWER	Personal Wellness and Responsibility Act
ED	Emergency Department	PPR	Potentially Preventable Readmissions
EPSDT	Early Periodic Screening, Diagnosis and Treatment	PPV	Potentially Preventable Emergency Dept Visit
EQR	External Quality Review	QI	Quality Improvement
EQRO	External Quality Review Organization	QIP	Quality Improvement Project
FPL	Federal Poverty Level	QNXT	The name of software used by CMCS
FQHC	Federally Qualified Health Center	RCP	Right Choices Program
FSSA	Family and Social Services Administration	RM	Re-measurement Year
HCPCS	Healthcare Common Procedure Coding System	RY	Reviewed Year
HSA	Health Savings Account	SAS	Statistical Analysis System
HEDIS	Healthcare Effectiveness Data and Information Set	SMA	State Medicaid Agency
HHW	Hoosier Healthwise	SOI	Severity of Illness
HIP	Healthy Indiana Plan	TANF	Temporary Assistance for Needy Families
IRR	Inter-Rater Reliability	TAT	Turnaround Time
		URAC	Utilization Review Accreditation Commission
		WMDS	The name of software used by Anthem

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EXECUTIVE SUMMARY

As the state agencies responsible for Indiana’s Medicaid program, the Family and Social Services Administration (FSSA) and the Indiana Office of Medicaid Policy and Planning (OMPP) have implemented two managed care programs using Section 1115 waiver authority. The Hoosier Healthwise (HHW) program, which began in 1994, covers children, pregnant women, and low-income families. The Healthy Indiana Plan (HIP), which began in 2008, covered custodial parents, noncustodial parents and childless adults ages 19 through 64 with family income up to 200 percent of the Federal Poverty Level who were not otherwise eligible for Medicare or Medicaid during Calendar Year (CY) 2014. In January 2015, the State received waiver authority from the Centers for Medicare and Medicaid (CMS) to change the design of HIP (often called HIP 1.0) to a non-traditional Medicaid model (called HIP 2.0) that effectively terminated HIP 1.0 on January 31, 2015. Since this year’s External Quality Review (EQR) covers the Review Year of CY 2014, only HIP 1.0 was reviewed in this year’s EQR.

At the end of CY 2014, enrollment in HHW was 556,496 and enrollment in HIP was 60,286.¹ Enrollment decreased 2.1 percent for HHW children and decreased 3.0 percent for HHW adults when comparing the populations from the end of CY 2013 to the end of CY 2014. The HIP enrollment increased 74.4 percent in CY 2014 from the end of the previous year.

Indiana Medicaid contracts with managed care entities (MCEs) to provide most services available to HHW and HIP members. Indiana Medicaid pays the MCEs a capitation rate per member per month (PMPM) based on the member cohort and the member’s home region (there are eight defined regions). Providers choose to contract with one or more MCE.

Three MCEs are under contract to provide services to both the HHW and HIP programs under a single contract that requires each MCE to offer services statewide. The MCEs—Anthem, Managed Health Services (MHS), and MDwise—have all been working with Indiana Medicaid for a number of years. Anthem’s contract with the OMPP began in 2007 while MHS and MDwise have both been involved with the program since the inception of Medicaid managed care in Indiana in 1994.

Burns & Associates (B&A) has served as the External Quality Review Organization (EQRO) and has conducted External Quality Reviews (EQRs) for Indiana Medicaid each year since 2007. For our reviews, we have relied on the protocols defined by CMS. This year was no exception. B&A utilized the new protocols released by CMS in September 2012 to serve as the basis for the format of the EQR this year.

EQRO Activities in CY 2015

B&A has worked with the OMPP on the topics to cover in each annual review. This year, in cooperation with the OMPP, B&A developed focus studies in addition to the mandatory activities. This year’s topics include the following:

- Validation of Performance Measures
- Validation of MCE Performance Improvement Projects (PIPs)
- Optional EQR Activity: Focus Study on Service Authorization Processes
- Optional EQR Activity: Focus Study on Potentially Preventable Hospital Readmissions
- Optional EQR Activity: Focus Study on Potentially Preventable Emergency Department Visits

¹ Source: Optum, OMPP’s data warehouse vendor, provided enrollment data to B&A on July 17, 2015.

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Validation of Performance Measures

In many previous EQRs, B&A has selected performance measures to validate from among the various reports that the OMPP requires its MCEs to submit as part of the OMPP MCE Reporting Manual. Separate from these reports, the MCEs are also required to submit Healthcare Effectiveness Data and Information Set (HEDIS®)² measures on an annual basis that are tabulated by a certified HEDIS auditor.

For this year's EQR, with guidance from the OMPP, B&A selected performance measures that tie directly to the OMPP Quality Strategy initiatives that were set by the State for Calendar Year 2014. Most of these Quality Strategy initiatives use HEDIS measures as the basis for assessing the OMPP's goals.

This year's validation of performance measures, therefore, differs from prior years in that the certified HEDIS auditor already validates the viability of reporting each measure in the standard HEDIS Audit Tool that is submitted to the OMPP. The HEDIS results are tabulated separately for HHW and HIP. Since this year's measures are solely HEDIS and have been independently certified by a HEDIS auditor, B&A's focus this year was to analyze how each MCE has performed on the HEDIS measures that tie to the OMPP's Quality Strategy initiatives and to assess if there has been improvement in any measures across a three-year period. The period of analysis compares the results from HEDIS Years 2013, 2014 and 2015 (which are experience years in Calendar Years 2012, 2013 and 2014).

The HEDIS measures selected for review in this year's EQR include:

1. PPC: Prenatal and Postpartum Care (HHW only)
2. FPC: Frequency of Ongoing Prenatal Care (HHW only)
3. W15: Well Child Visits in the First 15 Months of Life, 6+ Visits (HHW only)
4. W34: Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (HHW only)
5. AWC: Adolescent Well Care (HHW only)
6. ADD: Follow-up Care for Children Prescribed ADHD Medication (HHW only)
7. FUH: Follow-up After Hospitalization for Mental Illness, 7-Day and 30-Day (HHW and HIP)
8. AMBA (ER): Emergency Department Visits, multiple age groups (HHW and HIP)
9. AMBA (OP): Outpatient Visits, multiple age groups (HHW and HIP)

Detailed findings are provided in Section III of this report. The rates for PPC have been flat in the last three years in the All MCE average rate computed as well as for each MCE individually. It should be noted, however, that the MCEs already perform at a high threshold in the Prenatal Care component of the PPC measure. Improvement is possible in the Postpartum Care component, however. The FPC measure examines the rate of women who received 81 percent or more of their scheduled prenatal care visits. In the last three years, the results here have been mixed.

The greatest improvement among the measures examined was found in the well child visit measures (W15, W34 and AWC). The All MCE averages improved year-over-year on all three measures in the three years studied. Similarly, all three MCEs saw improvement in all three measures.

The results for the ADD measure in HHW were flat over the three years. For the FUH measure, improvement was found among the HHW population, but the rates eroded among the HIP population.

In the utilization measures (AMBA), emergency department visits decreased slightly among all age groups in HHW, but the rate of these visits increased in HIP. Outpatient visits decreased in both the HHW and HIP programs across all age groups.

² HEDIS® is a registered trademark of the NCQA.

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Validation of Performance Improvement Projects

B&A chose to validate three PIPs from each MCE. The PIPs that were selected this year were the same as those last year (with one minor exception) because this year's EQR process is a continuation of what began last year with the development of a new Quality Improvement Program (QIP) Report. This new form serves as the documentation of the MCE's performance improvement projects (PIPs) to the OMPP.

The three QIPs validated were:

- Postpartum Care (HHW program only)
- ED Utilization (HHW and HIP programs)
- Tobacco Cessation (HHW and HIP programs); for Tobacco Cessation, however, the primary focus was on items in the QIP related to tobacco cessation for pregnant women

Whereas last year the MCEs piloted the new tool by identifying their measures with baseline data and their proposed interventions, this year's EQR focused more on the results of the interventions to determine their effectiveness in improving the results of the measures in the QIP.

The EQR Team members first reviewed the QIP Reports submitted by the MCEs to the OMPP as part of a desk review. Then, the team members conducted onsite meetings with each MCE to go over the QIPs in detail. This included follow-up questions and a discussion with the relevant staff who had primary responsibility for the interventions that were put in place for the QIPs that were selected.

After the onsite meetings were completed, the EQR Team members completed a PIP Review Worksheet (based on CMS's EQR Protocol 3 tool). B&A customized components in the Worksheet to better assess the specific QIPs at the MCE. Justifications were provided to responses completed on the tool.

The table below summarizes the EQR Review Team's assessment of the measures and the interventions reported on by the MCEs for CY 2014 activities:

Summary of Validation of QIPs

	Improvement in the Measure(s)?	Confidence in the Measure Calculations?	Confidence in Intervention Calculations?
Postpartum Care			
Anthem	No	High	Low
MHS	Yes	High	High
MDwise	Yes	High	High
ED Utilization			
Anthem	Yes	High	Low
MHS	Mixed	High	High
MDwise	Mixed	Moderate	High
Tobacco Cessation			
Anthem	Yes	High	Low
MHS	Yes	High	Low
MDwise	No	High	Low

Specific recommendations were provided to the MCEs on ways to drill down into the measure results as well as opportunities to involve more parties in the interventions. A recommendation was made to the OMPP about ways to consider amending the pay-for-outcomes related to smoking cessation.

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Focus Study on Service Authorization Processes

The focus study related to service authorization policies and procedures is a re-examination of this functional area that was originally conducted by B&A in the EQR conducted in CY 2009. In that review, B&A reviewed the policies and procedures as well as a desk review of a sample of 960 authorization requests for the HHW and HIP programs. The same MCEs that are in place today were also the contracted MCEs in the program in CY 2009. This year's focus, therefore, examines how the MCEs perform this function today and whether or not recommendations from the CY 2009 study were implemented.

In this year's review, the three members of the onsite EQR Review Team conducted a desk review of the MCE policies and procedures related to this function. This was followed up with a series of interviews conducted onsite at the MCE offices on July 7-8, 2015. On July 28, the EQR Review Team visited each MCE again to test out our authorization tool on actual authorizations. B&A had requested a data file of all service authorization requests from each MCE covering CY 2014. After working with the MCEs to scrub the datasets, B&A presented the MCE-specific results to each plan for further validation and then constructed a sample for individual case reviews. The EQR Review Team then reviewed the sample of 825 authorizations (275 at each MCE) onsite at the MCE's offices the week of August 17.

Aspects of MCE authorization policies and procedures that were covered in the review include:

- Authorization processes and requirements of requesting providers
- Process flows
- Turnaround time requirements
- Application of clinical guidelines in the authorization process

Findings related to the policies and procedures, the total CY 2014 authorizations submitted by providers to the MCEs, and the results of B&A's analysis of the 825 sample cases are all presented in Section V of this report. Some of the key findings are shown below.

1. With few exceptions, all three MCEs appear to be in compliance with turnaround time (TAT) requirements for pre-service, concurrent and retrospective authorization reviews.
2. In 420 cases out of 818 reviewed in the sample, the reason for denial that was cited was lack of medical necessity. In each one of these cases, the rationale for determining it was medically unnecessary was documented in the records. In 96 percent of these cases, the specific citation of the clinical guideline applied was stated in denial letters to the requesting provider and member.
3. When MCEs used clinical guidelines to make their determination, the resources used most often were MCG, Interqual, and ASAM which are all nationally recognized guidelines. When internal guidelines were applied, it was found that they were appropriately researched and peer reviewed.
4. Clinical documentation was submitted in 78 percent of the cases in our sample, but much more so for MHS and MDwise than Anthem. However, correspondence notes in the files reviewed showed evidence by the MCEs to seek more complete clinical information before making a determination.
5. In 33 percent of the cases reviewed in which an administrative denial was determined (n=167), the reason was lack of documentation because the time expired for the requesting provider to fulfill the MCE's request for more clinical information.
6. The MCEs routinely offer peer-to-peer reviews when authorization requests are denied. When a request was denied for medical necessity, the letter to the provider offers a peer-to-peer consult.

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7. The proactive work of obtaining clinical information and utilizing clinical guidelines in assessing denials for lack of medical necessity appears to have had a positive effect on the rate of appeals. When compared to a similar study of MCE authorizations that B&A conducted in 2009 with these same MCEs, the appeals rate has decreased significantly.
8. Internal controls (via login and password) are in place in the authorization software so that the physician decision and text is locked and cannot be changed by other users.
9. Since the 2009 EQR, there has been noticeable improvement in the outbound letters sent by all three MCEs related to authorizations both in completeness and member comprehension level.
10. Also in the 2009 study, the EQR Review Team cited the preponderance of cases where Anthem and MHS denied inpatient stays for less than 72 hours but would offer observation payment in lieu of the inpatient DRG case payment. This was still found to be true for these MCEs and for MDwise as well in this year's review, but in each of the cases reviewed in the sample where this occurred, the clinical guideline was cited referencing the reason why an inpatient level of care was not medically necessary.

Since our review of this MCE function in CY 2009, the EQR Review Team observed considerable improvement in the processes outlined for authorization reviews and the manner in which these processes were used day-to-day through our review in the onsite study sample. With this in mind, B&A has offered some additional recommendations to the MCEs and the OMPP in an effort to instill continuous quality improvement in this functional area. For the OMPP in particular, the use and application of terminology can be confusing in some instances, such as use of the term "modified" or "modified approval" by the MCEs and how this is being applied. The OMPP may want to consider releasing working definitions for the use of these terms in the HHW and HIP programs, at least with respect to data reporting. To the extent that the National Committee on Quality Assurance (NCQA) already provides guidance on these definitions, the OMPP should consider using NCQA definitions for consistency. Also, if the OMPP is going to continue requiring a quarterly report on MCE service authorization requests, it may want to consider more specific definitions around specific terms or scenarios when the MCEs are reporting authorization trends so that these can be fairly compared across the MCEs.

Focus Study on Potentially Preventable Hospital Readmissions

Hospital readmission rates are often used as a measure to assess the quality of care delivered to patients in the inpatient hospital setting and are often publicly reported as a means to encourage hospitals and their community health care partners to work closer together both prior to admission to the hospital and at the time of discharge.

There are a variety of ways in which readmissions are currently being defined and used. B&A has been working with 3M in the application of its Core Grouping Software which contains a suite of modules aimed at identifying potentially preventable events (PPEs). Among these modules is an application to identify what 3M defines as potentially preventable readmissions (PPRs). As part of this year's EQR, B&A utilized this software to analyze and report on the rate of PPRs that are occurring in the HHW and HIP programs. Unlike all cause readmissions, the 3M software takes into account not only the time span between two patient admissions (in this case, a 30-day span or less between the initial discharge and the subsequent readmission was used as the trigger), but also a determination of the clinical relationship between the two inpatient stays. This, in effect, is what determines whether or not the readmission was potentially preventable or not. Therefore, not all readmissions are PPRs.

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To further control for utilization and membership changes, B&A analyzed inpatient admissions in HHW and HIP that occurred in CYs 2013 and 2014. The PPR rates for each year were computed in isolation. In addition to the overall PPR rates, B&A separately computed PPR rates for the eight managed care regions and also for each MCE separately. To account for case mix differences in populations either by MCE or by region, the Actual PPR rates computed are compared to an Expected PPR rate which is risk-adjusted. The factors used to risk adjust the PPR rates were age (adult vs. pediatric) and whether or not the member had an indicator for a major mental health condition, since mental health co-morbidities with acute care diseases is often an indicator of higher hospital readmission rates.

The way to measure health plans, hospitals or regions comparably is to compare the Actual-to-Expected PPR rate. If the entity studied (e.g., an MCE) has an Actual-to-Expected ratio equal to 1.0, it means that their readmissions are what would be expected for their population mix when compared to statewide averages. An Actual-to-Expected ratio below 1.0 means the MCE performed better than was expected. A ratio above 1.0 indicates the MCE performed worse than expected.

Some inpatient stays are excluded from the analysis either due to their very low expected readmission rates (e.g., maternity cases and well babies) or very high expected readmission rates (e.g., NICU babies, transplant cases). After these exclusions were conducted, the remaining sample within a CY was deemed too small to compute PPR rates specific to the HIP program (this will not be an issue in CY 2015 since HIP 2.0 was expanded). The Actual-to-Expected ratios analyzed by B&A, therefore, were for CY 2014 utilization for the HHW and HIP programs combined.

The Actual-to-Expected ratios related to PPRs for CY 2014 show that the three MCEs—when considering their total population (after the exclusions) all had utilization with hospitals that performed near expectations, although MHS had done better than expected and better than its peers. The hospital experience at the regional level, however, was quite varied. Four regions (Northeast, Central, Southwest and Southeast) exceeded the expectations after risk adjustment of their PPR rates since all have ratios below 1.0. The Southwest Region far exceeded expectations with the lowest ratio of 0.845.

Alternatively, the other four regions (Northwest, North Central, West Central and East Central) did not meet expectations since their ratios were all above 1.0. The West Central region had the worst Actual-to-Expected ratio among regions of 1.285; however, it should be noted that this region had the fewest admissions in the study (5.0%) of any region examined.

B&A recommends that the OMPP and the MCEs may want to explore if the reasons are consistent across the regions where the ratios are greater than 1.0. For example, the root cause may be specific diagnostic conditions (consistent) or specific hospitals (not consistent). Another finding of the study was that the PPR rates were higher for Adult Circulatory, Adult Gastroenterology and Mental Health diagnoses. A root cause analysis could help explain if the regional variation is tied to the major diagnostic conditions.

Focus Study on Potentially Preventable Emergency Department (ED) Visits

Another module in 3M's software suite measures the incidence of potentially preventable emergency department visits (PPVs). The manner in which PPVs are computed is similar to that of PPRs.

Actual-to-Expected Ratios Related to PPRs in CY 2014

Statewide	1.000	Northwest	1.048
Anthem	1.011	North Central	1.173
MHS	0.969	Northeast	0.935
MDwise	1.012	West Central	1.285
		Central	0.965
		East Central	1.160
		Southwest	0.845
		Southeast	0.981

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PPVs are ED visits that may result from a lack of adequate access to care or ambulatory care coordination. PPVs are ambulatory sensitive conditions (e.g., asthma) in which adequate patient monitoring and follow-up (e.g., medication management) should be able to reduce or eliminate.

The basis upon which ED visits are assessed to determine if they are PPVs are 3M's Enhanced Ambulatory Patient Groupings (EAPGs). The EAPGs are the classification system used in 3M's proprietary outpatient payment classification system. Although there are over 500 EAPG classifications, not all of them are considered for testing as a PPV. Since the EAPGs include everything from outpatient surgeries to lab and x-rays to chemotherapies to medical equipment, only those EAPGs which are related to ambulatory sensitive conditions are tested for PPVs. When submitted to the PPV software, these cases are given a flag that is called a medical visit indicator. For purposes of testing for PPV, a claim may have both a medical visit indicator and another significant procedure (e.g., an outpatient surgery code) on the claim. Only those cases that solely have the medical visit indicator with no other significant procedure are considered for the PPV test.

The term used to flag cases in the software is a *potentially* preventable visit. There may be other information not submitted on the claim (e.g., the medical record) that would disqualify the visit from being classified as preventable. The software is limited, however, to standard information submitted on a claim, so the assessment made is that the case was potentially preventable given the information provided to make the determination.

B&A used CY 2014 ED utilization for the HHW and HIP programs to test the rate of PPVs. Like PPRs, it is best to risk adjust the Actual PPV rates that are computed. The manner in which the PPV rates are risk adjusted is by using 3M's clinical risk groups (CRGs). For this project, each member enrolled in HHW and HIP was assigned to one of 27 CRGs based on their health status using utilization from CY 2013 (the lookback year used for risk adjustment). PPV rates were then computed for each of the 27 CRGs. The MCEs were then assigned an Expected PPV rate based on their membership and the blend of CRG assignments to their members. If one MCE had members in CRGs with higher expected PPV rates than the average, then this MCE would have a higher Expected PPV rate. Just like the PPR project, the focus of interest is on measuring the Actual-to-Expected PPV rate. If an MCE or hospital had an Actual-to-Expected ratio at 1.0, this means that they performed as expected given the composition of their members.

Overall, the Actual PPV rates varied in CY 2014 between the HHW and HIP programs, with the HHW program at a PPV rate of 69.5 percent and the HIP program at a PPV rate of 81.1 percent. Whereas the total ED claims per 1,000 member months were similar between HHW and HIP, the PPV claims per 1,000 member months were different between the two programs. In HHW, the rate of PPV claims was 38 per 1,000 member months in CY 2014; in HIP, it was 51 per 1,000 member months.

Despite differences across the two programs, within each program the PPV rates at the MCE level are very consistent. The spread of the MCE PPV rates in HHW is two percentage points (from 68.3% to 70.2%); in HIP, the spread is one percent (from 80.3% to 81.4%).

After drilling into potential differences in the PPV rates between HHW and HIP, a primary reason is related more to billing than to member behavior. Claims considered for PPV testing had to either have one of the standard ED visit codes (CPT 99281-99285) or one of the standard ED revenue codes (45x series). In HHW, 16.9 percent of ED claims had only the 45x revenue code and not the CPT code. The PPV rate in this group of claims was only 17 percent. If these cases were removed from the analysis, the overall HHW PPV rate would rise to 81.2 percent; for HIP, it would rise only slightly to 82.6 percent.

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As was seen with the PPR results, the Actual-to-Expected ratios related to PPVs are similar across the three MCEs in CY 2014, but once again there is variability across the regions. All of the MCEs have Actual-to-Expected ratios that hover around 1.0 which is what is expected.

At the regional level, one interesting finding is that the regions that performed better than expected in HHW (<1.0) are not always the same regions that performed better than expected in HIP. Four regions performed better than expected in the HHW program, while all but one region performed as generally expected in HIP (ratios between 0.98 and 1.02 can be assumed to generally be as expected).

Only the Central Region performed better than expected in both the PPR and PPV measures.

Actual-to-Expected Ratios Related to PPVs in CY 2014

	HHW	HIP
Statewide	1.000	1.000
Anthem	1.004	1.003
MHS	0.983	1.004
MDwise	1.010	0.990
Northwest	0.912	0.990
North Central	1.112	0.999
Northeast	1.131	0.980
West Central	0.978	0.988
Central	0.940	1.004
East Central	0.904	1.007
Southwest	1.071	0.999
Southeast	1.073	1.032

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SECTION I: OVERVIEW OF INDIANA’S MEDICAID MANAGED CARE PROGRAMS

Introduction

As the state agencies responsible for Indiana’s Medicaid program, the Family and Social Services Administration (FSSA) and the Indiana Office of Medicaid Policy and Planning (OMPP)³ have implemented two managed care programs using Section 1115 waiver authority. The Hoosier Healthwise (HHW) program began in 1994. By the end of 2005, all Medicaid members that had previously been enrolled in the HHW Primary Care Case Management (PCCM) system were transitioned into managed care entities (MCEs).⁴ Effective January 1, 2008, the HHW program was subsumed under the state’s Section 1115 waiver.

The HHW program delivers services to the following populations under what is known as Benefit Package A:

- Caretakers and children less than 18 years receiving TANF (Temporary Assistance for Needy Families);
- Pregnant women who do not receive TANF. The full scope of benefits are available to women who meet strict income and resource criteria;
- Children whose families do not receive TANF but who are under age 21 and meet the eligibility requirements; and
- Children in families whose income exceeds TANF requirements, but who are at or below 150 percent of the federal poverty level (CHIP I).

Additionally, HHW is offered to children in families whose income is 151 percent to 250 percent (CHIP II & III) of the FPL. This benefit package (CHIP Package C) requires premiums to be paid depending on income and family size factors.

Also part of the January 2008 Section 1115 approval was the creation of the Healthy Indiana Plan (HIP). In Calendar Year (CY) 2014, the HIP covered 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 FPL but are not otherwise eligible for Medicaid or Medicare (the “Caretakers” category); and
- 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 “Adults” category).

Note: In January 2015, the State received waiver authority from the Centers for Medicare and Medicaid (CMS) to change the design of HIP (often called HIP 1.0) to a non-traditional Medicaid model (called

³ FSSA and OMPP are collectively referred to as Indiana Medicaid throughout this report.

⁴ In Indiana, the term MCE is synonymous with the term managed care organization and will be used as such throughout this report. It refers to those entities that Indiana Medicaid contracts with under a full-risk arrangement.

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HIP 2.0) that effectively terminated HIP 1.0 on January 31, 2015. Since this year's External Quality Review (EQR) covers the Review Year of CY 2014, only HIP 1.0 was reviewed in this year's EQR.

The Personal Wellness and Responsibility (POWER) Account is the feature of HIP that makes it unique among programs developed nationally for the low-income uninsured. The POWER Account was used in HIP 1.0 and will continue to be used in the HIP 2.0 program. The POWER Account is modeled on the concept of a Health Savings Account (HSA). A \$1,100 allocation is contributed for each HIP member's 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 contribution to the \$1,100 balance is calculated based upon household income. The member is allowed to pay for his/her POWER account contribution in 12 monthly installments throughout the year.

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 covered by the MCE and are not drawn from 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 met program requirements in the prior year. This will effectively reduce the amount of the member's monthly POWER Account contribution in the next year.

HHW and HIP applicants are asked to select the MCE they would like to join if determined eligible for the program. If a member does not select an MCE within 14 days of obtaining eligibility, then Indiana Medicaid auto-assigns the member to an MCE. Once assigned, the MCE then has 30 days to work with the member to select a primary medical provider (PMP). If the member does not make a selection within this time frame, the MCE will auto-assign the member to a PMP.

Enrollment at a Glance

Enrollment in HHW was 556,496 at the end of CY 2014 and enrollment in HIP was 60,286 at this time. Enrollment decreased for HHW children by 2.13 percent from 2013 to 2014 and decreased by 3.05 percent among HHW adults during this time period (refer to Exhibit I.1). Overall enrollment in HHW decreased by 2.3 percent year-over-year. The enrollment in HIP increased 74.4 percent from the end of 2012 to the end of 2013.

Exhibit I1
Enrollment Trends in Hoosier Healthwise and HIP

	Hoosier Healthwise Children	Hoosier Healthwise Adults	HIP Members
December 2013	568,597	117,077	34,567
December 2014	556,496	113,508	60,286
Pct Change			
Dec 13 to Dec 14	-2.1%	-3.0%	74.4%

Source: Optum, OMPP's Data Warehouse Vendor, provided enrollment data to B&A on July 17, 2015.

Indiana Medicaid has defined the 92 counties in Indiana into eight regions for analytical purposes. At the regional level, the proportion of members is consistent between HHW and HIP, with the exception that the Southwest Region has higher representation and the Central Region has lower representation in HIP than in HHW (refer to Exhibit I.2 below).

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Exhibit L2
Hoosier Healthwise and HIP Members by Region
As of December 2014

	Hoosier Healthwise Children	Hoosier Healthwise Adults	HIP Members
Northwest	13%	15%	13%
North Central	10%	9%	8%
Northeast	12%	10%	10%
West Central	7%	8%	7%
Central	32%	31%	27%
East Central	9%	10%	12%
Southwest	9%	9%	14%
Southeast	8%	8%	8%

Source: Optum, OMPP's Data Warehouse Vendor, provided enrollment data to B&A on July 17, 2015.

MCEs Contracted in the Hoosier Healthwise Program and Healthy Indiana Plan

Indiana Medicaid contracts with the MCEs to provide most services available to HHW and HIP members. The State pays the MCEs a capitation rate per member per month (PMPM) based on the member cohort and the member's home region. Individual service providers have the option to contract with one or more MCEs.

The three MCEs that contract with Indiana Medicaid serve both HHW and HIP members under one combined contract. All three MCEs serve HHW and HIP members statewide.

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 2012, WellPoint purchased Amerigroup to expand its coverage of Medicaid members. WellPoint is headquartered in Indianapolis, Indiana. In Indiana, Anthem has been under contract with Indiana Medicaid for HHW since January 2007 and for HIP since the program's inception in January 2008.

MDwise

MDwise is a locally-owned, Indianapolis-based, non-profit MCE that has been participating in HHW since its inception. MDwise has contracted with Indiana Medicaid to serve HIP members since the program's inception in January 2008. In January 2007, MDwise obtained its own HMO license with the State. MDwise subcontracts the management of services to eight delivery systems. One of these delivery systems serves members statewide while the other seven are regionally-based.

Managed Health Services (MHS)

MHS is a subsidiary of Centene Corporation, a St. Louis-based Medicaid managed care company founded in 1984. Centene created MHS in 1994 when it began serving the HHW population. MHS's

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headquarters is located in Indianapolis. MHS utilizes another Centene subsidiary, Cenpatco, for the management of behavioral health services.

Exhibit I.3 shows the distribution of the HHW and HIP enrollment as of December 2014 by MCE. MDwise has a higher proportion among the MCEs in the HHW child population and the HHW membership in total (40%) while Anthem had the most HIP members at the end of 2014 (51%).⁵

Exhibit I.3
Hoosier Healthwise and HIP Members by MCE
As of December 2014

	Hoosier Healthwise Children	Hoosier Healthwise Adults	Hoosier Healthwise Total	HIP Members
Anthem	31%	38%	32%	51%
MHS	28%	24%	27%	22%
MDwise	41%	38%	40%	27%

Source: Optum, OMPP's Data Warehouse Vendor, provided enrollment data to B&A on July 17, 2015.

Indiana Medicaid's CY 2014 Quality Strategy Plan

Indiana Medicaid, like other State Medicaid Agencies, develops an annual Quality Strategy Plan. In its 2014 Plan, Indiana outlined specific initiatives for its HHW and HIP programs as well as its non-risk based program for the Aged, Blind and Disabled called Care Select.⁶ The initiatives for HHW and HIP are shown on the next page in Exhibit I.4.

The Quality Strategy is created by the OMPP Quality Unit with feedback from the Quality Strategy Committee. Chaired by the OMPP Quality Director, the Committee consists of a wide range of stakeholders, including representatives from:

- OMPP
- Division of Mental Health and Addiction
- Indiana State Department of Health
- Providers in specialties including pediatrics, adult health and behavioral health
- MCE Quality Managers
- Advocacy groups
- Consumers
- Academia
- Members of subcommittees (in 2014, this was neonatal quality and health services utilization management quality)

The Quality Strategy Committee meets quarterly throughout the year. The subcommittees also meet quarterly in different sessions from the main Committee meetings. MCEs are involved with the Quality Strategy Committee in multiple ways. Most importantly, the MCEs are required to submit to OMPP quarterly updates to their quality improvement projects that were identified on their annual work plan. The Quality Strategy Committee is briefed on these updates by the MCEs.

⁵ Since this enrollment profile is as of December 2014, it does not yet reflect the implementation of HIP 2.0 which has seen an increase in HIP of approximately 300,000 members.

⁶ In April 2015, the Care Select program was replaced with a risk-based program called Hoosier Care Connect.

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Exhibit L4

OMPP Quality Strategy Initiatives for 2014

Hoosier Healthwise

	Area of Focus	Goal
1	Improvements in Children and Adolescent Well-Care	Achieve at or above the 90th percentile for improvements in children and adolescent well-child visits (HEDIS).
2	Early Periodic Screening, Diagnosis and Treatment (EPSDT)	Improve the EPSDT participation rate to 80% in 2014.
3	Improvement in Behavioral Health	Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).
4	Ambulatory Care	Achieve at or above the 75th percentile of Ambulatory Outpatient Care Visits (HEDIS).
		Achieve at or below the 10th percentile of Ambulatory Emergency Department Care Visits (HEDIS).
5	Smoking Cessation	Achieve at or above the 50th percentile for members who are advised to quit during at least one visit with a health care provider.
6	Diabetes Care	Achieve at or above the 75th percentile of diabetic members who receive a LDL-C screening.
7	Pregnancy	Achieve a rate of less than 27% Cesarean Delivery Rate.
8	Frequency of Prenatal and Post-Partum Care	Achieve at or above the 90th percentile for the frequency of prenatal, and at or above the 90th percentile, for post-partum care (HEDIS).
9	Notification of Pregnancy	Increase the overall number of provider submitted Notification of Pregnancy forms by 1% above the the 2013 rate.
10	Monitoring Presumptive Eligibility (PE) for Pregnant Women	Increase the number of submitted PE applications during the 1st trimester of pregnancy by 2%.
11	Right Choices Program (RCP)	Achieve at or above 96% of the RCP periodic reviews that are completed on time.

Healthy Indiana Plan

	Area of Focus	Goal
1	Access to Care	90% of all HIP members shall have access to primary care within a minimum of 30 miles of a member's residence and at least two providers of each specialty type within 60 miles of their residence.
2	POWER Account Rollover	Achieve at or above 85% of the number of members who receive a preventive exam during the year.
3	ER Admissions per 1000 Member Months	Achieve at or below 80 visits per 1000 member months.
4	Improvement in Behavioral Health	Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).
5	Ambulatory Care	Achieve at or above the 90th percentile of Ambulatory Outpatient Care Visits (HEDIS).
6	Smoking Cessation	Achieve at or above the 50th percentile for members who are advised to quit during at least one visit with a health care provider.
7	Right Choices Program (RCP)	Achieve at or above 96% of the RCP periodic reviews that are completed on time.

Source: Indiana Medicaid Managed Care Quality Strategy Plan 2014

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

Background

Burns & Associates, Inc. (B&A) has served as the External Quality Review Organization (EQRO) and has conducted External Quality Reviews (EQRs) for Indiana Medicaid each year since 2007. B&A is a Phoenix-based health care consulting firm whose clients almost exclusively are state Medicaid agencies or sister state agencies. In the State of Indiana, B&A is contracted only with the OMPP.

The Centers for Medicare and Medicaid Services (CMS) require that EQROs complete three mandatory activities on a regular basis as part of the EQR:

- 1) A review to determine MCO compliance with federal Medicaid managed care regulations;
- 2) Validation of performance measures produced by an MCO; and
- 3) Validation of performance improvement projects undertaken by the MCOs

For the first activity, B&A completed a full review of compliance with all federal Medicaid managed care regulations as well as additional contractual requirements mandated by Indiana Medicaid in its contract with the managed care entities (MCEs) in the EQR conducted in 2012 covering Calendar Year (CY) 2011. B&A utilized the CMS 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.* to complete this review. This periodic review was completed in 2012 because the OMPP entered into new contracts with the MCEs effective January 1, 2011 in which the requirements for administering the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) programs were subsumed under one contract.

In other years, B&A has worked with the OMPP to develop focus studies covering specific aspects of the HHW and HIP programs. This approach began with the CY 2009 review. The functional areas where focus studies have been completed in the last five years appears in Exhibit II.1 on the next page.

For the mandatory activity related to the validation of performance measures, B&A has selected a sample of reports that the MCEs are required to submit to the OMPP on a regular basis in order to validate the performance measures reported. In the EQR conducted in 2012, an exception was made so that the full compendium of reports that the MCEs are required to submit to the OMPP (usually on a quarterly basis) were reviewed. After completing a desk review of the data reported for each measure on the reports (which comprised over 85 in total), B&A convened a workgroup with all of the MCEs as well as OMPP representatives to identify the measures/reports where the greatest differences were found in the results reported across the MCEs. The outcome of these meetings was a new MCE Reporting Manual which took effect January 1, 2013. Since then, the OMPP has made periodic updates to the MCE Reporting Manual to account for report specification changes, the retiring of old reports, and the addition of new reports.

In CY 2010, B&A began the validation of MCE performance improvement projects (PIPs) for the Review Year (RY) 2009 (prior to this, PIPs were not required by the OMPP). During the EQR conducted in CY 2014, B&A worked with the OMPP and convened a workgroup with all of the MCEs to develop a streamlined and standardized reporting tool for Quality Improvement Projects (in Indiana, PIPs are referred to as QIPs). The results from the MCEs' QIPs are being reported and reviewed for the first time in this year's EQR.

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Exhibit II.1

EQR Focus Studies Conducted of MCE Operations in HHW and HIP, 2010 - 2014

Year Review Conducted	Review Year	Program	Functional Area	Review Topic
CY 2010	CY 2009	HHW, HIP	Member Services	Initiatives to Address Cultural Competency
CY 2010	CY 2009	HHW, HIP	Program Integrity	Program Integrity Functions
CY 2010	CY 2009	HHW, HIP	Provider Network	Availability and Accessibility of Providers to Members
CY 2010	CY 2009	HHW, HIP	Utilization Management	Retrospective Authorization and Claim Denial Review
CY 2011	CY 2010, Q1 2011	HHW, HIP	Disease Management	Review of Disease, Case and Care Management Practices
CY 2011	CY 2010	HHW, HIP	Clinical Practices	Clinical Review of Complicated C-sections and Hospital Readmissions
CY 2011	CY 2010	HHW, HIP	Emergency Services	ER Utilization and Payment Practices
CY 2012	CY 2011	HHW, HIP	Utilization Management Behavioral Health	Review of Inpatient Psychiatric Stays
CY 2012	CY 2011	HHW, HIP	Utilization Management	Review of the Right Choices Program
CY 2013	CY 2012	HHW, HIP	Access to Care	Review of member access to care and provider perceptions of the MCEs
CY 2013	CY 2012	HHW, HIP	Mental Health Utilization and Care Coordination	Clinical review of care plans and review of care coordination for members with co-morbid physical health and behavioral health ailments
CY 2014	CY 2013	HHW	Access to Care	Review of Non-Emergency Medical Transportation Services
CY 2014	CY 2013	HHW, HIP	Member Services	New Member Activities
CY 2014	CY 2013	HHW, HIP	Provider Relations	Review of MCE Provider Services Staff and Communication with Providers
CY 2014	CY 2013	HHW, HIP	Program Integrity	Review of Processes Related to Third Party Liability

EQRO Activities in CY 2015

B&A met with the OMPP in early 2015 and developed the following topics for this year’s EQR:

- Validation of Performance Measures
- Validation of MCE Performance Improvement Projects (PIPs)
- Optional EQR Activity: Focus Study on Service Authorization Processes
- Optional EQR Activity: Focus Study on Potentially Preventable Hospital Readmissions (PPRs)
- Optional EQR Activity: Focus Study on Potentially Preventable Emergency Department Visits (PPVs)

For the validation of performance measures and PIPs, B&A utilized the September 2012 editions of CMS Protocols EQR Protocol #2: *Validation of Performance Measures* and EQR Protocol #3: *Validating*

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Performance Improvement Projects for guidance in completing these mandatory activities. For the three focus studies, B&A worked with the OMPP Quality Director to develop the elements of each study.

The details pertaining to each aspect of this year's EQR were released to the MCEs in an EQR Guide on May 27, 2015. The EQR Guide appears in Appendix A of this report. It contains information about the focus of each review topic in the EQR, the expectations of MCEs in the review, a document request list, and a schedule of events. For all review topics, a desk review, onsite reviews and post-onsite follow-up occurred. All of this year's EQR tasks were conducted during May through September, 2015.

The EQR Review Team

This year's review team included the following staff:

Onsite Team

- Mark Podrazik, Project Manager, Burns & Associates, Inc. Provided project oversight and participated in onsite reviews for this year's EQR. He has worked with the OMPP in various capacities since 2000. Previously, Mr. Podrazik has led the EQRs of HHW in CYs 2007-2014 as well as the EQRs for the HIP in CYs 2009-2014.
- Dr. Linda Gunn, AGS Consulting, Inc. Participated as a team member in the desk review of service authorizations, the interviews with the MCEs about these policies, and the onsite review of the sample of service authorizations. Dr. Gunn also participated in B&A's EQRs for Indiana programs in CYs 2009-2014.
- Kristy Lawrance, Lawrance Policy Consulting. Participated as a team member in the desk review of service authorizations, the interviews with the MCEs about these policies, and the onsite review of the sample of service authorizations. She also conducted the desk review of PIPs and led the onsite interviews related to this topic as well as participated in onsite meetings related to the validation of performance measures. Ms. Lawrance also participated in B&A's EQRs for Indiana programs in CYs 2013 and 2014.

Analytics Team

- Steven Abele, Senior Consultant, Burns & Associates, Inc. Analyzed all service authorization data submitted by the MCEs in this year's EQR. He conducted calls with MCE staff to better understand the data and normalized the data across service categories to allow for comparative reporting. Mr. Abele has worked on three previous EQRs for Indiana.
- Kara Suter, Senior Consultant, Burns & Associates, Inc. Served as Project Lead in the analytics related to the validation of performance measures and computing the rate of PPRs and PPVs. This is Ms. Suter's first EQR with Indiana, having recently completed serving three years as the Director of Payment Reform for Vermont's Medicaid program.
- Jesse Eng, SAS Programmer, Burns & Associates, Inc. Conducted analytical support in SAS in the validation of performance measures and the calculation of PPRs. He has participated in analytical aspects of B&A's EQRs for Indiana since 2010. Mr. Eng has also served as the lead analyst on B&A's project to write an independent evaluation of Indiana's Children's Health Insurance Program (CHIP). He also assists in preparing Indiana's annual CHIP report to CMS.

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- James Maedke, SAS Programmer, Burns & Associates, Inc. Conducted analytical support in SAS in the validation of performance measures and the calculation of PPVs. Mr. Maedke also provided all of the SAS analytic support in B&A's EQRs for Indiana in 2014. He has also served as the lead analyst on B&A's project to write an independent evaluation of Indiana's CHIP. He also assists in preparing Indiana's annual CHIP report to CMS.
- Barry Smith, Analyst, Burns & Associates, Inc. Assisted in the tabulation of information related to the validation of performance measures and he summarized the results of the review tools completed for the onsite review of the sample of service authorizations. Mr. Smith has worked on the Data Analysis Team for the EQRs conducted in CYs 2009-2014.

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SECTION III: VALIDATION OF PERFORMANCE MEASURES

Introduction

In many previous External Quality Reviews (EQRs), Burns & Associates, Inc. (B&A) has selected performance measures to validate from among the various reports that the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) managed care entities (MCEs) submit to the Office of Medicaid Policy and Planning (OMPP) on a regular basis in the OMPP MCE Reporting Manual.

For this year's EQR, with guidance from the OMPP, B&A selected performance measures that tie directly to the OMPP Quality Strategy initiatives that were set by the State for Calendar Year 2014. These initiatives were identified previously in Section I of this report.⁷ Most of these Quality Strategy initiatives use Healthcare Effectiveness Data and Information Set (HEDIS®)⁸ measures as the basis for assessing the OMPP's goals.

The HEDIS measures are different from the measures reported in the OMPP MCE Reporting Manual. The HEDIS measures may be tabulated using the hybrid method (both administrative claims and medical records). Also, the MCEs are required to contract with a certified HEDIS auditor to tabulate the HEDIS measures and then submit the results from the HEDIS auditor on the standard HEDIS Audit Tool to the OMPP. The HEDIS results are tabulated separately for HHW and HIP. Alternatively, the measures submitted on reports in the OMPP MCE Reporting Manual are tabulated using administrative data only and are self-reported by the MCEs. Most of these reports are submitted quarterly whereas HEDIS measures are reported annually.

Since this year's measures are solely HEDIS and have been independently certified by a HEDIS auditor, B&A's use of the Centers for Medicare and Medicaid's (CMS's) EQR Protocol #2, *Validation of Performance Measures*, has been curtailed. A summary of B&A's use of the Protocol #2 activities appears in Exhibit III.1.

The focus of this section of the report is to analyze how each MCE has performed on the HEDIS measures that tie to the OMPP's Quality Strategy initiatives and to assess if there has been improvement in any measures across a three-year period. The period of analysis compares the results from HEDIS Years 2013, 2014 and 2015 (which are experience years in Calendar Years 2012, 2013 and 2014).

The HEDIS measures selected for review in this year's EQR include:

1. PPC: Prenatal and Postpartum Care (HHW only)
2. FPC: Frequency of Ongoing Prenatal Care (HHW only)
3. W15: Well Child Visits in the First 15 Months of Life, 6+ Visits (HHW only)
4. W34: Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (HHW only)
5. AWC: Adolescent Well Care (HHW only)
6. ADD: Follow-up Care for Children Prescribed ADHD Medication (HHW only)
7. FUH: Follow-up After Hospitalization for Mental Illness, 7-Day and 30-Day (HHW and HIP)
8. AMBA (ER): Emergency Department Visits, multiple age groups (HHW and HIP)
9. AMBA (OP): Outpatient Visits, multiple age groups (HHW and HIP)

Findings for each performance measure appear in the pages that follow.

⁷ Refer back to Exhibit I.4 on page I-5 to see the 11 HHW initiatives and 7 HIP initiatives.

⁸ HEDIS® is a registered trademark of the NCQA.

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Exhibit III.1

Burns & Associates' Application of EQR Protocol #2: Validation of Performance Measures

Protocol Activity / Step	EQRO Action
Activity 1: Pre-Onsite Visit Activities	
Step 1: Define the scope of the validation	Related to OMPP's Quality Strategy initiatives
Step 2: Assess the integrity of the MCO’s information system	Confirmed all HEDIS results were reportable by the HEDIS auditor (with one exception noted)
Step 3: Select measures for detailed review	Defined by OMPP's Quality Strategy initiatives
Step 4: Initiate review of medical record data collection	Not required; completed by HEDIS auditor
Step 5: Prepare for the MCO onsite visit	Not required; HEDIS audit tools submitted to OMPP for EQRO to conduct desk review
Activity 2: Onsite Visit Activities	
	Onsite not required this year due to nature of the review. Performed desk review instead.
Step 1: Review information systems underlying performance measurement	Deferred to HEDIS auditor's Information Systems Capabilities Assessment for each MCO
Step 2: Assess data integration and control for performance measure calculation	see above
Step 3: Review performance measure production	see above
Step 4: Conduct detailed review of selected measures	Analyzed HEDIS Audit tools for most recent three years of submissions
Step 5: Assess the sampling process (if applicable)	Not required this year
Step 6: Preliminary findings and outstanding items	Not required this year
Activity 3: Post-Onsite Visit Activities	
Step 1: Determine preliminary validation findings for each measure	Not required this year
Step 2: Assess accuracy of MCO’s performance measure reports to the State	Confirmed that the HEDIS Audit tools submitted contained reportable information
Step 3: Submission of validation report to the State	Included in this section of the EQR report

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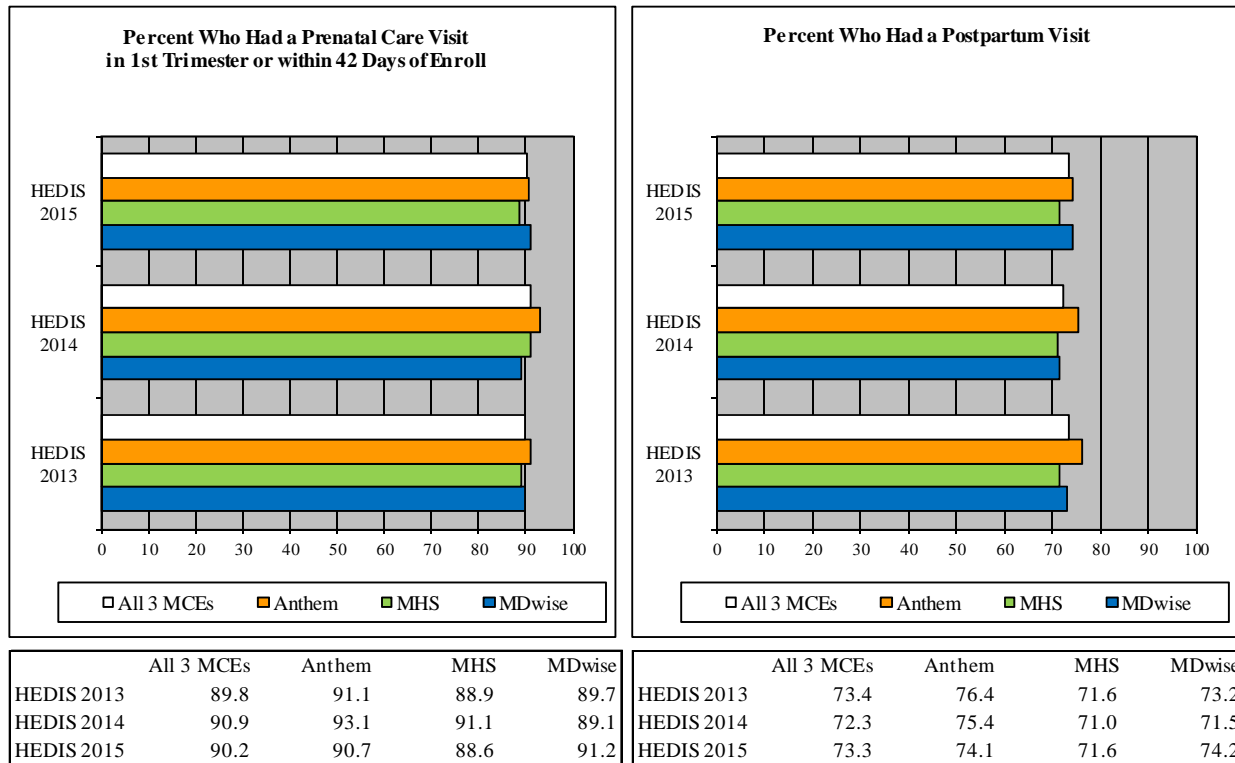
Findings

PPC: Prenatal and Postpartum Care (HHW only)

All three MCEs have a strong record of ensuring that HHW women are receiving a prenatal care visit in the first trimester of pregnancy or within 42 days of their enrollment in HHW. This is evidenced by the All MCE average rate of 90 percent in the last three years and consistency in this rate for each MCE as well.

There is room for improvement in postpartum visits, however. The All MCE average of women who had a postpartum visit has remained steady at 73 percent in each of the last three years. There is some variation among the MCEs on this measure. Anthem outperforms the statewide average, MDwise’s results are near the statewide average, and MHS’s results are slightly below the statewide average. Across years, Anthem has seen a decrease in their rate, MDwise has seen an increase in their rate, and MHS has a rate that has stayed constant.

Exhibit III.2
Prenatal and Postpartum Measures



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FPC: Frequency of Ongoing Prenatal Care (HHW only)

When examining the HEDIS measure for frequency of prenatal care, the goal is to obtain the highest rate for women with 81 percent or more of their prenatal care visits received. The threshold below this is women who received 61 to 80 percent of their prenatal visits.

For the 81 or more percent of visits measure, there have been mixed results in the All MCE average as well as within each MCE. When examining the All MCE average, the rate stayed constant in HEDIS 2013 and 2014 at 82 percent but then dropped in HEDIS 2015 to 78.6 percent.

The decrease in the All MCE average in HEDIS 2015 was driven by results seen by all three MCEs. All three MCEs had results on this measure in HEDIS 2015 that was below their rate in HEDIS 2013.

The results for women who had 61 to 80 percent of their prenatal visits are usually low at around 10 percent. In HEDIS 2015, however, the All MCE average increase to 11.1 percent. This was primarily driven by a sharp increase in MDwise’s rate from the prior year (from 8.8 to 14.3 percent).

Exhibit III.3
Frequency of Prenatal Care Measures



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Well Child Visits (HHW only)

W15: Well Child Visits in the First 15 Months of Life, 6+ Visits (HHW only)

W34: Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (HHW only)

AWC: Adolescent Well Care (HHW only)

The HEDIS rates for all three well child measures have seen steady gains in the HHW program in the last three years. Each of the three measures—W15, W34 and AWC—have seen year-over-year increases in the three year study period (refer to Exhibit III.4 on the next page). Each of the MCEs is contributing to the increases in these All MCE averages.

For W15, the rate of children with six or more visits in their first 15 months of life increased from 66.8 percent in HEDIS 2013 to 72.9 percent in HEDIS 2015. Anthem was higher than the other two MCEs in HEDIS 2013 and their rate went down and then back up so that it remains at the HEDIS 2013 level. Both MHS and MDwise, however, have seen significant increases in their rates for W15 since HEDIS 2013. MHS increased from a rate of 65.1 percent in HEDIS 2013 to 71.6 percent in HEDIS 2015. MDwise jumped even further during this time, from 65.2 percent to 77.4 percent.

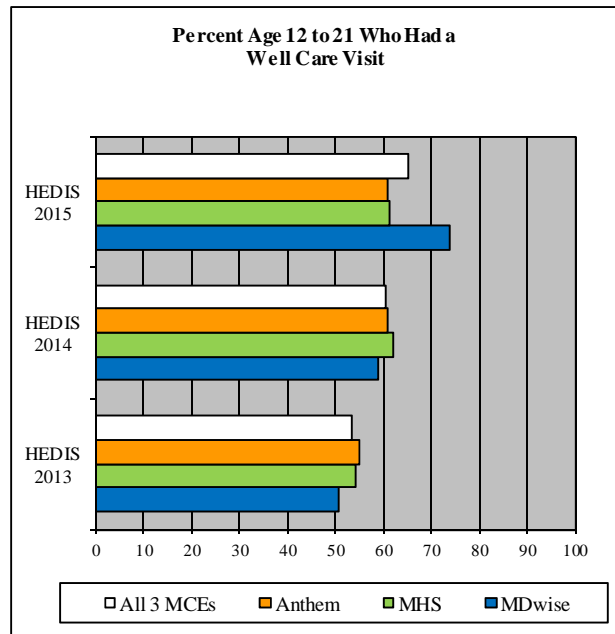
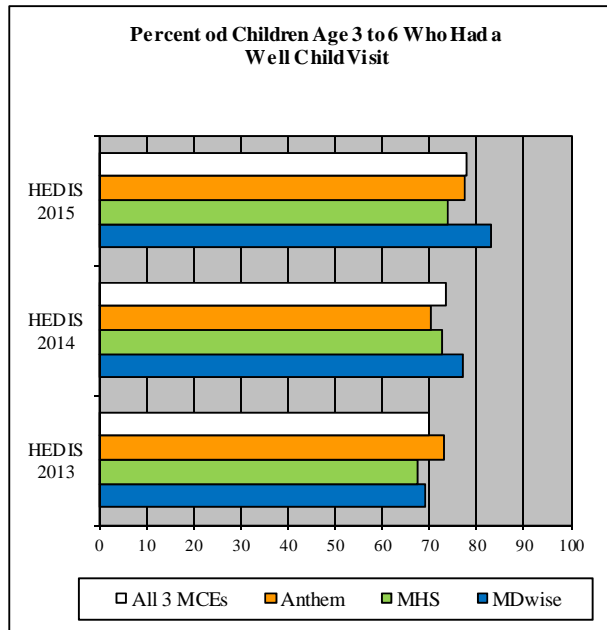
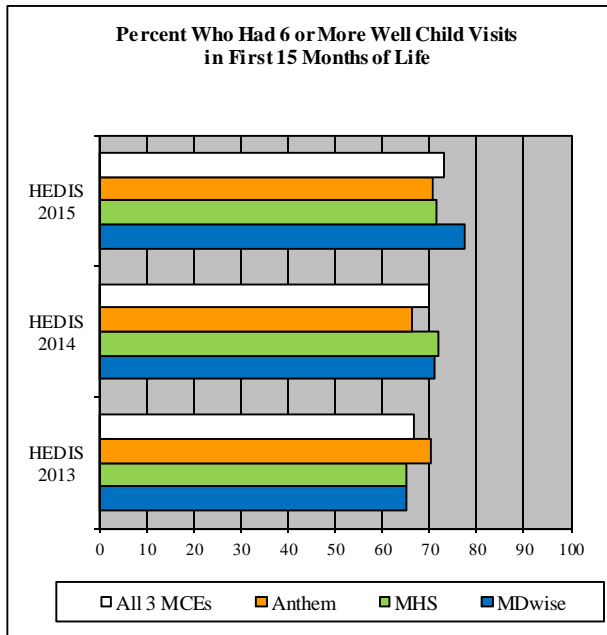
The results for W34 have also improved even at a higher rate than W15. The All MCE average has increased from 69.9 percent in HEDIS 2013 to 77.8 percent in HEDIS 2015. For this measure, all three MCEs have experienced gains in their rate. MDwise once again saw the largest increase, from 69.3 in HEDIS 2013 to 83.2 percent in HEDIS 2015.

The greatest improvement, however, was found to be in the AWC measure. The All MCE average increased from 53.4 in HEDIS 2013 to 60.7 in HEDIS 2014. It increased once again to 65.1 in HEDIS 2015. Each of the three MCEs contributed to the increase in HEDIS 2014. But in HEDIS 2015, MDwise once again saw a large increase in their AWC rate (from 58.9 percent to 73.8 percent) which drove the All MCE average to move up as well. Anthem held constant on the AWC measure in HEDIS 2015 at 65.1 percent, but MHS went down in HEDIS 2015 to 61.3 percent from 62.0 found in HEDIS 2014.

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Exhibit III.4
Well Child Visit Measures



	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	66.8	70.3	65.1	65.2
HEDIS 2014	70.0	66.4	71.7	71.1
HEDIS 2015	72.9	70.6	71.6	77.4
	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	69.9	73.3	67.6	69.3
HEDIS 2014	73.5	70.4	72.6	76.9
HEDIS 2015	77.8	77.6	74.0	83.2

	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	53.4	55.1	54.3	50.9
HEDIS 2014	60.7	60.9	62.0	58.9
HEDIS 2015	65.1	60.8	61.3	73.8

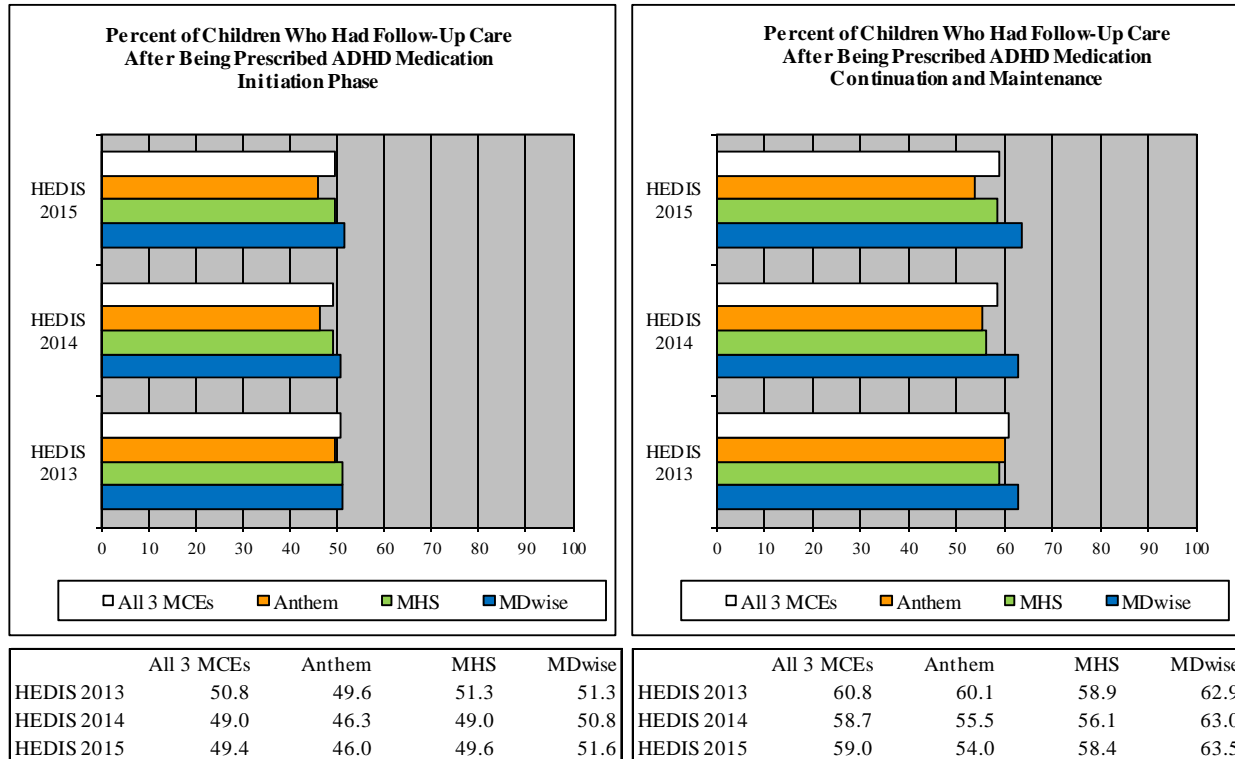
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ADD: Follow-up Care for Children Prescribed ADHD Medication (HHW only)

The results for the two measures related to ADHD prescriptions—the initiation phase and the continuation and maintenance phase—have both remained constant in the HHW program from HEDIS 2013 to HEDIS 2015. At the MCE level, both Anthem and MHS have decreased some on the Initiation Phase measure while MDwise has remained steady. For the Continuation and Maintenance measure, Anthem has decreased here as well, whereas MHS has remained steady and MDwise has increased some.

Exhibit III.5
Follow-up Care from Prescription for ADHD Measures



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FUH: Follow-up After Hospitalization for Mental Illness, 7-Day and 30-Day (HHW and HIP)

The OMPP requires that the MCEs measure FUH in both the HHW and HIP programs. This measure has two components—one that measures follow-up within seven days, the second that measures follow-up within 30 days. It has been consistently found that the rate for the 30-day follow up is higher than the 7-day follow up.

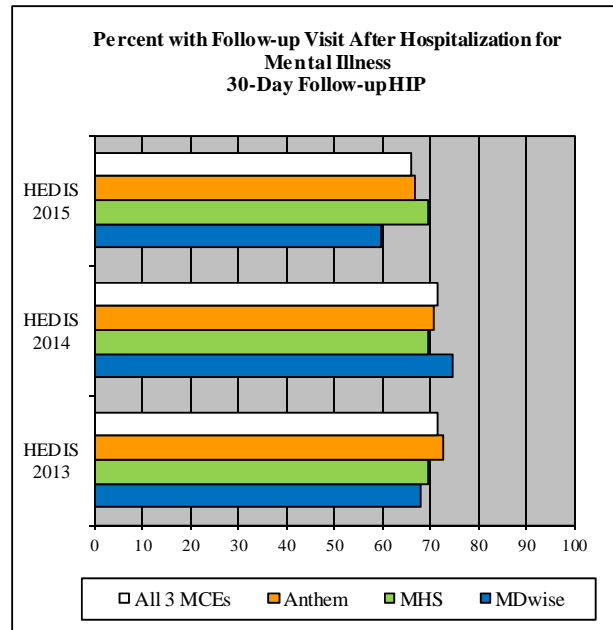
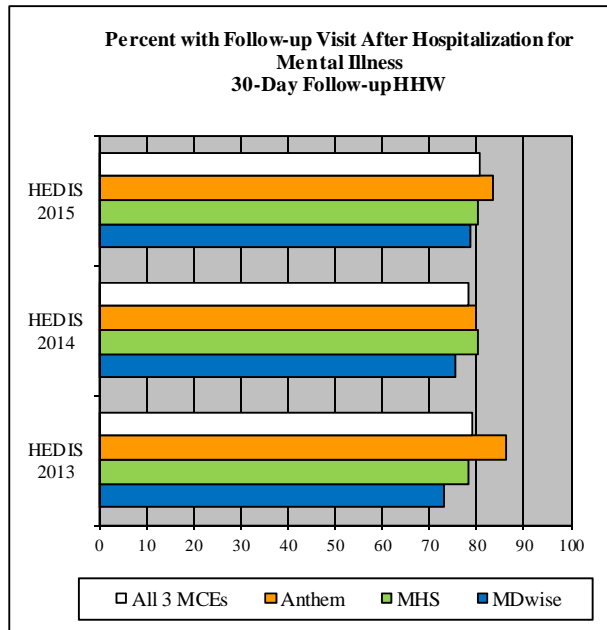
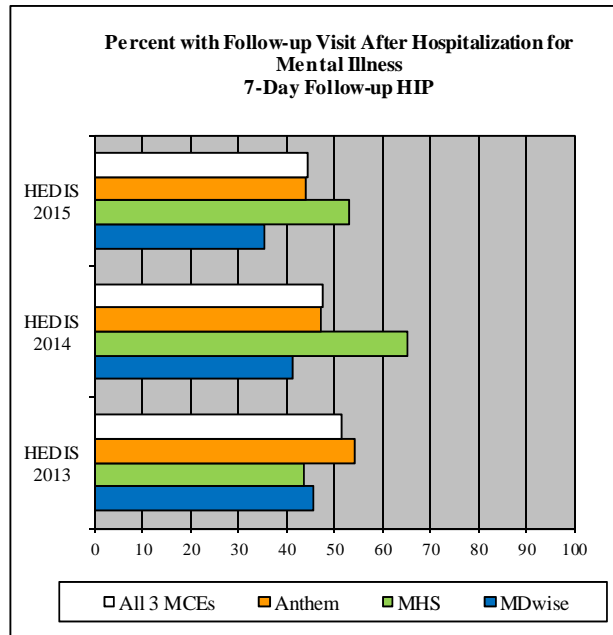
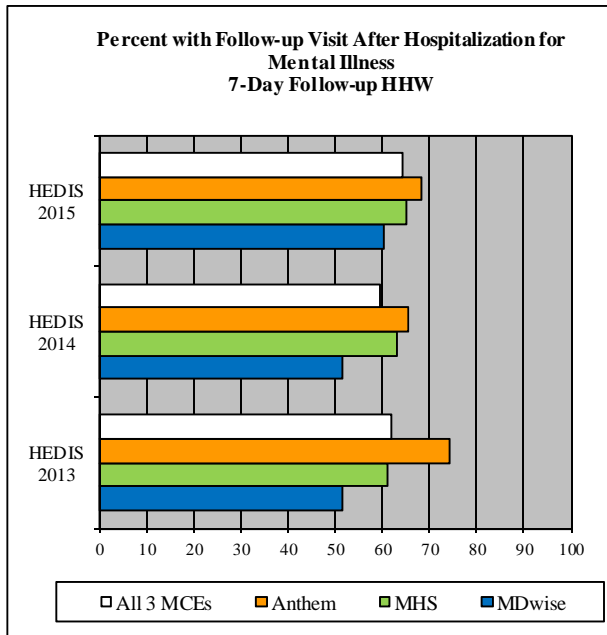
The trends for this measure differ between HHW and HIP. Some improvement was found in both the 7-day and 30-day measure when examining the All MCE averages in HHW. At the MCE level, Anthem has experienced a decrease in its 7-day results while MHS and MDwise have gained improvements. This, however, is in the context that Anthem had a much higher FUH result than both MHS and MDwise to start. A similar pattern was found among the MCEs in HHW for the 30-day follow-up measure.

The greatest contrast was seen between the results of both the 7-day and 30-day measures between HHW and HIP. This held true for the All MCE averages and each MCE alone. In HEDIS 2015, the HIP rate is just 44.6 percent for 7-day which contrasts with the 64.4 percent found for HHW in that same year (refer to Exhibit III.6 on the next page for details). The 30-day measure had a 15 point spread instead of 20 points. The HIP All MCE average for HEDIS 2015 was 65.9 percent, but in HHW it was 80.8 percent.

The large difference between the two programs on this HEDIS measure appears to be driven by different populations. Members in the pediatric population appear to be more likely to comply with follow-up visits after hospitalization than the adults.

Exhibit III.6

Follow-up After Hospitalization for Mental Illness Measures



	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	62.0	74.2	61.1	51.4
HEDIS 2014	59.7	65.4	63.1	51.7
HEDIS 2015	64.4	68.4	64.9	60.5

	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	51.6	54.2	43.5	45.8
HEDIS 2014	47.4	47.2	65.2	41.3
HEDIS 2015	44.6	44.2	53.0	35.3

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AMBA: Emergency Department Visits (HHW and HIP)

The utilization of ED visits is based on actual claims and is measured in ED visits per 1,000 members. Therefore, the axis shown on Exhibits III.7 and III.8 on the next two pages can exceed since it is the actual count of claims and not a percentage.

For the AMBA measure for ED, a lower value is the goal. Among the pediatric population, there has been modest improvement since the rates per 1,000 HHW child members has decreased slightly for age less than one, age one to nine and age ten to 19. [Refer to Exhibit III.7 on the next page.] These modest improvements were also seen in Anthem's and MHS's results, but MDwise saw no improvement for children under age one and age one to nine. MDwise did have slight improvement in its ED utilization per 1,000 members age ten to 19. MDwise also had the lowest result of any MCE on the measure for HHW age ten to 19.

There is modest improvement in the ED visit rates among adults in HHW as well. [Refer to Exhibit III.8 on page III-12.] For adults age 20 to 44, the rate of ED visits fell from 127.2 in HEDIS 2013 to 121.0 in HEDIS 2015 in HHW. For adults age 45 to 64, the rate of ED visits fell from 94.8 to 86.3 per 1,000 member months. In both measures, each of the three MCEs contributed to the reduction in HHW.

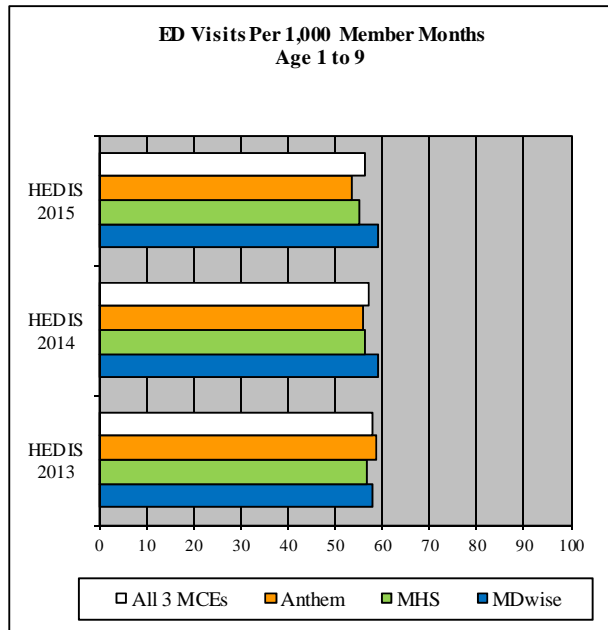
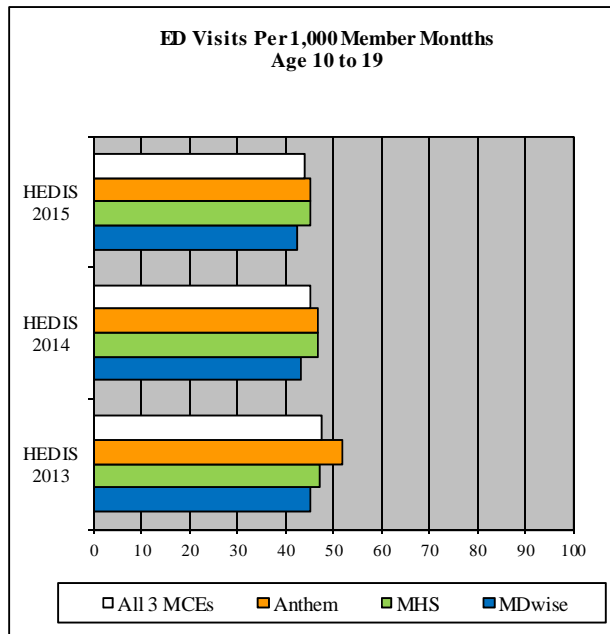
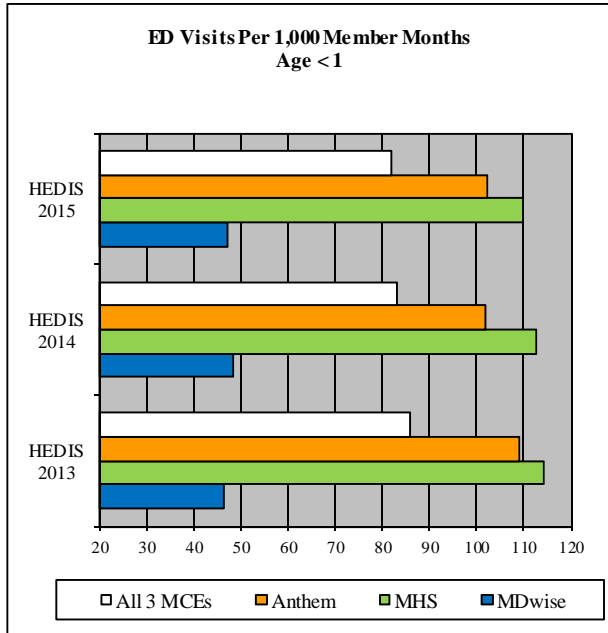
The results of ED visit measures are much different for the adults in HIP than they are for the adults in HHW. The HIP results are significantly lower. For adults age 20 to 44, the rate of ED visits increased some from HEDIS 2013 to HEDIS 2015, but the HEDIS 2015 rate is only 92.8 compared to the HHW rate of 121.0. For adults age 45 to 64, the rate of ED visits per 1,000 members also went up slightly from 56.3 in HEDIS 2013 to 62.8 in HEDIS 2015. But the HIP rate of 62.8 still contrasts with the HEDIS 2015 All MCE rate of 86.3 for adults age 45 to 64 in HHW.

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Exhibit III.7

Emergency Department Utilization Among Children



	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	85.9	109.1	114.2	46.5
HEDIS 2014	83.2	101.7	112.8	48.4
HEDIS 2015	81.8	102.2	110.0	47.1
	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	57.8	58.6	56.7	58.0
HEDIS 2014	57.3	55.9	56.3	59.1
HEDIS 2015	56.2	53.5	55.0	59.0

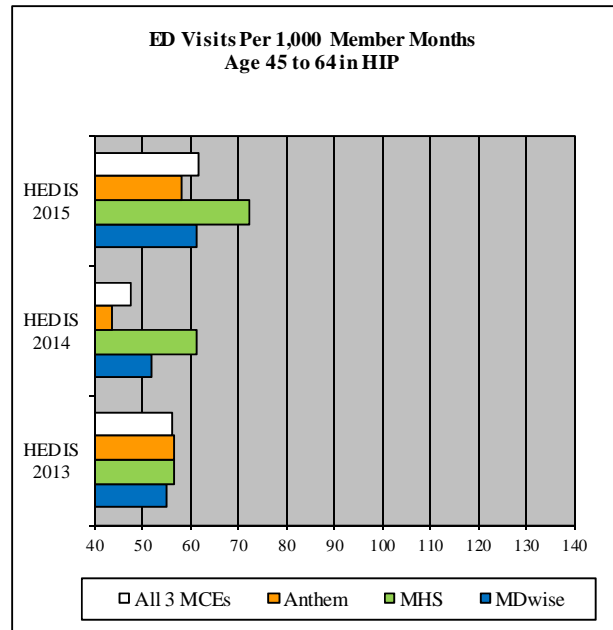
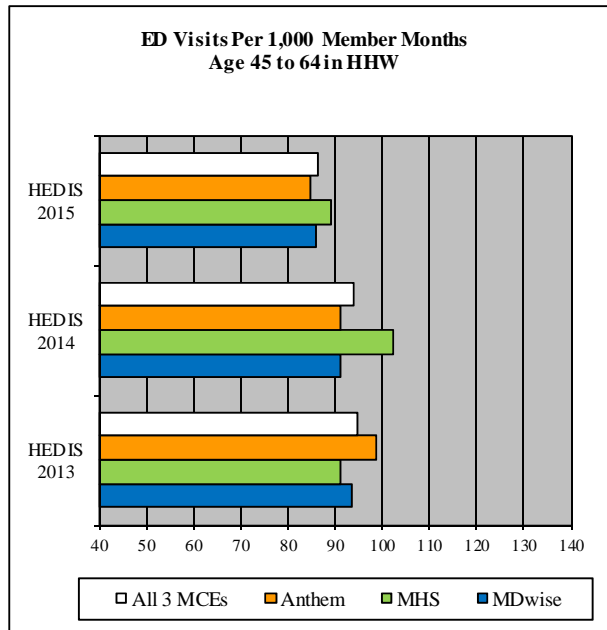
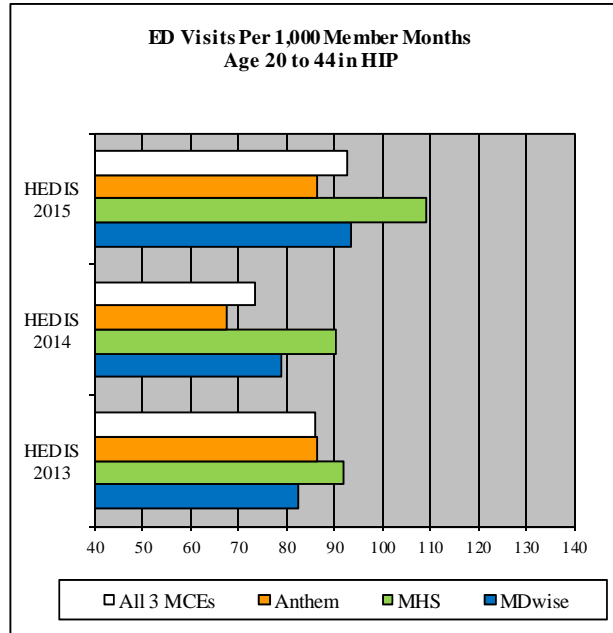
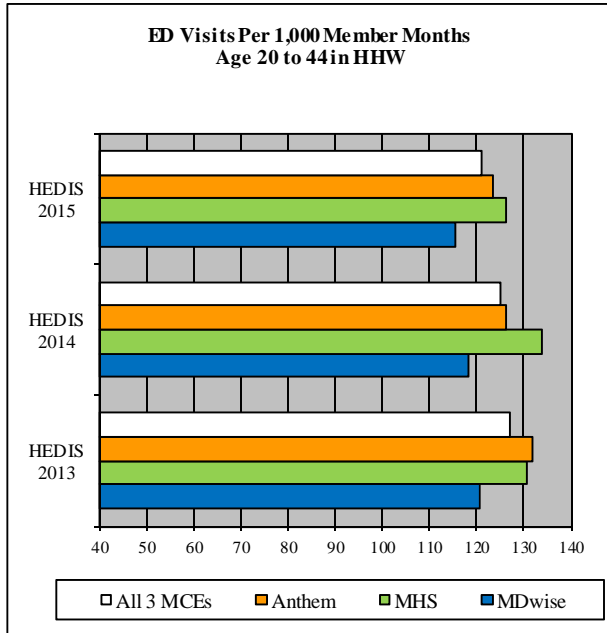
	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	47.7	52.0	47.3	45.1
HEDIS 2014	45.4	46.8	46.7	43.3
HEDIS 2015	44.2	45.2	45.2	42.6

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Exhibit III.8

Emergency Department Utilization Among Adults



	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	127.2	131.7	130.8	120.5
HEDIS 2014	125.0	126.3	133.7	118.2
HEDIS 2015	121.0	123.3	126.1	115.6
	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	94.8	98.6	91.2	93.7
HEDIS 2014	93.9	91.2	102.3	91.2
HEDIS 2015	86.3	84.7	89.2	86.1

	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	85.9	86.5	92.0	82.4
HEDIS 2014	73.4	67.7	90.3	78.8
HEDIS 2015	92.8	86.5	109.0	93.4
	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	56.3	56.8	56.5	55.1
HEDIS 2014	47.5	43.8	61.4	52.1
HEDIS 2015	61.8	58.3	72.2	61.2

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AMBA: Outpatient Visits (HHW and HIP)

Outpatient visits are also measured on a per 1,000 member month basis within specific age groups. The MCEs collect results for this HEDIS measure separately for the HHW and HIP programs.

Among the pediatric population in HHW, the rate of outpatient visits was lower in HEDIS 2015 than in HEDIS 2013. [Refer to Exhibit III.9 on the next page.] This trend held true for the All MCE averages in each of the three age groups in HHW. Also, each MCE saw decreases in their outpatient utilization rate for the three pediatric age groups as well, with the one exception being MDwise that saw little change among children under age one. It should also be noted that the actual utilization rate for children under age one is more than double that found for children age one to nine or ten to 19.

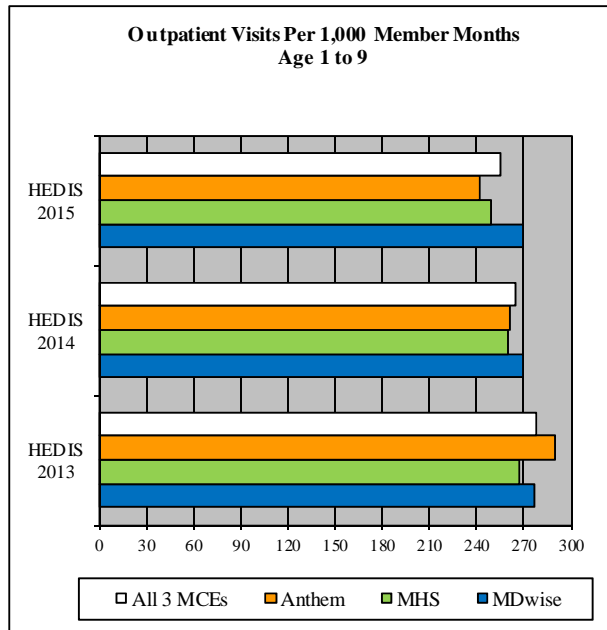
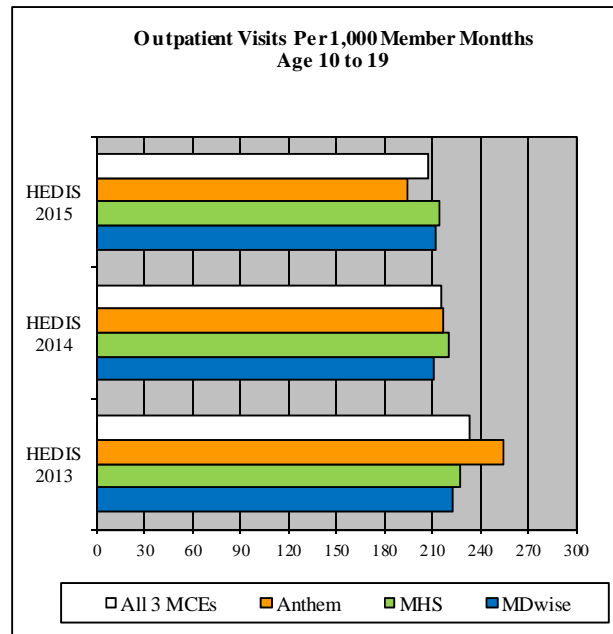
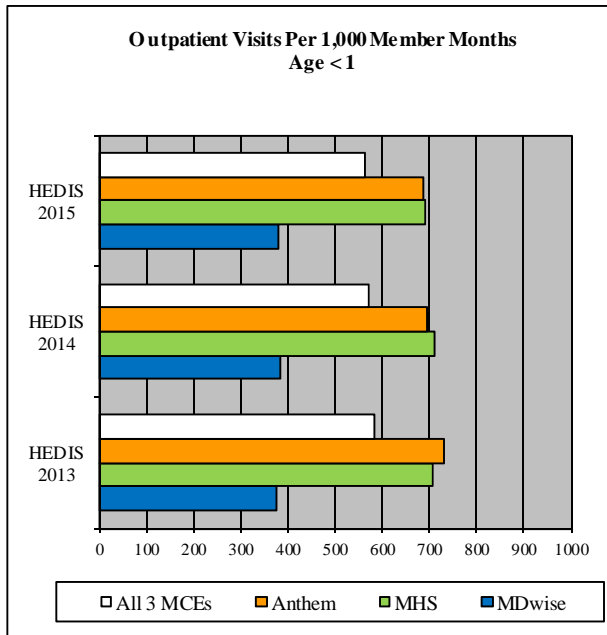
For the adult population, the rate of outpatient visits was also lower in HEDIS 2015 than in HEDIS 2013. This was true for both the 20 to 44 age group and the 45 to 64 age group. It also held true for the All MCE averages and each individual MCE's average in both of these age groups. [Refer to Exhibit III.10 on page III-15.]

Where it was found that the HIP adult population had lower ED visit rates than their counterparts in HHW, the HIP adults consistently have higher outpatient visit rates per 1,000 than the HHW population. This is true for every MCE as well except for MDwise's HIP population age 45 to 64. The outpatient visit rates are similar, but not lower, than the HHW results in HEDIS 2015 for that age group.

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**Exhibit III.9
Outpatient Utilization Among Children**



	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	583.9	730.5	707.1	374.4
HEDIS 2014	572.3	693.4	709.7	382.0
HEDIS 2015	563.4	688.7	691.9	379.5
	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	277.6	289.8	266.7	276.9
HEDIS 2014	264.5	261.1	260.3	270.0
HEDIS 2015	255.5	242.1	249.2	269.9

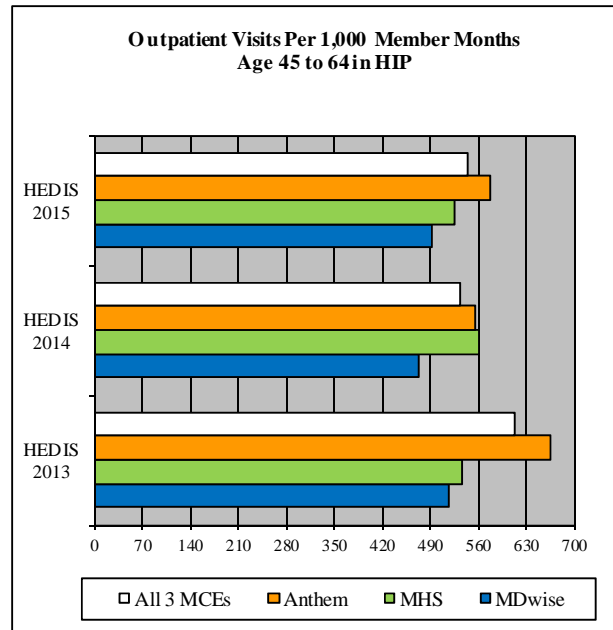
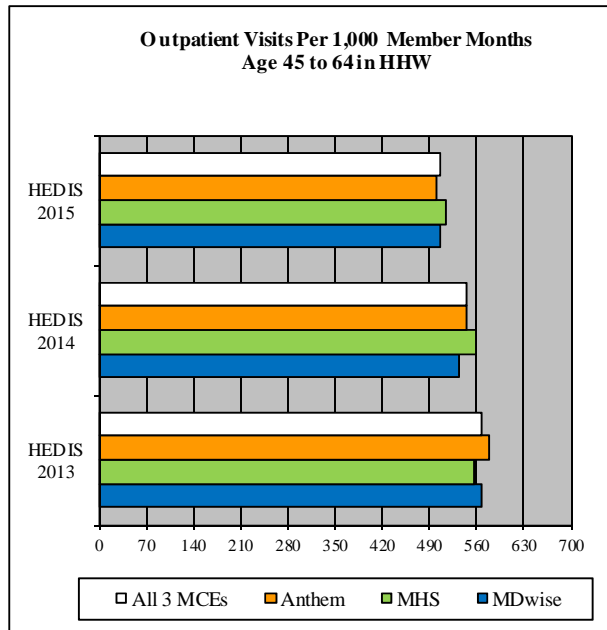
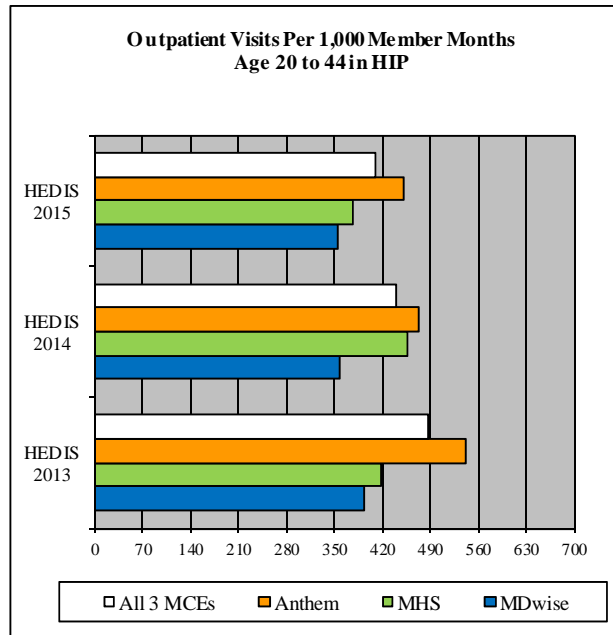
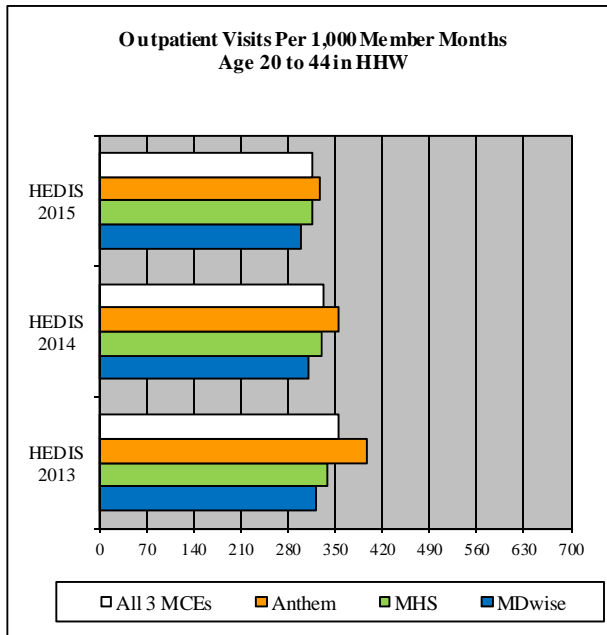
	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	233.2	254.4	227.3	222.5
HEDIS 2014	216.0	217.5	220.5	211.5
HEDIS 2015	207.8	194.9	214.1	212.8

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Exhibit III.10

Outpatient Utilization Among Adults



	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	353.9	398.4	339.7	320.5
HEDIS 2014	332.5	356.3	330.9	310.1
HEDIS 2015	314.7	328.4	315.3	300.6

	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2013	488.0	543.1	417.5	393.8
HEDIS 2014	441.2	473.5	457.1	357.8
HEDIS 2015	410.4	451.2	376.4	354.2

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SECTION IV: VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

Introduction

As part of the Calendar Year (CY) 2014 External Quality Review (EQR), the Office of Medicaid Policy and Planning (OMPP) asked Burns & Associates (B&A) to assist in revising the reporting mechanism for the managed care entities (MCEs) to submit to the OMPP the results of their Performance Improvement Projects (PIPs).

B&A convened quality team members from each MCE and the OMPP to work collaboratively on a new reporting tool that became known as the Quality Improvement Project (QIP) Report. The draft of the new tool is in Microsoft Excel and combined elements from the NCQA Quality Improvement Project Form and elements from the CMS EQR Protocol 3: *Validating Performance Improvement Projects*. More of the focus on this new reporting tool is the definition of interventions, how they will be measured, and an assessment of the interventions on quality outcomes.

The MCEs pilot tested using the tool and met with B&A to make improvements on the tool design as part of last year's EQR. This year's EQR is the first time the QIP report is being used as part of a year-end quality review at the MCEs.

The OMPP selected the QIP term to differentiate between it and the Performance Improvement Projects that it requires of MCEs resulting from Corrective Action Plans. Before the implementation of this tool, the State and the MCEs used the terms "QIPs" and "PIPs" synonymously in the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) programs. Going forward, the OMPP is using the term "QIP" when referring to the quality-related improvement projects. The QIP Report became effective January 1, 2015.

Whereas last year the MCEs piloted the QIP form, it was agreed that the first complete submission for QIPs would be due to the OMPP by August 1, 2015. B&A has reviewed these final QIPs, as well as the quarterly updates that each MCE provided to the OMPP in CY 2014 as the basis for this validation process.

Although each MCE may have selected a variety of QIPs, in an effort to follow through on the process initiated last year, the QIPs selected for this year's EQR are the same for each MCE as last year, with one minor exception. The three QIPs validated were:

- Postpartum Care (HHW program only)
- ED Utilization (HHW and HIP programs)
- Tobacco Cessation (HHW and HIP programs); for Tobacco Cessation, however, the primary focus will be on items in the QIP related to tobacco cessation for pregnant women

EQR Team members Mark Podrazik and Kristy Lawrance reviewed the QIP submissions as part of a desk review first. Then, during the week of August 10, the team members conducted onsite meetings with each MCE to go over the QIPs under review. This included follow-up questions from our desk review as well as a discussion with the relevant staff who had primary responsibility for the interventions that were put in place for the QIPs that were selected.

Review of Performance Improvement Projects

B&A followed the steps in Activity 1 of the CMS EQR Protocol #3: *Validating Performance Improvement Projects* to complete this validation.

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Activity 1: Assess the Study Methodology

1. Review the selected study topic(s)
2. Review the study question(s)
3. Review the identified study population
4. Review the selected study indicators
5. Review sampling methods
6. Review the data collection procedures
7. Assess the MCE's improvement strategies
8. Review data analysis and interpretation of study results
9. Assess the likelihood that reported improvement is "real" improvement
10. Assess sustainability of the documented improvement

Activity 2, Verify Study Findings, is an optional activity and was not completed as part of this year's EQR.

Activity 3, Evaluate and Report Overall Validity and Reliability of QIP Results, is presented in this section of the EQR report.

B&A completed the Centers for Medicare and Medicaid's (CMS's) *EQR Protocol 3, Attachment A, PIP Review Worksheet* for each QIP reviewed as part of the validation. B&A did customize some of the components in the PIP Review Worksheet to better assess the specific QIPs at the MCE. A subset of components, but not all of them, was selected for review in Steps 1 through 6 of Protocol 3. More of the focus of this year's QIP validation centered on Step 7 of Protocol 3- Assess the MCE's Improvement Strategies. In particular, interventions were reviewed in depth for each QIP to determine if distinct interventions were measureable and how the MCEs measure their interventions and outcomes.

Desk Review

MCEs were asked to submit descriptions of their QIP which included the study question, the methodology used, interventions chosen, and results from both the benchmark period and any remeasurement periods. Information was reported by each MCE using the new QIP Report form. The EQR team members reviewed these materials and created customized interview protocols for each MCE/QIP for the onsite meeting in order to conduct a full assessment.

Onsite Meeting

The MCEs had representatives from their team who were the leads for each QIP and those that could speak to the specific QIP interventions available for the onsite interviews. The EQR team members jointly met with MCE representatives to go over the questions in the customized interview protocols for each QIP. In some instances, the MCEs brought supplemental information to the meeting to explain more fully the analytics completed on QIP measure results.

Post-Onsite Evaluation

The EQR team members considered the items from the desk review, the responses in onsite interviews, and supplemental information provided by the MCEs as requested to complete the PIP Review Worksheet on each MCE QIP.

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Anthem QIP Findings

Postpartum Care

Anthem began its QIP for Postpartum Care in HEDIS Rate Year (RY) 2012 (services dates in 2011). B&A examined results through Remeasurement Year (RM) 3 (HEDIS RY 2015).

For this QIP, Anthem elected to include one measure to determine the efficacy of its QIP activities—the percentage of women that received a postpartum care visit on or between 21 and 56 days after delivery. Anthem uses the current HEDIS definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year.

Interventions

To try to improve scores on this HEDIS measure, Anthem has modified their interventions over the course of this QIP. Anthem originally had one intervention which was to identify members who were in their ninth month of pregnancy and send them a mailer to remind them to obtain postpartum care. In November 2011, Anthem added an intervention which was to conduct automated calls members to remind them to complete their postpartum care visit. In 2013, Anthem added an additional intervention in the fourth quarter of the year of individual live-voice calls to members to remind them to complete their postpartum care visit and assisting with appointment scheduling. Throughout the QIP, Anthem has continued calling postpartum women to remind them of the need for a follow-up visit.

Results

Exhibit IV.1 shows that the rate in RM1 stayed constant with the baseline period, the RM2 rate showed statistically significant improvement over RM1, and the rate in RM3 declined slightly, but it was not statistically significant. The benchmark for this measure is the HEDIS 90th percentile. Anthem has surpassed the benchmark in each of the last three years.

Exhibit IV.1
Results Reported for Anthem Quality Improvement Project
Postpartum Care
Hoosier Healthwise

Measure #1: Percentage of Women that Received a Postpartum Care Visit on or between 21 and 56 Days after Delivery								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	HEDIS 2012	239	313	76.4	NA	74.4	2011, 90th	NA
RM1	HEDIS 2013	233	305	76.4	77.0	74.7	2012, 90th	No
RM2	HEDIS 2014	230	305	75.4	75.5	73.8	2013, 90th	Yes
RM3	HEDIS 2015	318	429	74.1	75.5	74.0	2014, 90th	No

Because of these strong results that exceeded the HEDIS 90th percentile, Anthem will be discontinuing this QIP. It will continue its interventions and continue to monitor activity via monthly reports to measure administrative claims.

The one time intervention of calling and assisting members in making appointments in RM2 was effective in obtaining better adherence to timely postpartum care. This intervention was not necessary in RM3, but remains an option if needed in RM4. From these calls and additional data analysis, Anthem learned non-adherence to the postpartum visit standard could be attributed to:

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1. Provider saw the member while they were still in the hospital and the member did not know or was told she did not need to come back to see the provider.
2. Visit fell just "outside of" the day range.
3. The member had a C-Section delivery and visits the doctor for the one and only postpartum visit one week after delivery to have sutures removed.

The MCE will continue to provide information/education on postpartum timely visit time frames to providers and to members. In the Spring of 2015, Anthem transitioned to a new maternal care program that has more intensive case management. The program includes home care nursing to those members who cannot make it to the provider office or are unable to have a timely appointment with the provider.

Emergency Department Utilization

Anthem began its QIP for Emergency Department (ED) Utilization in CY 2012. B&A examined results through RM Year 2 (CY 2014).

ED utilization is one of the current pay-for-outcome (P4O) measures that the OMPP has in its contract with the MCEs. For this QIP, Anthem elected to include two measures in 2014 to determine the efficacy of its QIP activities:

1. Members age 18 and over who visit the ED two times within 180 days
2. Members under age 18 who visit the ED two times within 180 days

In 2013 only, an additional measure was added to monitor utilization as it relates to targeted interventions in the Evansville area in the Southwest Region.

Anthem does not use the HEDIS definition for these measures and developed its own logic for computing results each remeasurement year.

Interventions

In 2013, Anthem had one intervention, their ED Action Campaign, which consisted of educational mailings sent to members who used the ED more than twice in 180 days. However, due to data issues in the 2nd and 3rd Quarters of 2013, there was a significant drop in the number of mailings being sent. In 2013 Q4, mailings returned to normal volume.

To supplement the ED Action Campaign, Anthem has developed, in concert with community stakeholders (FQHCs, Health Systems, clinics, a university, a health department, schools, CMHCs, and township trustee in the Evansville area) targeted educational interventions that went into effect in CY 2014.

The measured interventions in 2014 were automated calls to members going to the ED two or more times in 180 days and monitoring the number of calls to the nurse call line for Warrick and Vanderburgh counties.

Results

Exhibit IV.2 on the next page shows that statistically significant improvement was made in RM2 (a lower rate is desired for this measure). However, it is not clear if the interventions caused this reduction or if it was other activities undertaken by the MCE or its providers.

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**Exhibit IV.2
Results Reported for Anthem Quality Improvement Project
Emergency Room Utilization
Hoosier Healthwise and Healthy Indiana Plan**

Measure #1: Rate of member ages 18 and over who visit the ER two times within 180 days								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	13,165	49,766	18.3	NA	NA	NA	NA
RM1	CY 2013	4,974	49,103	9.0	10.0	15.0	NA	-
RM2	CY 2014	2,098	73,586	2.8	5.0	5.0	NA	Yes
Measure #2: Rate of member under age 18 who visit the ER two times within 180 days								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	20,138	167,122	12.0	NA	NA	NA	NA
RM1	CY 2013	11,791	168,150	7.0	10.0	15.0	NA	-
RM2	CY 2014	4,387	171,025	2.5	5.0	5.0	NA	Yes
Measure #3: Rate of Anthem members assigned to Deaconess Family Residency to total the total living in Evansville, IN								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	CY 2013	1,870	11,814	1.5	NA	-	NA	NA
RM1	CY 2014	1,662	10,645	1.6	1.0	1.3	NA	-

Because of these strong results, Anthem will be discontinuing this QIP but will continue tracking and monitoring ED utilization. Additionally, Anthem implemented new Care Management (CM) software/processes in 2015. This system allows the CM department to identify those members who have high probability in utilizing the ED with the goal of reaching out to the member prior to his or her ED use. This system also provides information by provider. Staff will be able to share this information with providers so that they can assist in reducing utilization.

Smoking Cessation for Pregnant Women

Anthem began its QIP for Smoking Cessation in CY 2012 and only developed pregnancy-related interventions in late 2014. Results for those were not yet available. The QIP provided and evaluated was for overall smoking cessation. B&A examined results through RM2 (CY 2014).

Smoking cessation is one of the current P4O measures that the OMPP has in its contract with the MCEs. For this QIP, Anthem elected to include four measures to determine the efficacy of its QIP activities:

1. Increase the percent of members who were advised by their doctor or other health professional to quit smoking in the last six months.
2. Increase the percent of members whose provider recommended medication to assist with smoking cessation.
3. Increase the percentage of members whose provider recommended other strategies to assist with smoking cessation.
4. Increase the prescribing of Nicotine Replacement Therapy (NRT).

The first three of these measures are based upon responses from members when asked questions during the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS). The fourth was an Anthem measure developed for computing results.

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Interventions

In 2014, Anthem had four interventions to try and improve these measures.

1. Provide an educational mailing to members who smoke and offer a smoking cessation kit.
2. Follow-up with members that request smoking cessation Quit Kits.
3. Measure the prescribing patterns of nicotine replacement therapies.
4. Follow-up with members that received NRTs to determine if they were helpful and if the member stopped smoking.

Intervention #1 is Anthem's current measurable intervention. It addresses the number of kits requested. To determine if this intervention is effective, Anthem hopes to survey a sample of those requesting a Quit Kit.

Anthem had barriers with Interventions #2, #3, and #4. Due to the time frame and script approval process, the MCE was unable to get a list of members to make outreach phone calls for Q4 2014. Interventions #3 and #4 had barriers in obtaining NRT prescription information due to the State's current policy of carving pharmacy out of managed care. It was also difficult to identify which members were pregnant and smoked.

In addition to the interventions listed in Anthem's QIP, Anthem developed several new strategies in its Tobacco Cessation Work Plan for Pregnant Women. These efforts were not begun until the fourth quarter of 2014, so there is little data in this measurement year

Results

Exhibit IV.3 shows that improvement was made for HHW members on Measures #1, #2 and #3. Measure #1 had statistically significant improvement in the most recent measurement year. Exhibit IV.4 shows improvement was made with HIP members on Measure #2, but it was not statistically significant.

Data was not readily available for Measure #4 in either population due to the pharmacy carve out and therefore was not collected. Anthem was unable to determine valid data for which members who were pregnant and taking NRT.

Anthem could not prove that the interventions directly correlated to the change in the CAHPS scores.

Anthem will not be continuing this QIP for HHW. Upon review of this QIP, the measures and interventions are not in alignment. The tobacco cessation QIP will continue for HIP, but will be modified from this QIP.

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Exhibit IV.3

**Results Reported for Anthem Quality Improvement Project
Smoking Cessation
Hoosier Healthwise**

Measure #1: Increase the percent of members who were advised by their doctor or other health professional to quit smoking in the last six months								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	99	137	72.3	NA	-	NA	NA
RM1	CY 2013	113	146	77.4	75.0	75.2	NA	No
RM2	CY 2014	93	139	66.9	> 76.0	75.2	NA	Yes
Measure #2: Increase the percent of members whose provider recommended medication to assist with smoking cessation								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	48	137	35.5	NA	-	NA	NA
RM1	CY 2013	56	143	39.2	38.0	-	NA	No
RM2	CY 2014	53	136	39.0	40.0	-	NA	No
Measure #3: Increase the percentage of members whose provider recommend other strategies to assist with smoking cessation								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	61	136	44.9	NA	-	NA	NA
RM1	CY 2013	57	145	39.3	45.0	-	NA	No
RM2	CY 2014	49	139	35.3	45.0	-	NA	No
Measure #4: Prescribing of Nicotine Replacement Therapy (NRT)								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	7/13 - 6/14			283.0				

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**Exhibit IV.4
Results Reported for Anthem Quality Improvement Project
Smoking Cessation
Healthy Indiana Plan**

Measure #1: Increase the percent of members who were advised by their doctor or other health professional to quit smoking in the last six months								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	160	199	80.4	NA	-	NA	NA
RM1	CY 2013	181	221	81.9	> 76.0	76.0	NA	No
RM2	CY 2014	167	210	79.5	> 76.0	76.0	NA	No
Measure #2: Increase the percent of members whose provider recommended medication to assist with smoking cessation								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	111	199	55.8	NA	-	NA	NA
RM1	CY 2013	127	223	57.0	56.0	-	NA	No
RM2	CY 2014	111	209	53.1	58.0	-	NA	No
Measure #3: Increase the percentage of members whose provider recommend other strategies to assist with smoking cessation								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	84	197	42.6	NA	-	NA	NA
RM1	CY 2013	99	221	44.8	42.0	-	NA	No
RM2	CY 2014	91	211	43.1	45.0	-	NA	No
Measure #4: Prescribing of Nicotine Replacement Therapy (NRT)								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	7/13 - 6/14			283.0				

MHS QIP Findings

Postpartum Care

MHS began its QIP for Postpartum Care in HEDIS RY 2014 (service dates in 2013). Postpartum Care is one of the current P4O measures that the OMPP has in its contract with the MCEs. For this QIP, MHS elected to include one measure to determine the efficacy of its QIP activities—the percentage of women that received a postpartum care visit on or between 21 and 56 days after delivery.

MHS uses the current HEDIS definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year.

Interventions

To try to improve scores on this HEDIS measure, MHS planned three interventions:

1. Member calls by Case Management staff two weeks after delivery (First Year of Life Program)
2. Baby Shower educational events (for pregnant and postpartum members)
3. CentAccount rewards

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For Intervention #1, an analysis of the claims-based rates (based on the HEDIS sample, which took enrollment eligibility into account), did not reveal a difference in timely postpartum visit rates between the groups of women reached by phone and those that did not. The calls will continue, since the primary purpose of the series is to promote a healthy start for the infant. Even if it is not directly affecting postpartum rates, it has proven effective for other measures. MHS reports that infant outcome studies indicate higher well child visit rates among First Year of Life participants and lower ED visit rates for 0-12 month olds since the program's inception.

Intervention #2 did not seem to affect postpartum rates. Only 29 percent of members who attended an MHS Baby Shower event had a postpartum visit. Of special note, all of the postpartum visits among Baby Shower attendees were timely (within the HEDIS-defined timeframe). While this assessment did not confirm the effectiveness of Baby Showers in promoting postpartum care, it did suggest effectiveness of this personal approach in promoting timely care. The events will continue due to the educational and overall preventive health opportunities that they provide including those for the newborn.

For Intervention #3, MHS stated that this intervention was somewhat difficult to assess, as members can reportedly receive CentAccount rewards in two ways, either from provider attestation of a postpartum visit (as part of the Start Smart for Baby program) or by completing the OB Case Management postpartum survey.

Results

Exhibit IV.5 shows that the interventions did not increase postpartum HEDIS rates in a statistically significant manner.

Exhibit IV.5
Results Reported for MHS Quality Improvement Project
Postpartum Care
Hoosier Healthwise

Measure #1: Percentage of Women that Received a Postpartum Care Visit on or between 21 and 56 Days after Delivery								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	HEDIS 2014	320	451	71.0	73.8	73.8	2013, 90th	NA
RMI	HEDIS 2015	308	430	71.6	74.0	74.0	2014, 90th	No

The Timely Postpartum Visit rate remains below the national 90th percentile benchmark rate, which is MHS's goal for this measure. MHS believes that the interventions evaluated through this QIP have been insufficient to progress the rate. In 2015, MHS implemented a Field Case Management home visit program and other activities have been put in place to promote more timely and effective perinatal care. MHS will continue this QIP in order to evaluate the effectiveness of these initiatives.

Emergency Department Utilization

MHS began its QIP for Emergency Department Utilization in HEDIS RY 2014 (service dates in 2013). ED utilization is one of the current P4O measures that the OMPP has in its contract with the MCEs.

For this QIP, MHS elected to include two measures to determine the efficacy of its QIP activities: (1) the HEDIS Emergency Department Utilization Rate and (2) the OMPP Report QR-GSU7 Type of Emergency Room Utilization rate. MHS uses the current HEDIS definition for the first measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year.

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Interventions

MHS planned three interventions for this measure:

1. ED Diversion counseling facilitated by Medical Case Management Team
2. Successful Right Choices Program (RCP) participation
3. First Year of Life Program enhancement

Intervention #1 did not seem to dramatically reduce ED utilization more than a mailing had. MHS evaluated pre/post call ED utilization rates among all members that the ED diversion team reached out to during the time period January 1- June 30, 2014. That study used the 1st successful call as the anchor date for the intervention group, and the 1st unsuccessful call attempt as the anchor date for the control group. ED usage was compared for the six-month periods before and after each member's anchor date.

MHS found that the intervention group had an average of 9.92 visits in the six-month period before the call and 1.46 in the six month period after the call. The control group includes individuals who MHS cannot reach by phone but still receive an educational mailing that includes information about the Nurse Wise 24/7 advice line. This group averaged 11.31 visits in the six-month period before the call attempt and 1.50 in the six-month period after the call attempt. MHS believes that the ED Diversion outreach education is an effective intervention, regardless of the communication method (call vs. mailing). They intend to continue the outreach program in the future.

The goal of the RCP (often known as a lock-in or restricted card program) is to reduce overutilization by linking a member to a single primary medical provider, hospital and pharmacy. Intervention #2 measures how many "graduate" from the program by reducing their overutilization. The intervention appears to be at least somewhat effective, but a higher graduation rate is desired. It is not clear from this metric how much the RCP affects the overall ED Utilization Rate. MHS intends to continue to monitor this program, especially to determine any positive future impact of the Case Management program changes it is implementing in 2015.

Intervention #3 does seem to significantly reduce ED utilization among children 0-12 months of age. The education provided in these calls resulted in a 13.1 percent reduction in ED utilization.

Results

The exhibits on the following page show the baseline year information for MHS HHW (Exhibit IV.6) and for MHS HIP (Exhibit IV.7). For this measure, a lower rate is favorable.

ED utilization remains an ongoing priority to MHS and they will continue this QIP in 2015. MHS will add additional metrics surrounding preventable ED visits (i.e., those related to ambulatory-sensitive conditions) in the coming year.

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**Exhibit IV.6
Results Reported for MHS Quality Improvement Project
Emergency Room Utilization
Hoosier Healthwise**

Measure #1: Emergency Room Visits per 1,000 Member Months								
Measurement Period	Time Period Measurement Covers	Numerator = ER Visits in the Year	Denominator = Member Months	Rate = Visits / 1,000 Member Months	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	HEDIS 2014	157,272	2,355,181	66.8	44.6	44.6	2013, 10th	NA
RMI	HEDIS 2015	145,213	2,247,543	64.6	39.4	39.4	2014, 10th	Yes

**Exhibit IV.7
Results Reported for MHS Quality Improvement Project
Emergency Room Utilization
Healthy Indiana Plan**

Measure #1: Emergency Room Visits per 1,000 Member Months								
Measurement Period	Time Period Measurement Covers	Numerator = ER Visits in the Year	Denominator = Member Months	Rate = Visits / 1,000 Member Months	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	HEDIS 2014	3,613	44,517	81.2	44.6	44.6	2013, 10th	NA
RMI	HEDIS 2015	10,966	118,700	92.4	39.4	39.4	2014, 10th	Yes

Smoking Cessation

MHS began its QIP for Smoking Cessation in CAHPS RY 2012 (services dates in 2011).

Smoking Cessation is one of the current P4O measures that the OMPP has in its contract with the MCEs. For this QIP, MHS elected to include one measure to determine the efficacy of its QIP activities-- increase the percent of members who were advised by their doctor or other health professional to quit smoking in the last six months.

MHS uses the current CAHPS definition for the measure and updates the logic for computing results with any changes from CAHPS, as required, in each remeasurement year.

Interventions

MHS has two interventions to reduce smoking in pregnant women. One is the provision of smoking cessation education/Quitline information to pregnant members. The second is disease management outreach via the Puff-Free Pregnancy program.

Intervention #1 measures the number of identified pregnant members who were provided with smoking cessation and Quitline referral information divided by the number of members who delivered a live infant during the measurement year. While this does not measure the results of the outreach, it does measure the number of educational contacts. It is not clear from this data analysis how these efforts affect the CAHPS rate.

Intervention #2 does measure cessation. It measures the smoking cessation rate among MHS Puff-Free Pregnancy disease management program participants divided by the total number of participants. The low number of participants does not show that this program has impacted the overall CAHPS rate. Still, MHS felt this to be successful among the limited number of participants. Due to the low denominator, in conjunction with a program shift to Indiana Quitline counseling, MHS plans to focus attention on case management outreach and outcomes monitoring going forward.

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MHS identified several barriers to these measures. For intervention #1, the number of members that MHS can provide with educational/Quitline information is dependent upon notification that a member is pregnant. If pregnant members are identified very late in pregnancy, there may be insufficient time to perform the intervention. Late notification or lack of member pregnancy identification was felt to be the primary barrier to successful intervention. The Notification of Pregnancy process that the State has in place was revised in June 2014. Subsequent monitoring indicates higher percentages of pregnant women enrolling in case management in earlier stages of pregnancy. Secondly, lack of Quitline data was initially identified as a barrier; however, Quitline data reporting has since been initiated.

For intervention #2, the MHS workgroup felt that the intervention was effective among participants, but was concerned about the low denominator size. The low denominator is affected by both the late notification issues discussed with intervention #1 as well as the fact that this program is by member choice. The lack of member interest in participating in the Puff-Free Pregnancy program was felt to be the primary barrier to large-scale intervention effectiveness. A decision has since been made to direct pregnant smokers to the Quitline, as member feedback suggests that the participation rate will be higher.

Results

Exhibit IV.8 shows that improvement was made in this measure, but it was not statistically significant.

Exhibit IV.8
Results Reported for MHS Quality Improvement Project
Smoking Cessation
Hoosier Healthwise

Measure #1: Increase the percent of members who were advised by their doctor or other health professional to quit smoking in the last six months								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2013	270	375	72.0	79.6	81.3	2012, 90th	NA
RM1	CY 2014	245	332	73.8	79.3	81.4	2013, 90th	No
RM2	CY 2015	260	352	74.4	79.3	81.4	2014, 90th	No

MHS will continue this QIP because the Quality Improvement (QI) and Medical Management workgroup still feels that improvement is needed since the measure result is 4.9 percentage points below the goal and 7.0 percentage points below the benchmark rate. While MHS has had improvement since the baseline, none of the improvement has been statistically significant.

MHS hopes that recent case management program changes will increase and enhance member outreach about Smoking Cessation. These include increased staffing; implementation of an Integrated Care Model involving joint care planning by a triad of Medical/Obstetrics Case Managers, Behavioral Health Case Managers and Social Workers; and the initiation of a Field Case Management program of home visits. MHS plans to further discuss smoking cessation strategies, including those directed at providers and the general member population, at the Clinical and Service QI Committee. MHS is also discussing a campaign aimed at encouraging teens and pre-teens not to start smoking.

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MDwise QIP Findings

Postpartum Care

MDwise began its QIP for Postpartum Care in HEDIS RY 2012 (services dates in 2011). B&A examined results through RM3 (HEDIS RY 2015).

Postpartum Care is one of the current P4O measures that the OMPP has in its contract with the MCEs. For this QIP, MDwise elected to include one measure to determine the efficacy of its QIP activities—the percentage of deliveries that received a postpartum care visit on or between 21 and 56 days after delivery.

MDwise uses the current HEDIS definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year.

Interventions

To try to improve scores on this HEDIS measure, MDwise has one intervention, which is to offer pregnant women who get their postpartum care visit Reward Points. MDwise has additional passive activities that are not measurable, such as mailing a pregnancy booklet and postpartum postcards, providing educational calls that stress the importance of postpartum care to newly pregnant members, Text4Baby, newsletter articles, and baby showers. They have also developed an OB billing chart and have made postpartum a P4O measure with their providers.

MDwise compared the rate of postpartum visits for members redeeming Reward Points and those who did not. MDwise saw a positive difference in the rate of postpartum exams. They believe that the program has a positive impact in motivating members to get their postpartum exam.

Results

Exhibit IV.9 shows that while RM1 showed improvement, it was not statistically significant and RM2 showed a decrease, but it too was not statistically significant. However, MDwise did have a significantly significant increase in RM3 and exceeded the HEDIS 90th percentile benchmark they selected for this measure.

Exhibit IV.9
Results Reported for MDwise Quality Improvement Project
Postpartum Care
Hoosier Healthwise

Measure #1: Percentage of Women that Received a Postpartum Care Visit on or between 21 and 56 Days after Delivery								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	HEDIS 2012	294	411	71.5	NA	75.2	2011, 90th	NA
RM1	HEDIS 2013	301	411	73.2	74.7	74.7	2012, 90th	No
RM2	HEDIS 2014	294	411	71.5	73.8	73.8	2013, 90th	No
RM3	HEDIS 2015	305	411	74.2	74.0	74.0	2014, 90th	Yes

When asked what they thought attributed to the increase in the rate, MDwise stated that they implemented P4O for all MDwise obstetricians, not just those enrolled as Primary Medical Providers (PMPs). This is the only incentive that MDwise gives to non-PMPs in its programs. The payment is attributed to the doctor who does the majority of the prenatal care rather than the one that delivers the baby.

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MDwise did not originally select this as a QIP of focus. They are undetermined on whether they will continue the QIP. They will still continue to offer and promote incentives for pregnant members.

Emergency Department Utilization

MDwise began its QIP for Emergency Department Utilization in HEDIS RY 2012 (services dates in 2011). B&A examined results through RM 3 (HEDIS RY 2015).

For this QIP, MDwise elected to include three measures to determine the efficacy of its QIP activities:

1. HEDIS Ambulatory Care (AMB-A) ER Visits per 1,000
2. Inappropriate ER Use
3. ER visits per 1,000 for high utilizers (4+ visits/year)

MDwise uses the current HEDIS definition for the first measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year. MDwise does not use HEDIS definitions for the other two measures. It developed its own logic for computing results each remeasurement year.

Interventions

To try to improve scores on these measures, MDwise has three interventions:

1. Automated calls for inappropriate use of the ED
2. Case management outreach to high utilizers
3. Identification of members for enrollment in the RCP

For Intervention #1, MDwise wants to determine if timely education after inappropriate ED use will influence subsequent behavior. For Intervention #2, MDwise wants to determine if live outreach by a case manager will influence subsequent behavior. For Intervention #3, MDwise wants to determine if restricting a member to one hospital, one doctor, and one pharmacy will impact ED use.

The results of the automated call program have been mixed. Three of the four reporting periods resulted in the intervention group having fewer post-ED visits. The case management program showed consistently better results for the intervention group than the control group studied. As designed, the RCP also reduced the number of post-intervention ED visits.

Results

Exhibit IV.10 on the next page shows that the interventions implemented by MDwise have made little statistically significant change in the results in Measure #1. The other two measures have only had one intervention year of data. There was no statistically significant change in that single year.

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Exhibit IV.10
Results Reported for MDwise Quality Improvement Project
Emergency Room Utilization
Hoosier Healthwise

Measure #1: Emergency Room Visits per 1,000 Member Months								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	HEDIS 2012	203,020	3,302,190	61.5	NA	63.3	2011, 50th	NA
RM1	HEDIS 2013	207,537	3,336,133	62.2	61.0	63.2	2012, 50th	No
RM2	HEDIS 2014	205,870	3,324,623	61.9	61.0	65.7	2013, 50th	No
RM3	HEDIS 2015	200,354	3,276,411	61.2	61.0	64.0	2014, 50th	No
Measure #2: Inappropriate Emergency Room Usage								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	CY 2013	145,557	3,299	44.1	NA	NA	NA	NA
RMI	CY 2014	138,028	3,222,836	42.8	40.0%	NA	NA	No
Measure #3: Emergency Room Visits per 1,000 Member Months for High Utilizers (4+ visits/year)								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	CY 2013	82,002	148	553.3	NA	NA	NA	NA
RMI	CY 2014	76,003	136,789	555.6	540.0	NA	NA	No

Smoking Cessation

MDwise began its QIP for Smoking Cessation in CAHPS RY 2012 (services dates in 2011). B&A examined results through RM3.

Smoking cessation is one of the current P4O measures that the OMPP has in its contract with the MCEs. For this QIP, MDwise elected to include one measure to determine the efficacy of its QIP activities-- increase the percent of members who were advised by their doctor or other health professional to quit smoking in the last six months. MDwise measured this for both HHW and HIP.

MDwise uses the current CAHPS definition for the measure and updates the logic for computing results with any changes from CAHPS, as required, in each remeasurement year.

Interventions

MDwise has two interventions for HHW members. Both began in 2012.

1. Automated calls to adult member households reminding members that their provider can help them with tobacco cessation.
2. Postcard mailings to adult member households reminding members that their provider can help them with tobacco cessation.

Only the second intervention is used for HIP members.

Starting in Q4 2014, MDwise is offering Rewards for the completion of a smoking cessation program. With proof of course completion, the member gets the highest level of Rewards that MDwise offers in its program.

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MDwise believes that these interventions have been successful based on the 6 percentage point improvement in the HHW CAHPS survey response to the smoking cessation question between the baseline and RM2. However, the improvement was not sustained in RM3 nor did the interventions affect the HIP rate.

Results

Exhibits IV.11 and IV.12 below shows that short-term improvement was made, but it was not statistically significant nor was it sustained. For HIP, MDwise consistently increased the rate over time meeting the benchmark for P40. However, the MCE fell just short of its improvement goal. While MDwise saw improvement over two years with its HHW rate, it saw a decrease in CAHPS 2015 for this measure.

Exhibit IV.11
Results Reported for MDwise Quality Improvement Project
Tobacco Cessation
Hoosier Healthwise

Measure #1: Rate of members advised by their doctor or other health professional to quit smoking in the last six months								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CAHPS 2012	242	353	68.6	70.0	73.0	-	NA
RM1	CAHPS 2013	294	404	72.8	70.0	73.0	-	No
RM2	CAHPS 2014	314	419	75.0	73.0	73.0	-	No
RM3	CAHPS 2015	267	373	71.6	73.0	73.0	-	No

Exhibit IV.12
Results Reported for MDwise Quality Improvement Project
Tobacco Cessation
Healthy Indiana Plan

Measure #1: Rate of members advised by their doctor or other health professional to quit smoking in the last six months								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CAHPS 2012	365	453	80.4	82.0	76.0	-	NA
RM1	CAHPS 2013	415	501	82.8	84.0	76.0	-	No
RM2	CAHPS 2014	408	489	83.4	84.0	76.0	-	No
RM3	CAHPS 2015	358	428	83.6	84.0	76.0	-	No

MDwise will continue to monitor this rate and will maintain this QIP. MDwise believes that the message conveyed and reinforced by the interventions are powerful and thinks that reiterating the importance of smoking cessations has the potential for even greater improvement.

Recommendations to the MCEs and the OMPP Related to Validation of Quality Improvement Projects

Based on our review of the QIPs, B&A has developed specific recommendations to each MCE and to the OMPP.

Recommendations to the MCEs

1. With respect to the QIP for postpartum visits specifically, the MCEs may want to consider studying data between women who have vaginal versus C-section deliveries. Is there a difference

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in the postpartum visit rate? Could lower rates be attributed to early postpartum visits for C-section deliveries?

2. With respect to ED utilization, the MCEs may want to consider using the drilldown reports that will be delivered in this EQR with respect to Potentially Preventable ED Visits (refer to Section VII) and examine these rates by age group, by region and by hospital to assist with future interventions.
3. For all QIPs, the MCEs should include interventions done by subcontractors (e.g., delivery systems, behavioral health organizations, etc.) in the QIP reports even if they are only available to a subpopulation of members.

Recommendations to the OMPP

1. The OMPP should consider leveraging the information that is gleaned from the examination of Potentially Preventable ED Visits in this EQR as an opportunity to customize a P4O related to ED use. The OMPP can use the information available through these reports at the statewide and MCE level as ways to develop a benchmark for this P4O.
2. The OMPP may want to consider redefining expectations and P4O surrounding Smoking and Tobacco Use Cessation. There are significant barriers to measuring cessation. It is reliant on member self-reporting of both smoking and cessation and, for the CAHPS measure, both if education was provided and the member remembers receiving it. The current nationally recognized CPT code also requires 15 minutes of cessation education, so very few providers bill it since they do not speak with the member for that length of time about this topic when in the office.

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SECTION V: FOCUS STUDY ON SERVICE AUTHORIZATION PROCESSES

The focus study related to service authorization policies and procedures is a re-examination of this functional area that was originally conducted by Burns & Associates (B&A) in the External Quality Review (EQR) conducted in Calendar Year (CY) 2009. In that review, B&A reviewed the policies and procedures as well as a desk review of a sample of 960 authorization requests for the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) programs. The same managed care entities (MCEs) that are in place today were also the contracted MCEs in the program in CY 2009. This year's focus, therefore, examined how the MCEs perform this function today and determined whether or not recommendations from the CY 2009 study were implemented.

In this year's review, the B&A team of Mark Podrazik, Linda Gunn, and Kristy Lawrance conducted a desk review of policies and procedures requested from each MCE. This review was followed up with a series of interviews conducted by the EQR Team at the MCE home offices on July 7-8, 2015. In those meetings, the MCEs also provided an introduction to B&A on the online tools used by authorization staff. In addition to reviewing the policies and procedures, B&A requested a data file of all service authorization requests from each MCE covering CY 2014. After working with the MCEs to scrub the datasets, B&A constructed a sample for individual case reviews. On July 28, 2015, the EQR Review Team visited each MCE again to test out its authorization pilot tool on actual authorizations. Finally, the team reviewed the sample of 825 authorizations (275 at each MCE) onsite at the MCEs the week of August 17.

In this section, we first summarize key facets of each MCE's authorization policies and procedures with respect to:

- Authorization processes and requirements of requesting providers
- Process flows
- Turnaround time requirements
- Application of clinical guidelines in the authorization process

Later in the section, a summary of findings related to the total CY 2014 authorizations requested is shown. The results of our analysis of the 825 sample cases are then presented. Specific recommendations to the Office of Medicaid Policy and Planning (OMPP) and the MCEs appear at the conclusion of this section.

Comparison of Authorization Processes and Staffing at Each MCE

Exhibit II.1 on the next page compares the staffing and requesting provider requirements for each of the three MCEs.

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Exhibit II.1

Comparison of Authorization Staffing and Provider Requirements at Each MCE

	Anthem	MHS	MDwise
<i>Location of Authorization Staff</i>	Indianapolis, California, Philippines, work-at-home	Indianapolis, St. Louis (for transplants)	Indianapolis and telework
<i>Any Subdelegated Entities?</i>	CMCS- (St.Francis delivery system) AIM- Anthem subsidiary for radiology Dentaquest (dental, starting in 2015)	Cenpatico (owned by Centene as is MHS) serves as the managed behavioral health organization for MHS and conducts authorizations for behavioral health. Cenpatico subcontracts with the company MBH for physician reviews.	MDwise subdelegates to 8 delivery systems. Six of these delivery systems further delegate to CMCS.
<i>Location of Authorization Appeals Staff</i>	California	Physical Health- MHS in Indianapolis Behavioral Health- Cenpatico in Austin, TX	MDwise corporate headquarters in Indianapolis
<i>Who Does Intake Process?</i>	Non-clinical staff	Non-clinical staff	Non-clinical staff (corporate) For some delivery systems, it is nurses.
<i>Who Does Administrative Approvals?</i>	Non-clinical staff, nurses	Non-clinical staff, nurses	Non-clinical staff, nurses
<i>Who Does Administrative Denials?</i>	Non-clinical staff and nurses but depends on the reason	Non-clinical staff and nurses but depends on the reason	Non-clinical staff and nurses but depends on the reason
<i>Who Does Initial Clinical Review?</i>	RNs	RNs	RNs/LPNs
<i>Who Does Final Determination for Clinical Reviews?</i>	Physicians or mental health professionals	Physicians or mental health professionals	Physicians or mental health professionals
<i>Documentation Required to Complete Authorization Request</i>	Clinical information necessary to make an informed decision related to medical necessity. In some cases, this may be verbally transmitted.	Clinical information necessary to make an informed decision related to medical necessity. In some cases, this may be verbally transmitted.	Clinical information necessary to make an informed decision related to medical necessity. Information may be transmitted verbally to start but must be followed up with written information.
<i>Use of Medical Records</i>	If documentation is sent by the provider, it is scanned into a separate documentation system outside of the authorization database.	If documentation is sent by the provider, it is attached to the record in the authorization database.	When documentation is sent by the provider, it is attached to the record in the authorization database (corporate). For some delivery systems, it is stored in hard copy.

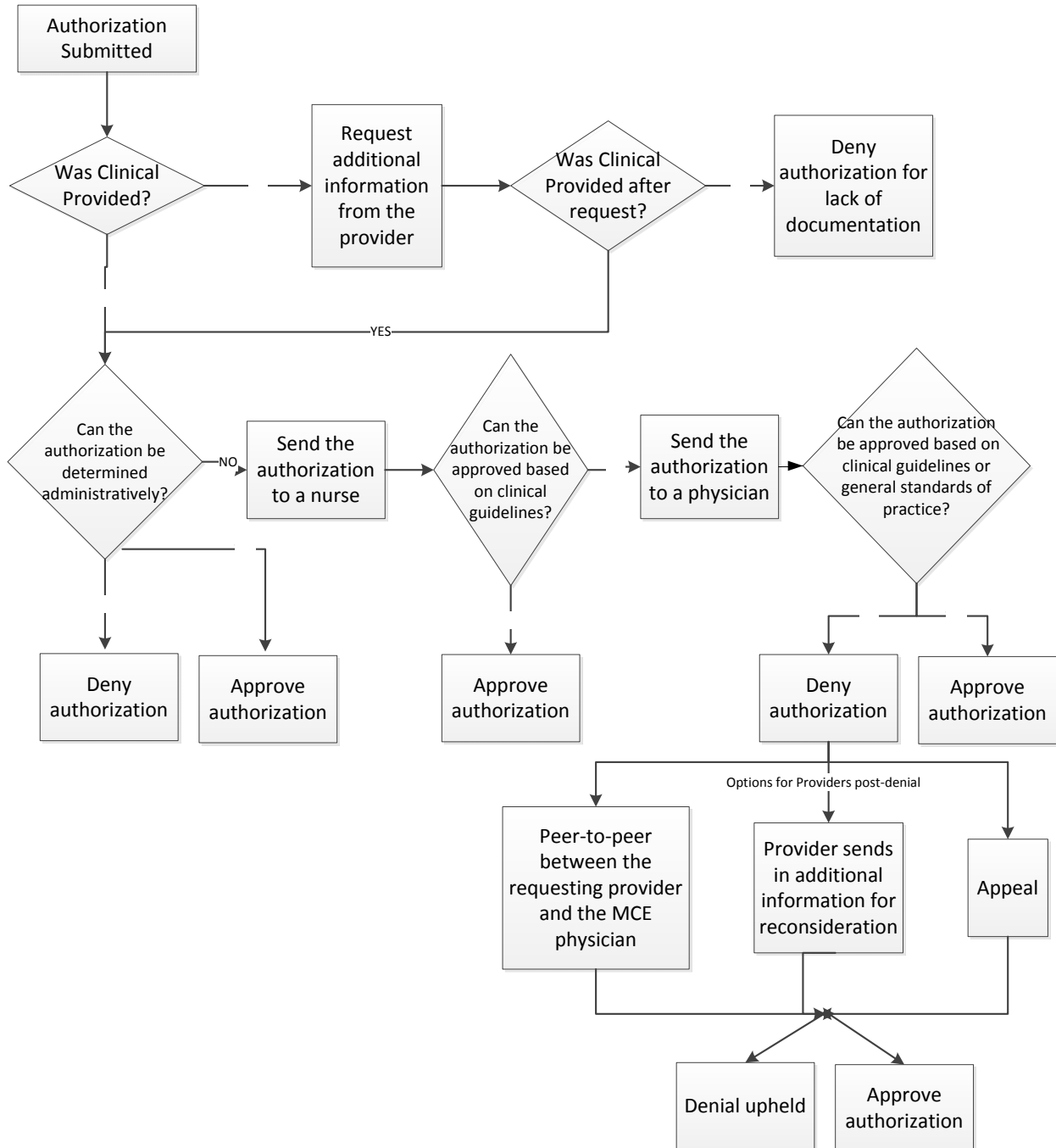
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Overview of Authorization Process Flows Consistent Across the MCEs

All three MCEs essentially follow a similar process for authorizations review. The flow chart shown in Exhibit V.2 represents the steps generally followed by all three MCEs. More information on the key steps appears after the exhibit.

**Exhibit V.2
Authorization Process at the MCEs in the HHW and HIP Programs**



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Step 1: Intake

Non-clinical staff (in most cases) receives requests and notifications via a phone call, fax, or web from a facility or provider's office. MHS is the only MCE that receives web submission of authorizations, but their volume is very low. Staff enter the demographic information of the member, the provider or facility, and the service category of the request into a proprietary desktop system at each MCE which tracks the request to its final determination. These systems are linked to the claims payment process. The staff person determines the answer to the following questions:

- Is the requested service a covered benefit?
- Is the member eligible to receive the service?
- Does the service require authorization?
- Is the requesting provider "in network"?
- Is the request submitted timely according to contractual requirements?

Based on the response to these questions, the intake representative may administratively deny the authorization. Administrative denials that can be done by a non-clinical staff person vary by MCE. The administrative staff can also "approve" the authorization if the service does not require prior authorization to start with or if it is on a list of services that do not require clinical review for approval. For example,

- Non-clinical staff at MHS review the MCE's authorization database and can inform the requestor that no authorization is required or they can auto-approve the request based on the information in the database.
- At Anthem, all non-contracted (non-PAR) providers require an authorization but these can be approved by non-clinical staff when the non-PAR provider is classified with a "treat as par" designation.

Once these determinations are made and entered into the system, the request is forwarded to a nurse for review. If the nurse finds that one of the above requirements is not met, then an administrative denial may be sent back to the provider with an explanation as to which element is missing. Certain exceptions may be made for out of network providers depending on the circumstances and availability of services.

Step 2: Initial Clinical Review

The nurse applies the MCE's selected criteria (referred to as "medical necessity" criteria) to the information sent by the provider to support the request and makes a determination as to whether, in her/his opinion, it meets medical necessity. If it does, then an approval is entered into the system and the provider is notified verbally. MDwise also sends an approval letter to both the provider and the member. Anthem and MHS stated that the member's notification is the receipt of approval of the service.

If the nurse is unable to approve based on lack of sufficient information or documentation to support the request, then the nurse contacts the requesting provider and asks the provider to submit additional documentation. If the documentation remains inadequate to support the request, or no further documentation is provided, the nurse forwards the request to a physician for a final approval/denial determination.

A nurse cannot deny an authorization request for non-administrative reasons. All three MCEs forward to the physician a summary of the clinical information as received from the requesting provider's office or hospital along with documentation of the medical necessity criteria selected by the nurse as appropriate to the specific service requested. Often, the nurse will also provide her/his personalized notes as to the

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rationale why the request is not medically necessary. Usually, all of this information is sent through the MCE's authorization system. CMCS, the claims payment and authorization review provider for portions of both Anthem's and MDwise's membership, forwards documentation to physicians via a separate fax system.

Step 3: Final Determination

The MCE physician (or behavioral health specialist) reviewer makes a final determination. If the physician approves the authorization, it is sent back to the nurse to verbally inform the provider and to process the notification letters. In cases where the physician and nurse are not linked in the authorization system, the nurse also enters the physician's notes into the authorization system. If the physician denies the request, it is sent back to the nurse along with the clinical rationale used by the physician in making the denial determination and verbiage to be used in the denial letter. The nurse verbally gives the denial decision to the requesting provider along with notification that the provider can request a "peer-to-peer" informal discussion about the denial decision or submit additional clinical documentation for "reconsideration". The MCE then provides this information in writing to the provider, to the member, and to the hospital facility, if appropriate.

The denial letter contains an explanation of why the MCE is denying the request and the clinical rationale behind the decision. The letters also contain instructions for appealing the decision if the provider or member wishes to do so.

Step 4: Post-Denial Processes

If a requesting provider disagrees with the denial decision and wants to pursue recourse to have the MCE review their original decision, the provider can submit additional clinical information for reconsideration, request a peer-to-peer meeting to discuss the case, or file an appeal.

For reconsideration, the provider can fax in additional information. The MCE will review it and make a determination to uphold the original denial or approve the request.

Providers can verbally communicate the clinical information via a peer-to-peer phone call. The MCE physician reviewer explains and discusses the basis for the denial. Then the requesting provider can add additional clinical information and/or can ask questions about the authorization process. The MCE physician may overturn the denial based on this discussion or may stick with the original denial decision. All three MCEs offer this option.

The requesting provider, or the member, can pursue a formal appeal which requires the MCE to re-review each step of the authorization process for that particular request to verify that the correct decisions were made. A different MCE physician conducts the re-review than the physician who originally denied the request. During the re-review, several questions are asked.

- Was the correct criteria selected?
- Was it interpreted correctly considering the specifics of the case in question?
- Is there new or additional clinical information that would allow a decision to approve?

The request may also be sent to a specialist in the same field of the requested service that was denied to review the determination.

This process results in either upholding the original denial or it is overturned and approved. If it is upheld and the requesting provider still disagrees and wishes to pursue it further, a request can be made for an

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independent review that is conducted outside the MCE or the provider or member may skip this step and request a State Fair Hearing.

The discussion below focuses on other processes that are unique to each MCE.

Other Features of Anthem's Processes

- Anthem has used its online authorization system stored in its WMDS system for many years. All authorizations worked by Anthem staff directly enter and access information from this system (including behavioral health).
- AIM is a related entity in the Wellpoint organization that uses a different authorization system than WMDS. Currently, Anthem extracts information from AIM's system into Anthem's WMDS system for claims payment purposes. Most information is brought into WMDS, but determination dates are not and some clinical notes are not carried over.
- Authorizations are queued based on region or specialty. Hospital-related authorizations are divided among nurses based on regions of the state so that the nurses get familiar with the hospitals they are reviewing. Non-hospital service requests are segmented by specialty, e.g. durable medical equipment (DME), gastric bypass, or enteral formulas.
- Behavioral health related requests are handled by professionals in this field, such as licensed clinical social workers (LCSWs), licensed marriage and family therapists (LMFTs), psychologists, or psychiatrists.
- When clinical information was not provided with the request, Anthem makes at least one attempt to collect the necessary information.
- Anthem has one staff member devoted to coordinating peer-to-peer reviews. Anthem reported that 1,283 peer-to-peer conferences were requested after denials were sent out. All but one of these was completed. In 92 percent of the cases, the denial was overturned after the peer-to-peer discussion.
- Anthem has a large library of peer reviewed text related to common reasons for denial of medical necessity that are used in the denial letters in order to maintain consistency of message and to ensure that language is at a 5th grade reading level.
- Management reviews all authorization appeals, particularly those that were overturned, to determine if there are opportunities to improve the authorization review process.

Other Features of MHS's Processes

- Since the EQR review in 2009, MHS has implemented a new authorization tracking system called Trucare. Both MHS and Cenpatico staff use this system. The software has the MCG guidelines loaded into it to assist the nurse reviewer navigate the requirements to meet medical necessity for the service requested.
- The software flags if clinical documentation was supplied with the authorization request.
- All nurses are assigned to the outpatient queue and review cases of all service types on a first-in, first-out basis. Nurses have regional assignments for inpatient cases.
- Cenpatico uses the services of BHM, a company that reviews denials for inpatient psychiatric services if they do not meet the criteria for inpatient stay. Due to the nature of this service, these reviews are turned around within 24 hours.
- Authorization is required for all inpatient behavioral health services. Outpatient authorization is only required for non-PAR providers.
- If an authorization is modified as a reduction in units from what was originally requested, the determination will still be labeled approved in the system.
- MHS will have authorizations assigned to modified status particularly in inpatient behavioral health. MHS reported that psychiatric hospitals often have the practice of submitting requests for

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a patient stay for five to seven days for all patients. Cenpatico will modify the number of days based on clinical criteria.

- MHS reports that, on average, they have 80 peer-to-peer sessions per month on authorization decisions. There is approximately a 95 percent completion rate of peer-to-peers sessions that are scheduled.
- Par providers do not require an authorization in the system for an observation to pay. Non-par providers do require an authorization.

Other Features of MDwise's Processes

- The authorization process at MDwise has been delegated to 8 delivery systems.
- Two delivery systems (Total Health and Select Health) use MDwise Corporate staff to perform their authorization reviews. Some delivery systems use CMCS. Other delivery systems use their own staff.
- In 2014, Hoosier Alliance was another delivery system that performed its own authorization reviews. In 2015, this delivery system was absorbed by the Corporate office into the Excel Network delivery system.
- The Corporate office and three delivery systems (Eskenazi, Hoosier Alliance and IU Health) used one online authorization system (JIVA) in 2014, but they were not all connected on the same platform. The delivery systems that used CMCS were on CMCS's authorization system called QNXT.
- Nurses cannot deny service requests outright but can and do impose limits on modified authorizations.
- MDwise is sending out both approval and denial letters to members which they state is OMPP policy, but approval letters are not required by the National Committee on Quality Assurance (NCQA).
- Rather than denying inpatient stays and authorizing observation stays, MDwise modifies them from inpatient to observation per NCQA guidelines.

Policies Specific to Inpatient Authorizations and Follow-up Process

One of the key findings of the CY 2009 EQR on authorizations was the preponderance of denied inpatient stays that were for three days or less. The EQR Review Team asked each MCE about this policy in particular and the process that each uses related to inpatient stays.

- When Anthem denies an inpatient stay for lack of medical necessity, Anthem will offer in its denial letter to the provider the option to seek payment for observation for up to three days (or fewer if the number of inpatient days was less than three). The inpatient stay is recorded as a denial. If the provider requests observation status payment, then a new authorization is created with an approved status for the observation payment specifically.
- When MHS denies an inpatient stay for lack of medical necessity, like Anthem it will offer to pay for observation instead for up to three days. The original inpatient request is recorded as a denial. PAR providers do not require a new authorization in the system to be paid for observation. Non-PAR providers do require an authorization. In either case, if an authorization is generated for observation, it is created with an approved status.
- When MDwise denies an inpatient stay for lack of medical necessity, it too will offer to pay for observation instead for up to three days. Unlike Anthem and MHS, however, MDwise does not record this authorization as denied. Instead, it is recorded as modified and changes the original authorization to observation. A new authorization is not created.

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Turnaround Time Requirements

MCE policies and procedures were reviewed to compare each MCE's internal policies against OMPP minimum requirements for timeliness in responding to authorization requests (commonly referred to as "turnaround time").

Exhibit V.3

Comparison of MCEs Policies on Turnaround Times for Response to an Authorization Request

	Non-Urgent Pre-Service	Urgent Pre-Service	Concurrent Review	Retro Review Post-Service
OMPP Contract	7 calendar days*	3 business days*	Must meet URAC standards	Must meet URAC standards
Anthem	7 calendar days	72 hours	24 hours- urgent continued stay inpatient [#]	30 calendar days
MHS	7 calendar days	72 hours	24 hours- urgent	30 calendar days
MDwise	7 calendar days (was 2 days in CY14)	24 hours	24 hours- urgent	30 calendar days

*An extension of up to 14 calendar days may be granted if the member or provider requests an extension or if the MCE justifies to FSSA a need for more information and explains how the extension is in the member's best interest.

For continued ongoing ambulatory services, 7 calendar days is permitted.

Application of Clinical Guidelines in the Authorization Process

As the managed care model of health care delivery has penetrated more and more of the health care market, it has become clear that medical management decisions need to be based on accepted standards of care and evidence-based peer reviewed literature. Several companies have created so called "guidelines" to help decisions be consistent and defensible. Currently, Milliman Care Guidelines (MCG) and Interqual are the two major nationally recognized options for these guidelines. The American Society of Addiction Medicine (ASAM) has created guidelines specific to substance abuse.

Exhibit II.4 summarizes the medical necessity guidelines cited by the MCEs in their authorization policies. It should be noted that each MDwise delivery system can choose which nationally recognized guidelines to use as part of their authorization review process for medical requests. In addition to nationally-published guidelines, each MCE also has developed its own guidelines, often for specialty services. Anthem often uses guidelines developed by Wellpoint, its parent company and MHS often uses guidelines developed by its parent company, Centene. MDwise develops guidelines which are recommended and reviewed by the Medical Directors at its delivery systems.

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Exhibit V.4

Managed Care Entity's Use of Clinical Guidelines in HHW and HIP

	Acute Care	Behavioral Health	Other
Anthem			
Corporate Office	MCG (inpatient)	Proprietary Wellpoint guidelines	Anthem guidelines for other specialty services (reviewed annually)
St Francis	MCG (inpatient)	N/A	
AIM	N/A	N/A	Specialty guidelines for radiology
MHS			
Corporate Office	MCG	N/A	Centene guidelines for other specialty services (reviewed annually)
Cenpatico	N/A	Interqual, ASAM	
MDwise			
Corporate Office (Excel Network)	Interqual	Interqual	MDwise guidelines for other specialty services are developed by corporate office and reviewed by Medical Mgmt Committee comprised of the Delivery System Medical Managers
Eskenazi	MCG	Interqual	
Select Health	done by Corporate	done by Corporate	
Total Health	done by Corporate	done by Corporate	
IU Health	Interqual	Interqual	
St Catherine/St Mary	MCG	Interqual	
St Vincent	MCG	Interqual	
St Margaret Mercy / St Anthony	MCG	Interqual	

Training of Authorization Staff on the Application of Clinical Guidelines

In its 2009 report, B&A provided several recommendations on training of authorization staff in clinical protocols. This year, all three MCE’s demonstrated some level of training on clinical guidelines.

Anthem corporate provides MCG training to new authorization staff. The course includes CareWeb navigation, recovery guidelines, inpatient management tools, prematurity guidelines, observation care guidelines and a knowledge/skills check. Incorporated in this course is training on WellPoint guideline customization and hierarchy. Each new staff member works with a preceptor for a minimum of four weeks. After five weeks, the goal is for each new staff member to review 20 cases per day. An audit of the new staff member’s review process is conducted within the first 30 days after training has been completed.

MHS requires new authorization staff to have MCG training. The first part is an MHS-designed course that contains both an overview of MCG but also integrates how to access it in the MHS TruCare system. The MHS course teaches staff how to search for a guideline, document clinical indicators for a procedure, and document therapy treatment plans. The formal training is a three week process—the first week is an overview, the second week covers specialty topics and the third week is a deeper dive into topics. The staff later have access to the MCG Learning Management System and must attain MCG certification. Cenpatico reviewers must complete a Cenpatico ASAM training course and an InterQual course.

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MDwise does not dictate which guidelines are used by its delivery system but does require them to adopt nationally recognized guidelines that are reviewed at least once a year. Licensure with Interqual or MCG provides access to guideline/criteria training throughout the year. MDwise contracts with McKesson for Interqual criteria and utilizes its web-based training which includes testing. There are no formal tests at the end of the training, however.

Monitoring of Authorization Staff through Inter-Rater Reliability Testing

In spite of all the published criteria to assist an authorization professional in making a determination of medical necessity, the final decision is a judgment call. One of the important requirements of a MCE is to have a process to assure a high degree of consistency and accuracy between professional staff reviewers in the authorization determination process. This is referred to as the Inter-Rater Reliability, or "IRR", process. Each of the three MCEs has an IRR policy and procedure which are outlined below.

Anthem

Anthem has two policies for non-physician IRR. The IRR audit is conducted once a year. Ten scenarios are created specific to each nurse's responsibilities (e.g. inpatient only, both in and outpatient). There is no partial credit for each case. Scores are given and, if issues are identified, additional training and mentoring are provided. The benchmark is for 90 percent consistency and accuracy but 80 percent is still considered passing and does not require a corrective action plan. Anyone who scores 80-90 percent is encouraged to review the material and re-test to achieve 90 percent or better. Any score below 80 percent requires additional education and re-testing. This information goes into the nurse's personnel file. Anthem also has a policy on physician IRR which requires an annual test for each physician conducting authorization reviews. All physicians are given the same test cases each year. The quality benchmark for passing is 80 percent.

In addition to the IRR related specifically to the use of the clinical guidelines, Anthem also has a process audit that verifies the accuracy and consistency of the documentation in the authorization files. Staff members are audited quarterly and the quality benchmark to achieve is 93 percent compliance.

MHS

MHS and Cenpatico have separate IRR policies for physicians, non-physicians, and behavioral health reviewers. According to its policy, MHS physicians take annual MCG tests of five cases and must score 90 percent or better. If not, they are re-trained and re-tested. They also attend annual MCG update training sessions. However, during our on-site interview, MHS clarified to the EQR Review Team they have adopted an enhanced process to the formal policy and they actually have their physicians do quarterly IRR tests of six cases (three inpatient, three non-inpatient).

The policy for non-physicians reviewers states that all licensed nursing staff must complete IRR on a biannual basis. They are given three test cases each time based on their job role. They must score 90 percent or face a corrective action plan and re-testing. Once again, the interview revealed that MHS exceeds this standard. MHS nurses take quarterly IRR tests consisting of multiple questions per case. Partial credit is available.

The Cenpatico policy states that they do an annual audit for both physicians and non-physicians. It states that they must score 80% or higher on InterQual criteria. However, when interviewed on-site Cenpatico stated that they audit case files rather than completing formal IRR on non-physicians. They also were not aware of what IRR was done for the subcontracted BHM psychiatrists.

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MDwise

MDwise did not provide a policy on IRR, but they did provide a statement about it in their Medical Management Training Manual. At least quarterly, MDwise selects three to five denials and provides the blinded cases to all of the Delivery Systems Medical Directors. The physicians review the cases and provide a decision and the guidelines that they used to make that decision. The results are shared with the MDwise Medical Advisory Committee.

At least annually, non-physician staff are evaluated through IRR. The Training Manual did not state how many cases or what percentage correct was a passing score. It did state that an action plan is created to address any deficiencies.

Review of CY 2014 Authorizations

In addition to reviewing authorization policies and procedures, B&A also analyzed the full set of service authorization requests submitted by providers to the MCEs for the period covering CY 2014 for both HHW and HIP. The purpose of the analysis was to understand trends in the types of requests that are being submitted to the MCEs, the approval and denial rates within each service, and the rate of appeals on denied authorization requests. From the full review of the CY 2014 authorizations, B&A drew a sample of 825 authorizations to review onsite with the MCE staff. The onsite review was intended to test how the policies and procedures documented by the MCEs related to this function are used in day-to-day operations. The results of our analytics on the full set of authorizations appear below. The results from our sample study appear in the next section.

Data Request to the MCEs

In our previous study of service authorizations conducted in CY 2009, B&A learned that the MCEs capture and store data related to authorization requests differently. With the release of the EQR Guide, B&A included proposed report templates for the MCEs to submit their authorization request and appeals data for the time period covering CY 2014. The following week, B&A conducted one-on-one calls with each MCE to obtain feedback on their ability to easily provide the data elements requested on the report templates. After confirming some MCE-specific definitions and processes, B&A updated the report templates so that all MCEs could submit the data in a standardized format.

One of the requests from the MCEs was for B&A to provide assistance in assigning authorization requests into service categories. B&A provided a crosswalk of CPT/HCPCS codes to assist the MCEs in mapping the requests they received into these categories. The specific service categories are as follows:

1. Inpatient acute care hospitalizations- internal classification defined by the MCE
2. Inpatient behavioral health hospitalizations- internal classification defined by the MCE
3. Outpatient surgical procedures- CPTs in the range 1000-6999 excluding a few non-surgical CPTs in this range
4. All other outpatient hospital services- Any other service requested in a hospital setting not in category 3 and excluding emergency department (99281-99285)
5. Physical, occupational and speech therapy- CPTs 92507, 92508, 97039-97530, G0157-G0161
6. Specialist referrals- internal classification defined by the MCE
7. Radiology- CPTs in the 7xxxx series

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8. Laboratory- CPTs in the 8xxxx series and a small number of 36xxx and Q-codes
9. Home health visits- CPT/HCPCS 99500-99602, G0151-156, G0162-164, T1000, T1002-03, T1019
10. Chiropractic services- CPTs 98940-98943
11. Other codes in the Medicine category of the CPT book not otherwise assigned (excluding CPT 99281-85 and behavioral health related codes assigned to Category 12)
12. Other codes in Medicine, behavioral health focus CPT 90801-90899, 96101-96155
13. Enterals- HCPCS in the B series
14. Orthotics- HCPCS A5500-5513 and L1000-L4630
15. Wheelchairs and wheelchair repairs- HCPCS E0950-E2396 and K0001-K0084 (or other codes defined in this category by the MCE)
16. DME other what is classified above- all other HCPCS not assigned in Categories 13, 14 or 15

In addition to the categories described above, MCEs were asked to split their authorizations between the HHW and HIP programs and to assign the requesting provider for each authorization as either a contracted (PAR) or non-contracted (non-PAR) provider. In relation to appeals, the MCEs were required to itemize each appeal that was submitted in CY 2014 and tie it to the original authorization request. The final action taken on the appeal (e.g., upheld or overturned) was also requested. The MCEs were required to submit their authorization data in the standardized format by June 26.

Standardizing the Data

After intake of the MCE's files, B&A produced a report series to compare the data across the MCEs to ensure that the data appeared complete and comparable across the MCEs. During the week of July 6, B&A met with each MCE to review their preliminary reports to obtain feedback on B&A's analysis. As a result of these meetings, all three MCEs resubmitted their CY 2014 authorization in whole or in part due to anomalies in the results that were tabulated from the original files submitted.

Even after this recompilation was completed, there are some known differences across the MCEs in how authorization data is stored in their internal database. These differences contributed to the statistics that B&A compiled for each MCE. As a result, B&A "scrubbed" the datasets to account for these differences to the extent possible so that the data could be standardized. Even after this process, it should be noted that some of the findings reported at the MCE level are suspect and this is in part due to B&A's inability to completely "scrub" the datasets based on the information provided.

Some of the validation tests completed by B&A are as follows:

- Within some of MDwise's delivery systems, authorizations are generated for a family of codes rather than for a specific code. B&A asked MDwise to resubmit these auths by identifying the most appropriate CPT code to assign to each authorization request.
- Both MHS and MDwise add an authorization ID to maternity inpatient claims. This is not an authorization per se since providers do not need to seek authorization for a childbirth claim. The authorization ID in this instance is used to ensure the claim is paid. The issue is that a significant number of these "auths" appeared in the MCEs' data files. B&A mapped the member ID on the authorization file to our claims extract for inpatient claims. If there was a maternity DRG

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matched to the authorization and the authorization had an approved status, B&A excluded it from the results shown below.

- When Anthem and MHS deny an inpatient hospitalization request due to lack of medical necessity, they will often authorize to pay for observation in lieu of the inpatient stay. The observation-specific authorizations likely appeared in the datasets provided to B&A, but they cannot easily be identified. The data suggests that these authorizations are categorized in Category 11 (other acute care, medicine) for Anthem and Category 4 (other outpatient hospital services) for MHS.
- Category 12 (other behavioral health codes) was created after B&A received the files from the MCEs to identify behavioral services specifically that are delivered outside of the inpatient setting.

Analysis of CY 2014 Authorization Requests

The final dataset used for analysis and our sampling of records onsite is the result of the final data submissions from the MCEs and the scrubbing process mentioned above.

A total of 240,286 authorizations on behalf of HHW members and 60,831 authorizations on behalf of HIP members were submitted to the MCEs in CY 2014. When measured on a per 1,000 member month basis, the results are similar for two of the three MCEs in HHW, with Anthem having the largest volume at 33.3 authorizations per 1,000 members. In HIP, Anthem and MHS have quite a bit more authorizations per 1,000 members than MDwise.

Exhibit V.5

Authorizations Submitted to MCEs in Calendar Year 2014, Per 1,000 Member Months

	Hoosier Healthwise	Healthy Indiana Plan
Total Auths Submitted	(n= 240,286)	(n= 60,831)
MCE	Auths Per 1,000 Member Months in CY 2014	
Anthem	33.3	122.3
MHS	21.2	94.8
MDwise	32.2	62.7

Note: MHS and MDwise had approved auth records for inpatient maternity which have been excluded in these totals. According to both MCEs, an authorization is not required for maternity, but it is created for claims processing.

Exhibit V.6 shows the distribution of authorization requests across the 16 service categories in HHW and HIP. The box at the top of the exhibit rolls up the 16 categories into larger groupings—inpatient hospital, outpatient hospital, radiology and all other categories.

Within HHW, the percentage of total authorization requests for inpatient hospital services varies significantly across the MCEs. As stated in the previous section, however, this may be more of an artifact of how information is stored by the MCEs. For example, MDwise reported only 15.5 percent of its total HHW authorizations for inpatient hospital, while Anthem had 26.9 percent and MHS had 22.1 percent. Alternative, Anthem has 20.7 percent of authorizations in Category 12 (All Other, Behavioral Health) while the other two MCEs had nominal numbers coded in this category. For HIP, however, Anthem had the lowest percentage of total authorizations as inpatient hospital (14.2%) compared to MHS (19.7%) and MDwise (20.5%) being more similar. There is also a variation in the total authorization requests for radiology services. This may be due to specific MCE policies regarding authorization requirements for this broad array of services. It is interesting to note that a greater percentage of Anthem and MHS authorizations are for radiology in HIP than in HHW, but the opposite is true for MDwise.

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The findings from this exhibit indicate other areas where categorization by the MCEs could be influencing results. For example, the percentages for MHS and MDwise inpatient authorizations may be artificially high due to each MCE's policy regarding generating an "auth" for maternity inpatient stays even though one is not required. Although B&A attempted to scrub these from the dataset, there may still be some included in MHS's and MDwise's totals. Similarly, some authorizations for all three MCEs may include records for observation payment for an authorization that was originally submitted for inpatient payment but was subsequently denied.

Finally, in the counts for all service categories, readers should be aware that the counts shown in Exhibit V.6 represent unique authorization episodes in some cases rather than a full event. One example was for a neonatal intensive care unit case with an extended inpatient stay over many months. For the same length of stay, close to 40 authorization requests were included in the dataset, each representing the request for a small number of days (e.g. seven) for inpatient. In this case, all but one of the segments was approved and the last request was denied because the MCE did not determine it was medically necessary to continue in inpatient status. Therefore, this baby counted as 40 records, not one, in the dataset.

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Exhibit V.6

Distribution of Authorizations Submitted to MCEs in Calendar Year 2014, by Service Category and OMPP Program

		Hoosier Healthwise Program				Healthy Indiana Plan			
		Anthem	MHS	MDwise	All 3	Anthem	MHS	MDwise	All 3
		(n= 86,536) (n= 47,736) (n= 106,014)(n= 240,286)				(n= 39,542) (n= 11,264) (n= 10,025) (n= 60,831)			
Auth Cat	Auth Category Title	Pct of Total	Pct of Total	Pct of Total	Pct of Total	Pct of Total	Pct of Total	Pct of Total	Pct of Total
	Inpatient Hospital (Categories 1 and 2)	32.6%	36.4%	18.9%	27.3%	17.9%	27.7%	24.7%	20.8%
	Outpatient Hospital (Categories 3 and 4)	11.6%	35.5%	28.5%	23.8%	20.0%	41.7%	14.5%	23.1%
	Radiology (Category 7)	14.6%	14.0%	8.2%	11.7%	38.5%	22.8%	3.5%	29.8%
	All Other Categories	41.1%	14.2%	44.5%	37.3%	23.5%	7.8%	57.4%	26.2%
1	Inpatient hospital stays other than Behavioral	26.9%	22.1%	15.5%	20.9%	14.2%	19.7%	20.5%	16.2%
2	Inpatient hospital stays only Behavioral Health	5.7%	14.2%	3.4%	6.4%	3.8%	8.0%	4.2%	4.6%
3	Outpatient surgical procedures	6.2%	14.6%	9.5%	9.3%	11.5%	24.8%	7.0%	13.2%
4	All other outpatient hospital services	5.4%	20.9%	19.0%	14.5%	8.5%	16.9%	7.5%	9.9%
5	Physical, occupational, speech therapy	2.5%	0.0%	8.4%	4.6%	5.4%	0.0%	17.6%	6.4%
6	Specialist referrals	0.4%	0.7%	14.0%	6.5%	0.0%	0.5%	11.4%	2.0%
7	Radiology	14.6%	14.0%	8.2%	11.7%	38.5%	22.8%	3.5%	29.8%
8	Laboratory	0.8%	0.9%	1.1%	0.9%	0.9%	1.0%	0.8%	0.9%
9	Home Health visits	0.1%	0.7%	0.5%	0.4%	0.1%	0.6%	1.6%	0.4%
10	Chiropractic services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
11	Other Acute Codes in Medicine Category not in Categories 1-10*	10.6%	7.4%	2.5%	6.4%	12.6%	4.8%	8.2%	10.4%
12	Other Codes in Medicine, Behavioral Health	20.7%	1.8%	1.2%	8.3%	0.9%	0.3%	0.9%	0.8%
13	Enterals	2.8%	1.1%	5.6%	3.7%	0.0%	0.0%	0.4%	0.1%
14	Orthotics	0.1%	0.3%	2.7%	1.3%	0.0%	0.1%	2.5%	0.4%
15	Wheelchairs and wheelchair repairs	0.1%	0.2%	1.4%	0.7%	0.0%	0.1%	0.9%	0.2%
16	DME other than those classified above	2.9%	1.0%	7.0%	4.3%	3.5%	0.6%	13.1%	4.5%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*excludes CPT 99281-99285

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The authorization requests were also analyzed between participating (“PAR”) and non-participating (“non-PAR”) providers. When considering the HHW and HIP programs combined, 72.8 percent of authorization requests overall were requested by PAR providers and 27.2 from non-PAR providers. Each MCE had between 70 and 79 percent of their authorizations requested from PAR providers.

When examining by type of authorization request, approximately 77 percent of the requests in HHW and HIP were for pre-service and 22 percent were for concurrent review. In HIP, the percentage of pre-service requests was higher at 87 percent of the total. Retrospective reviews were a minimal number of total authorizations, but they were more predominant in MDwise HHW. In CY 2014, Anthem did not classify any authorization requests as retrospective.

Exhibit V.7

Distribution of Authorizations Submitted to MCEs in Calendar Year 2014, by Authorization Category Type

Auth Category Type	Participating Providers				Non-Participating Providers			
	Anthem	MHS	MDwise	All 3	Anthem	MHS	MDwise	All 3
	(n= 100,200)	(n= 41,587)	(n= 85,686)	(n=196,481)	(n= 25,878)	(n= 17,413)	(n=30,353)	(n= 73,235)
	Pct of Total	Pct of Total	Pct of Total	Pct of Total	Pct of Total	Pct of Total	Pct of Total	Pct of Total
Pre-Service Authorization	95.2%	83.5%	79.8%	75.6%	98.6%	71.6%	87.6%	87.1%
Concurrent Authorization	4.8%	15.1%	13.4%	21.9%	1.4%	26.8%	11.0%	11.9%
Retrospective Authorization	0.0%	1.3%	6.9%	2.5%	0.0%	1.3%	1.4%	0.9%
Unclassified/Unknown	0.0%	0.1%	0.0%	0.0%	0.0%	0.3%	0.0%	0.1%

The distribution of requests by authorization type is not the same across service categories. This is shown graphically on the next page in Exhibit V.8 for the statewide totals (the three MCEs combined) as well as for each MCE individually. Also, starting with Exhibit V.8 and throughout the remainder of this section, the 10,066 authorizations reported by the MCEs to be cancelled by the requesting provider have also been removed from the analysis.

Within the major category of inpatient hospital services, 28 percent of requests were for pre-service, 70 percent were for concurrent review, and two percent were for retrospective review statewide. MHS and MDwise both reported close to half of their inpatient authorizations as concurrent review, but Anthem reported having almost all concurrent review requests for inpatient. MDwise had a higher proportion of retrospective requests in the inpatient category.

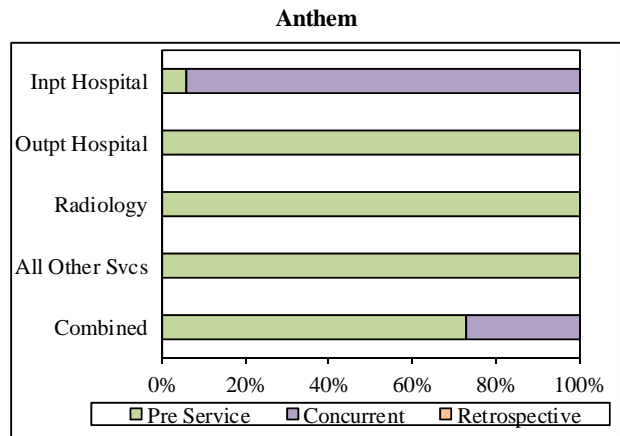
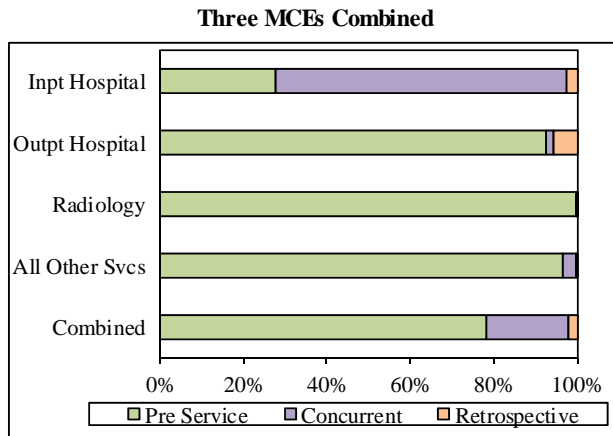
MDwise also had a sizeable proportion of outpatient hospital authorization requests as retrospective, but Anthem had none and MHS had almost none. MDwise was also unique among the MCEs to report concurrent review requests for non-hospital services, specifically therapies, enteral nutrition and durable medical equipment items. This was explained to B&A as an artifact of the way that the authorization is stored. If, for example, an authorization was approved for six therapy sessions and three more are requested, the three new sessions are tied to the original approved authorization and classified as concurrent since they are tied to a single continuous therapy series.

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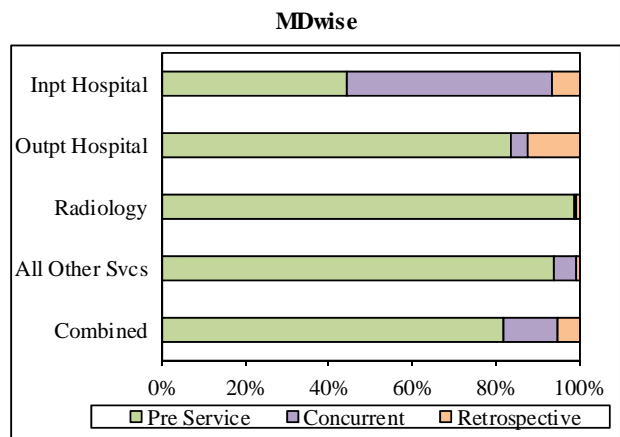
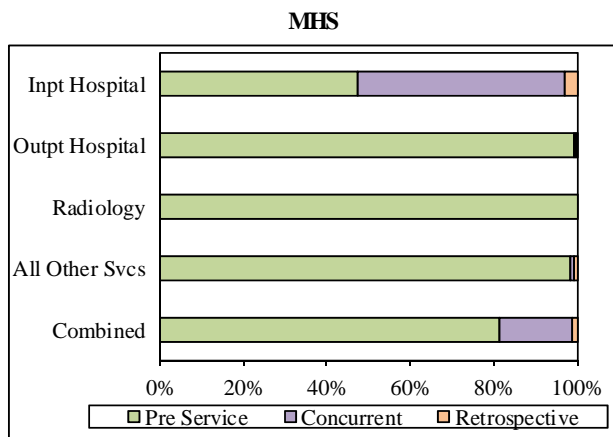
Exhibit V.8

Service Authorizations Reviewed by MCEs in CY 2014, by Authorization Type and Service Category



	Type of Authorization		
	Pre Service	Concurrent	Retrospective
Inpt Hospital	21,294	53,236	1,970
Outpt Hospital	64,836	1,317	3,830
Radiology	42,206	42	56
All Other Svcs	98,946	2,790	426
Combined	227,282	57,385	6,282

	Type of Authorization		
	Pre Service	Concurrent	Retrospective
Inpt Hospital	1,996	32,422	0
Outpt Hospital	17,545	0	0
Radiology	24,250	0	0
All Other Svcs	43,750	0	0
Combined	87,541	32,422	0



	Type of Authorization		
	Pre Service	Concurrent	Retrospective
Inpt Hospital	9,728	10,146	606
Outpt Hospital	21,436	86	39
Radiology	9,232	0	0
All Other Svcs	7,502	67	56
Combined	47,898	10,299	701

	Type of Authorization		
	Pre Service	Concurrent	Retrospective
Inpt Hospital	9,570	10,668	1,364
Outpt Hospital	25,855	1,231	3,791
Radiology	8,724	42	56
All Other Svcs	47,694	2,723	370
Combined	91,843	14,664	5,581

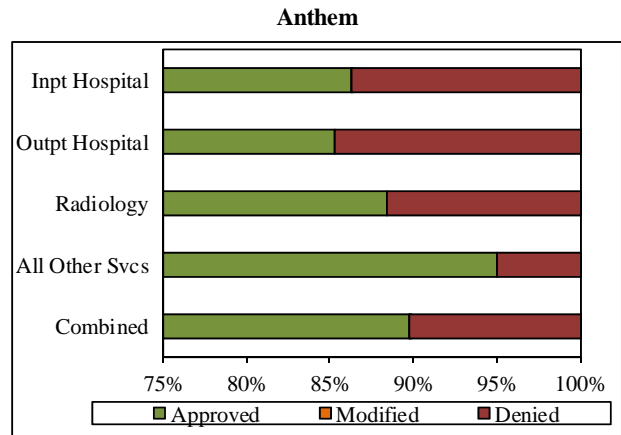
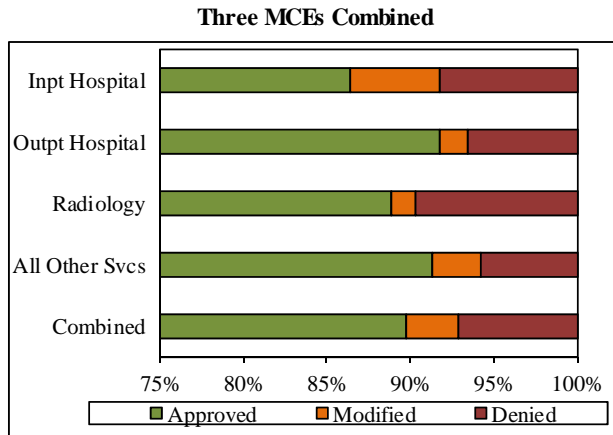
The results of the final determination of each authorization request appear on Exhibit V.9 on the next page. Across all three MCEs, the approval rate was 89.8 percent, the denial rate was 7.1 percent and the modified rate was 3.1 percent. There are differences at the MCE level, however. Anthem reported a denial rate of 10.2 percent but no modified requests. In other words, if the actual request is not

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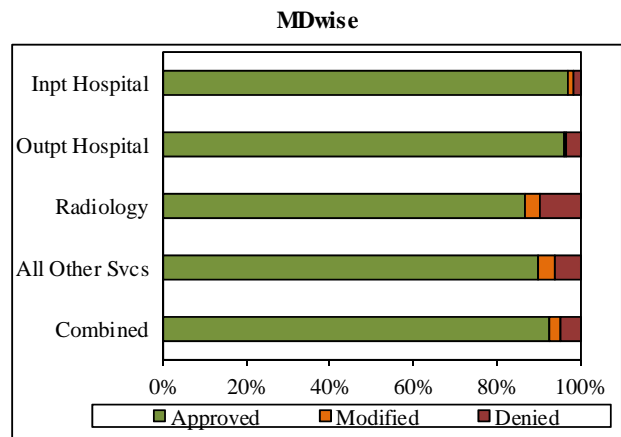
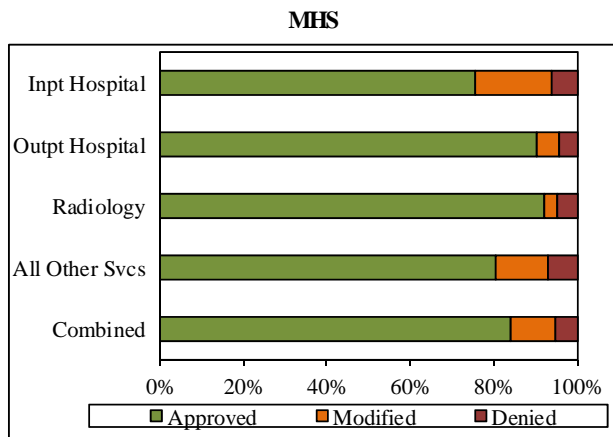
completely accepted, then the request is deemed denied. Both MHS and MDwise use modified to indicate a partial approval. MHS’s denial rate was 5.4 percent, but its modified rate was 10.4 percent. MDwise had the lowest denial rate at 4.8 percent and a modified rate of 2.5 percent. The greatest difference in the determination rates across MCEs was in the inpatient hospital category for Anthem.

**Exhibit V.9
Final Determination of Service Authorizations Reviewed in CY 2014**



	Final Determination of Authorization		
	Approved	Modified	Denied
Inpt Hospital	66,103	4,127	6,270
Outpt Hospital	64,263	1,191	4,605
Radiology	37,615	595	4,101
All Other Svcs	93,344	3,005	5,832
Combined	261,325	8,918	20,808

	Final Determination of Authorization		
	Approved	Modified	Denied
Inpt Hospital	29,695	1	4,722
Outpt Hospital	14,959	0	2,586
Radiology	21,439	0	2,811
All Other Svcs	41,576	0	2,174
Combined	107,669	1	12,293



	Final Determination of Authorization		
	Approved	Modified	Denied
Inpt Hospital	15,451	3,787	1,242
Outpt Hospital	19,593	1,100	944
Radiology	8,503	296	440
All Other Svcs	6,163	939	542
Combined	49,710	6,122	3,168

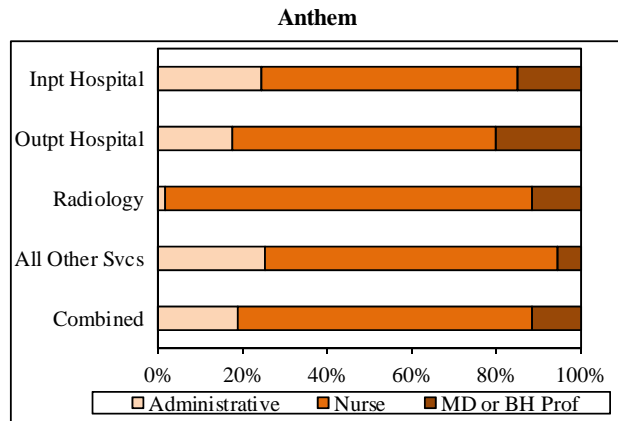
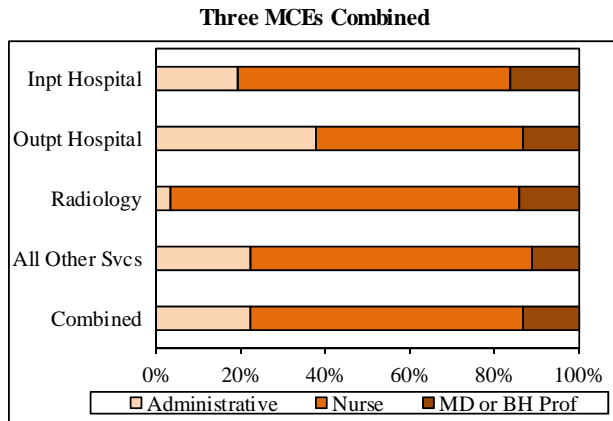
	Final Determination of Authorization		
	Approved	Modified	Denied
Inpt Hospital	20,957	339	306
Outpt Hospital	29,711	91	1,075
Radiology	7,673	299	850
All Other Svcs	45,605	2,066	3,116
Combined	103,946	2,795	5,347

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B&A examined who reviewed the authorizations primarily to learn how many were being reviewed by clinical staff. Statewide, the data showed that 22 percent of authorization requests were reviewed by administrative staff only, but the categories where this staff level reviewed authorizations varied. The fact that MDwise had a lower rate of physician reviews of inpatient is indicative of MDwise’s higher approval rate for inpatient than the other two MCEs, since only physicians can make denial decisions.

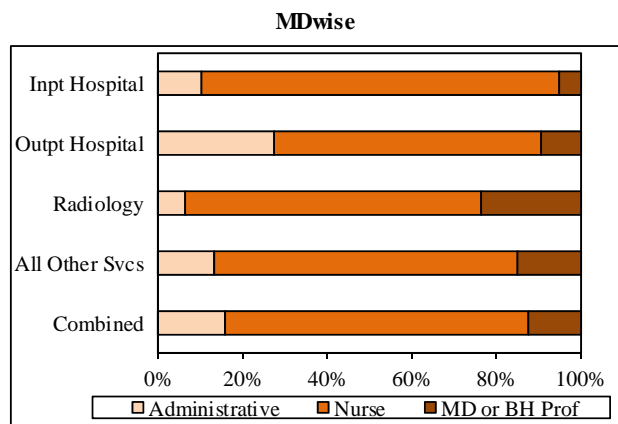
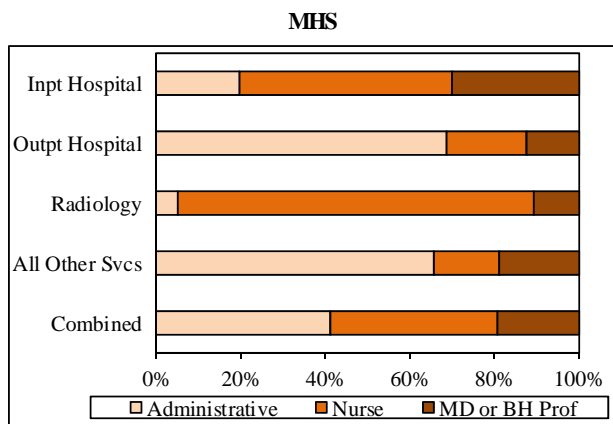
**Exhibit V.10
Highest Level Personnel Reviewer of Service Authorizations Reviewed in CY 2014**



	Highest Level Reviewer		
	Administrative	Nurse	MD or BH Prof
Inpt Hospital	14,727	49,407	12,353
Outpt Hospital	26,415	34,591	9,050
Radiology	1,421	35,049	5,841
All Other Svcs	22,716	68,140	11,324
Combined	65,279	187,187	38,568

	Highest Level Reviewer		
	Administrative	Nurse	MD or BH Prof
Inpt Hospital	8,450	20,814	5,152
Outpt Hospital	3,081	10,952	3,512
Radiology	380	21,059	2,811
All Other Svcs	11,011	30,394	2,344
Combined	22,922	83,219	13,819

*17 auths were excluded because reviewer could not be determined.



	Highest Level Reviewer		
	Administrative	Nurse	MD or BH Prof
Inpt Hospital	4,042	10,304	6,134
Outpt Hospital	14,852	4,099	2,686
Radiology	489	7,794	956
All Other Svcs	5,021	1,203	1,420
Combined	24,404	23,400	11,196

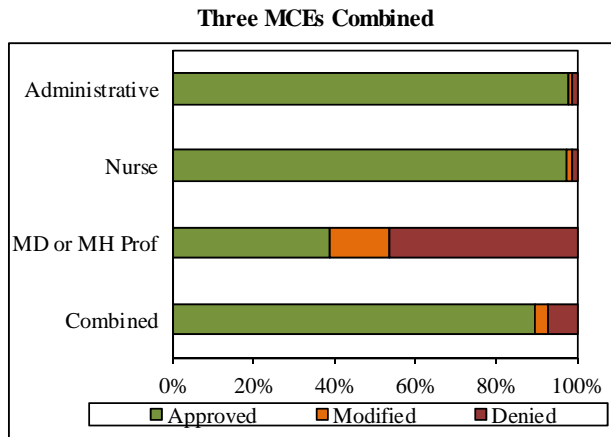
	Highest Level Reviewer		
	Administrative	Nurse	MD or BH Prof
Inpt Hospital	2,235	18,289	1,067
Outpt Hospital	8,482	19,540	2,852
Radiology	552	6,196	2,074
All Other Svcs	6,684	36,543	7,560
Combined	17,953	80,568	13,553

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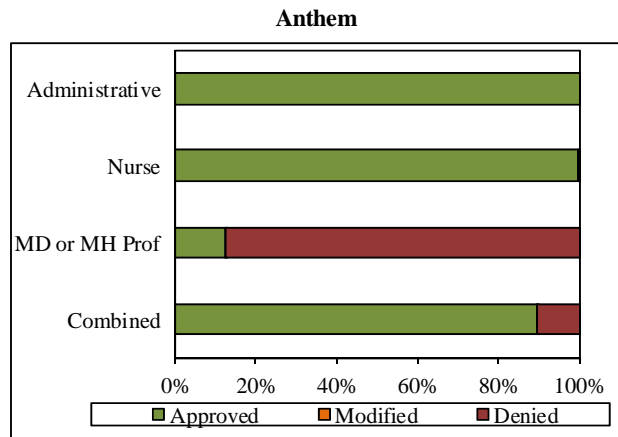
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Exhibit V.11 cross-tabulates the determination status of each authorization with the highest level reviewer. Exhibit V.10 showed that almost 20 percent of authorizations statewide were only reviewed by administrative staff, but this exhibit shows that 98 percent of these auths were approved. Nurses and administrative staff each denied one percent of the authorizations that they reviewed, whereas all other denied authorizations were reviewed by a medical doctor or a mental health professional.

**Exhibit V.11
Final Determination of Service Authorizations Reviewed, By Reviewer in CY 2014**

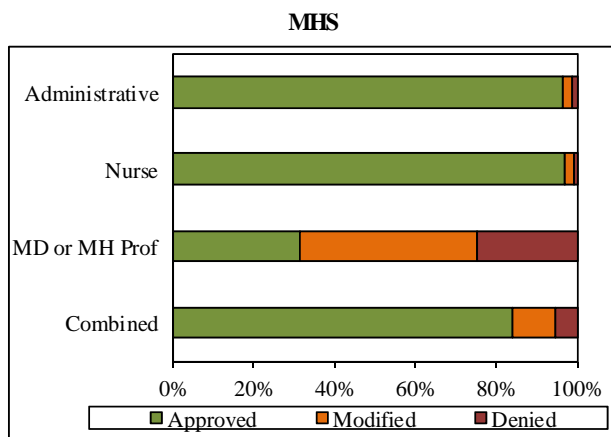


	Final Determination of Authorization		
	Approved	Modified	Denied
Administrative	63,905	702	672
Nurse	182,422	2,499	2,266
MD or MH Prof	14,981	5,717	17,870
Combined	261,308	8,918	20,808

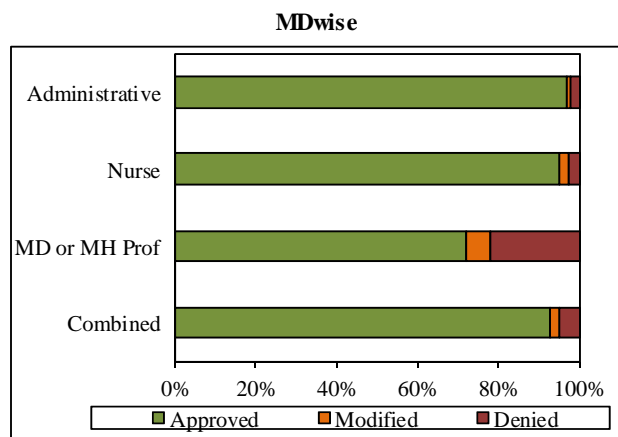


	Final Determination of Authorization		
	Approved	Modified	Denied
Administrative	22,922	0	0
Nurse	83,030	0	189
MD or MH Prof	1,714	1	12,104
Combined	107,666	1	12,293

*17 auths were excluded because reviewer could not be determined.



	Final Determination of Authorization		
	Approved	Modified	Denied
Administrative	23,533	580	291
Nurse	22,683	602	115
MD or MH Prof	3,494	4,940	2,762
Combined	49,710	6,122	3,168



	Final Determination of Authorization		
	Approved	Modified	Denied
Administrative	17,450	122	381
Nurse	76,709	1,897	1,962
MD or MH Prof	9,773	776	3,004
Combined	103,932	2,795	5,347

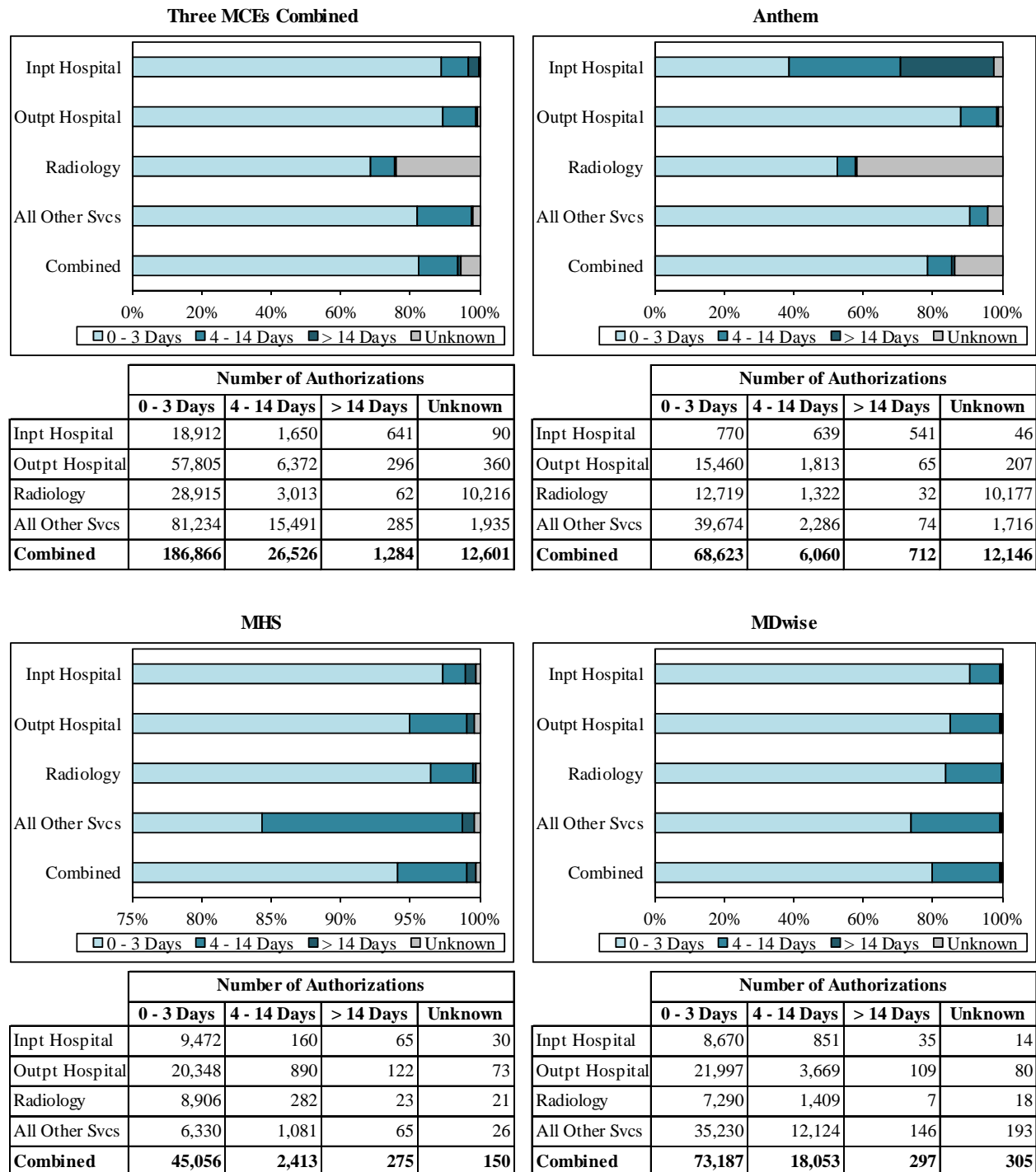
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B&A also examined turnaround time (TAT) for the MCEs to review the authorizations. B&A examined TAT using the national thresholds as well as OMPP’s. Among pre-service only authorization requests where TAT dates were available, 99.4 percent were reviewed within the national standard of 14 days. In fact, 82.2 percent were reviewed within three days. The OMPP requires a seven day turnaround time. All of the MCEs easily met these targets. Anthem did have missing TAT information for some radiology authorizations completed by their vendor. TAT data was in the vendor’s database but not Anthem’s.

Exhibit V.12

Average Turnaround Time for Service Authorizations Reviewed in CY 2014 - Pre Service Only

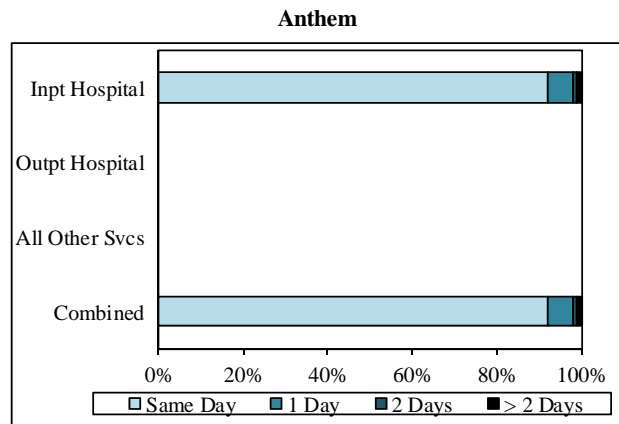
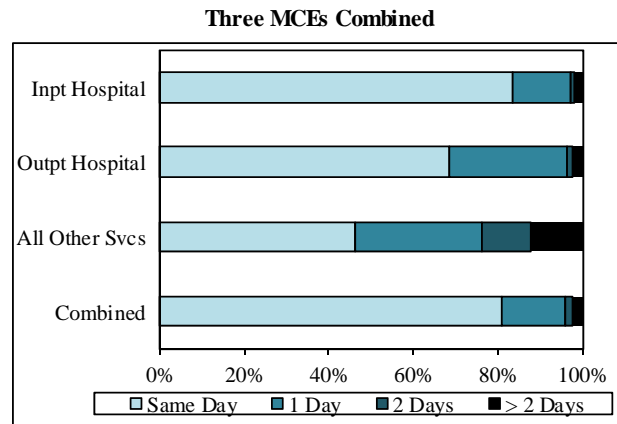


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Exhibit V.13 examines concurrent review authorizations specifically. Statewide, 68 percent of requests were handled the same day and 80 percent were reviewed the same day or within one day. Both MHS and MDwise reported similar results slightly higher than the statewide average. Anthem’s same day TAT for concurrent reviews was 66 percent and 70 percent were reviewed the same day or within one day. But for 29 percent of Anthem’s concurrent reviews, the data was not available to compute the TAT. The standard for this request type is 24 hours from receipt which could include same day or the next day.

**Exhibit V.13
Average Turnaround Time for Service Authorizations Reviewed in CY 2014 - Concurrent Only**

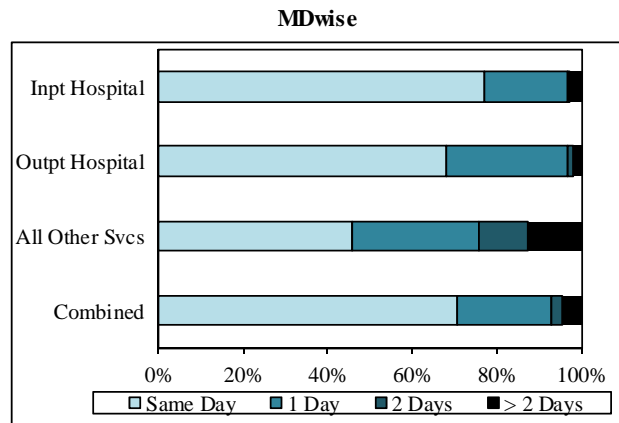
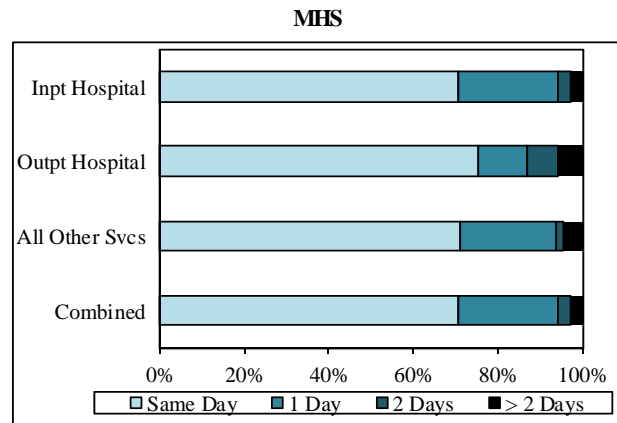


	Number of Authorizations			
	Same Day	1 Day	2 Days	> 2 Days
Inpt Hospital	36,669	5,948	541	769
Outpt Hospital	903	364	19	29
All Other Svcs	1,303	836	328	345
Combined	38,875	7,148	888	1,143

	Number of Authorizations			
	Same Day	1 Day	2 Days	> 2 Days
Inpt Hospital	21,288	1,446	170	231
Outpt Hospital	0	0	0	0
All Other Svcs	0	0	0	0
Combined	21,288	1,446	170	231

*9,325 auths excluded because dates to compute TAT not available.

*9,281 auths excluded because dates to compute TAT not available.



	Number of Authorizations			
	Same Day	1 Day	2 Days	> 2 Days
Inpt Hospital	7,148	2,417	305	261
Outpt Hospital	64	10	6	5
All Other Svcs	47	15	1	3
Combined	7,259	2,442	312	269

	Number of Authorizations			
	Same Day	1 Day	2 Days	> 2 Days
Inpt Hospital	8,233	2,085	66	277
Outpt Hospital	839	354	13	24
All Other Svcs	1,256	821	327	342
Combined	10,328	3,260	406	643

*17 auths were excluded because dates to compute TAT not available.

*27 auths were excluded because dates to compute TAT not available.

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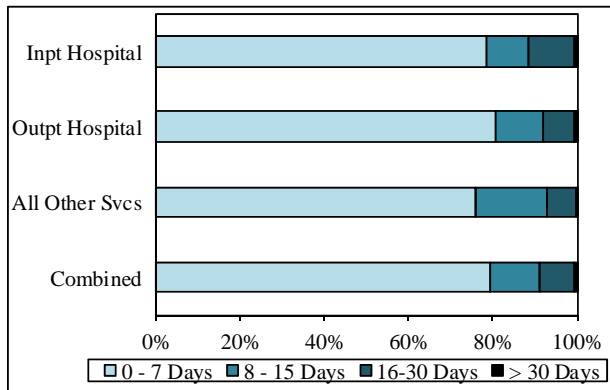
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For retrospective reviews, the standard nationally is 30 calendar days. The statewide averages found that 79 percent were reviewed within seven days and 90 percent were reviewed within 15 days. Almost all (99.3%) were completed within the 30 day requirement. Both MHS and MDwise showed similar trends among retrospective authorizations. Anthem did not report any retrospective authorizations.

Exhibit V.14

Average Turnaround Time for Service Authorizations Reviewed in CY 2014 - Retrospective Only

Three MCEs Combined



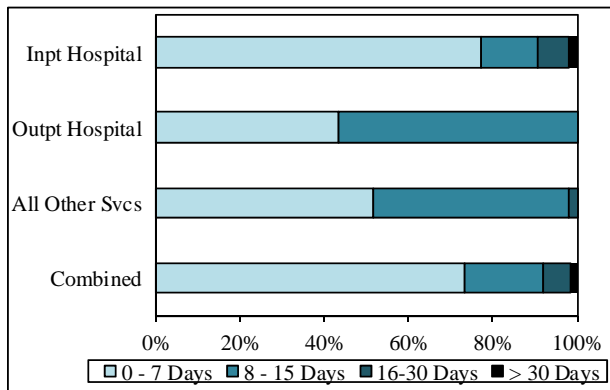
	Number of Authorizations			
	0 - 7 Days	8 - 15 Days	16-30 Days	> 30 Days
Inpt Hospital	1,544	194	213	16
Outpt Hospital	3,081	443	285	18
All Other Svcs	365	81	34	1
Combined	4,990	718	532	35

Anthem

Anthem did not report any retrospective reviews.

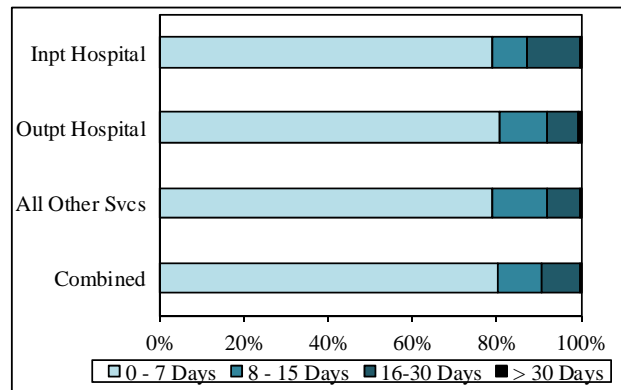
	Number of Authorizations			
	0 - 7 Days	8 - 15 Days	16-30 Days	> 30 Days
Inpt Hospital				
Outpt Hospital				
All Other Svcs				
Combined				

MHS



	Number of Authorizations			
	0 - 7 Days	8 - 15 Days	16-30 Days	> 30 Days
Inpt Hospital	467	83	45	11
Outpt Hospital	17	22	0	0
All Other Svcs	29	26	1	0
Combined	513	131	46	11

MDwise



	Number of Authorizations			
	0 - 7 Days	8 - 15 Days	16-30 Days	> 30 Days
Inpt Hospital	1,077	111	168	5
Outpt Hospital	3,064	421	285	18
All Other Svcs	336	55	33	1
Combined	4,477	587	486	24

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B&A also examined the rate of appeals of authorizations determined in CY 2014. The information shown in Exhibit V.15 is self-reported from each MCE. B&A compared the appeals information from CY 2014 to our study conducted in 2009 which examined authorization data in CY 2008. When compared to the volume six years ago, the total appeals decreased significantly from 1,143 in CY 2008 to 442 in CY 2014. When measuring appeals as a percent of denials rate, the result is 2.4 percent in CY 2014 as compared to 12.0 percent in CY 2008. This measure varied slightly across the MCEs from a low of 1.5 percent for Anthem to 3.6 percent for MDwise.

The percent of appeals where the original denial was completely or partially overturned has also reduced since our last study. In CY 2014, the overturned rate for all three MCEs combined was 30 percent as compared to 37 percent in CY 2008. This measure does vary by MCE, however. MHS has a very low overturned rate of two percent while Anthem is 33 percent and MDwise is 42 percent. Since CY 2008, both Anthem and MHS saw significant improvement in this measure.

The most frequently appealed services were in the categories for inpatient hospital acute care stays (one third of all appeals) followed by DME (14%), radiology (12%) and specialist referrals (11%).

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**Exhibit V.15
Summary Statistics on MCE Authorization Appeals in Calendar Year 2014**

	Anthem	MHS	MDwise	All 3 MCEs
Total Appeals in CY 2014	149	101	192	442
Compare to Appeals in CY 2008	164	888	91	1,143
Percent of All Appeals in CY 2014	34%	23%	43%	100%
Total Denials in CY 2014	9,983	3,271	5,404	18,658
Compare to Total Denials in CY 2008	1,385	5,199	2,972	9,556
Appeals as a Percent of Denials in CY 2014	1.5%	3.1%	3.6%	2.4%
Compare to Appeals as Pct of Denials in CY08	11.8%	17.1%	3.1%	12.0%

Upheld	100	99	112	311
Partially Overturned	2	0	26	28
Overturned	47	2	54	103
Total Appeals in CY 2014	149	101	192	442
Percent Partially or Fully Overturned- CY14	33%	2%	42%	30%
Percent Partially or Fully Overturned- CY08	68%	32%	40%	37%

Auth Cat	Auth Category Title - Appeals Only	Number	Pct of Total	Number	Pct of Total	Number	Pct of Total	Number	Pct of Total
1	Inpatient hospital stays other than Beh Health	42	28.2%	96	95.0%	9	4.7%	147	33.3%
2	Inpatient hospital stays just BH	4	2.7%	0	0.0%	1	0.5%	5	1.1%
3	Outpatient surgical procedures	0	0.0%	0	0.0%	17	8.9%	17	3.8%
4	All other outpatient hospital services	3	2.0%	1	1.0%	34	17.7%	38	8.6%
5	Physical, occupational, speech therapy	2	1.3%	0	0.0%	14	7.3%	16	3.6%
6	Specialist referrals	16	10.7%	0	0.0%	33	17.2%	49	11.1%
7	Radiology	37	24.8%	1	1.0%	14	7.3%	52	11.8%
8	Laboratory	1	0.7%	0	0.0%	10	5.2%	11	2.5%
9	Home Health visits	0	0.0%	0	0.0%	3	1.6%	3	0.7%
10	Chiropractic services	0	0.0%	0	0.0%	0	0.0%	0	0.0%
11	Other Codes in Medicine Category not Otherwise Assigned excludes 99281-99285	2	1.3%	0	0.0%	4	2.1%	6	1.4%
12	Other Codes in Medicine, Behavioral Health	0	0.0%	0	0.0%	8	4.2%	8	1.8%
13	Enterals	0	0.0%	0	0.0%	16	8.3%	16	3.6%
14	Orthotics	0	0.0%	0	0.0%	7	3.6%	7	1.6%
15	Wheelchairs and wheelchair repairs	0	0.0%	0	0.0%	4	2.1%	4	0.9%
16	DME other than those classified above	42	28.2%	3	3.0%	18	9.4%	63	14.3%
	TOTAL	149		101		192		442	

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Methodology for Defining the Study Sample and Review Process

Upon initial review of the attributes of the authorization requests in CY 2014, B&A constructed a sample that included representative cases using the following variables:

- The 16 service categories
- The type of authorization request—pre-service, concurrent or retrospective
- The determination status of the case—approved or denied
- The reviewer of the case—administrative staff, nurse or physician/mental health professional

Because the focus of the study was on the validation of internal processes, the sample was not random. The sample was constructed to force it to include 75 percent denials and 25 percent approvals. Further, inpatient hospital requests were oversampled within some MCEs compared to their total volume of authorization requests. This forced the sample to include more clinical denials than administrative denials.

Although the volume of authorization requests for each MCE varies, the sample was constructed to select 250 cases from each MCE with an oversample of 10 percent to account for unforeseen circumstances. In the end, all 825 authorizations (including the oversample) were reviewed. Five cases were removed from MHS's sample due to accessibility issues and two were removed from Anthem's sample because they were not actual authorization requests. In the end, 818 cases were considered in the study.

A comparison of the stratified sample by service category when compared to the total universe of authorization requests appears in Exhibit V.16.

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**Exhibit V.16
Service Authorizations Reviewed in the Sample, by Service Category**

Auth Cat	Sample of Auths Reviewed from CY 2014	Anthem		MHS		MDwise		TOTAL	
		MCE Total	Pct of Total	MCE Total	Pct of Total	MCE Total	Pct of Total	Total	Pct of Total
1	Inpatient acute care	53	19.4%	97	35.9%	16	5.8%	166	20.3%
2	Inpatient behavioral health	9	3.3%	8	3.0%	2	0.7%	19	2.3%
3	Outpatient surgeries	19	7.0%	18	6.7%	34	12.4%	71	8.7%
4	Other outpatient hospital services	35	12.8%	17	6.3%	16	5.8%	68	8.3%
5	Physical, occupational or speech therapy	7	2.6%	1	0.4%	7	2.5%	15	1.8%
6	Referral to specialist provider	8	2.9%	3	1.1%	26	9.5%	37	4.5%
7	Radiology	74	27.1%	37	13.7%	43	15.6%	154	18.8%
8	Laboratory test	10	3.7%	17	6.3%	24	8.7%	51	6.2%
9	Chiropractic service	2	0.7%	1	0.4%	2	0.7%	5	0.6%
10	Home health visits	2	0.7%	2	0.7%	3	1.1%	7	0.9%
11	Orthotics	2	0.7%	2	0.7%	20	7.3%	24	2.9%
12	Enteral nutrition	20	7.3%	11	4.1%	16	5.8%	47	5.7%
13	Wheelchair, wheelchair accessories or repairs	3	1.1%	1	0.4%	3	1.1%	7	0.9%
14	DME other than orthotics, enterals, wheelchairs	2	0.7%	4	1.5%	38	13.8%	44	5.4%
15	Other medical services not specified above	23	8.4%	36	13.3%	7	2.5%	66	8.1%
16	Other behavioral health svcs not specified above	4	1.5%	15	5.6%	18	6.5%	37	4.5%
Total		273	100%	270	100%	275	100%	818	100%

Auth Cat	Comparison: All Auths Received in CY 2014	Anthem		MHS		MDwise		TOTAL	
		MCE Total	Pct of Total	MCE Total	Pct of Total	MCE Total	Pct of Total	Total	Pct of Total
1	Inpatient acute care	28,899	22.9%	12,791	21.7%	18,493	15.9%	60,183	20.0%
2	Inpatient behavioral health	6,392	5.1%	7,689	13.0%	3,999	3.4%	18,080	6.0%
3	Outpatient surgeries	9,892	7.8%	9,771	16.6%	10,758	9.3%	30,421	10.1%
4	Other outpatient hospital services	8,079	6.4%	11,866	20.1%	20,869	18.0%	40,814	13.6%
5	Physical, occupational or speech therapy	4,308	3.4%	18	0.0%	10,665	9.2%	14,991	5.0%
6	Referral to specialist provider	371	0.3%	387	0.7%	15,965	13.8%	16,723	5.6%
7	Radiology	27,913	22.1%	9,239	15.7%	9,016	7.8%	46,168	15.3%
8	Laboratory test	1,026	0.8%	561	1.0%	1,236	1.1%	2,823	0.9%
9	Chiropractic service	136	0.1%	397	0.7%	714	0.6%	1,247	0.4%
10	Home health visits	38	0.0%	1	0.0%	9	0.0%	48	0.0%
11	Orthotics	14,192	11.3%	4,068	6.9%	3,521	3.0%	21,781	7.2%
12	Enteral nutrition	18,239	14.5%	909	1.5%	1,314	1.1%	20,462	6.8%
13	Wheelchair, wheelchair accessories or repairs	2,454	1.9%	513	0.9%	5,998	5.2%	8,965	3.0%
14	DME other than orthotics, enterals, wheelchairs	113	0.1%	142	0.2%	3,166	2.7%	3,421	1.1%
15	Other medical services not specified above	128	0.1%	110	0.2%	1,543	1.3%	1,781	0.6%
16	Other behavioral health svcs not specified above	3,898	3.1%	538	0.9%	8,773	7.6%	13,209	4.4%
Total		126,078	100%	59,000	100%	116,039	100%	301,117	100%

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Onsite Review Process

A draft review tool was developed and piloted with each MCE. On July 28, the three onsite reviewers met with each MCE to pilot six actual cases from the MCE to test how the tool would be completed for the 275 actual cases in the sample. It also gave the ERQ Review Team the opportunity to become familiar with the online authorization systems at each MCE. The feedback provided from each MCE enabled B&A to customize the tool to ensure that data elements were captured in a consistent manner across the three MCEs.

The MCEs were given their sample list on July 24 in advance of the onsite reviews which were conducted the week of August 17. The same three EQR Review Team members participated throughout this authorization review process. All reviews were done by viewing information recorded in the MCE's authorization software, including documents attached to the record that were submitted by requesting providers (e.g., clinical information). When onsite at the MCE, each EQR Team member had an assigned MCE staff member to assist in navigating the MCE's authorization system to ensure that we did not miss information stored in the system. The EQR Team member would request a specific data element and the MCE staff member would point out its location in the software. Results were recorded on the review tool by hand along with other relevant notes.

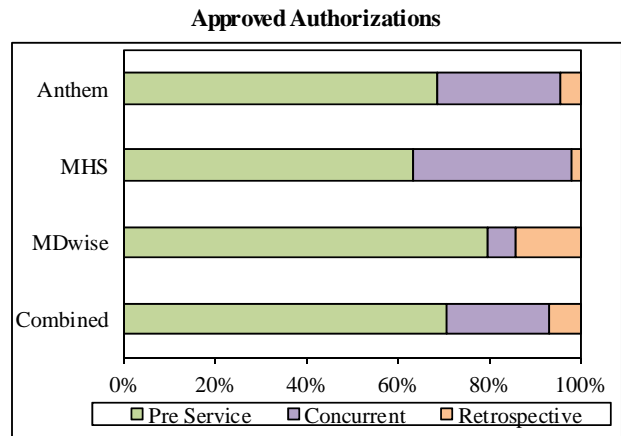
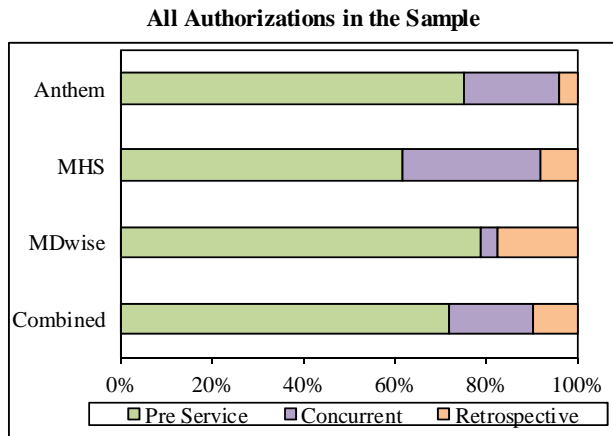
Post onsite, data from the review tools was entered into a Microsoft Access database. The data was validated by running totals for each question and ensuring responses to questions that were dependent on responses from previous questions were entered properly. Queries were run to sum the responses to each question on the tool and cross-validated with the responses to other questions. The results of this task are shown in the next section.

Findings from the Review of the Study Sample

The 818 authorizations that were reviewed were stratified by final determination and authorization type. Four authorizations were excluded from Exhibit V.17 appearing on the next page because the authorization type (pre-service, concurrent, or retrospective review) could not be determined. Out of 814 authorizations remaining, 210 (25.8%) were approved, 167 (20.5%) were denied for administrative reasons, and 424 (52.1%) were denied for clinical reasons. An additional 14 authorizations (1.7%) were modified and are not shown in the exhibit.

The sample of concurrent review authorizations is more concentrated in the MHS sample, and the retrospective authorizations are more concentrated with MDwise. It was also found that retrospective authorizations were much more likely to be denied for administrative reasons (54.4% of all retrospective authorizations) than pre-service (18.8% of all pre-service authorizations) or concurrent reviews (8.0% of all concurrent authorizations).

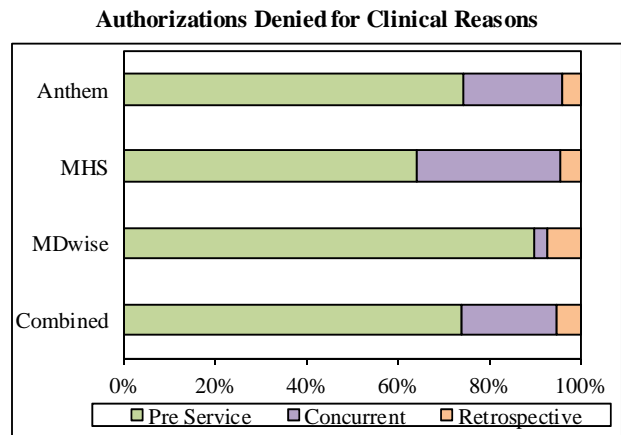
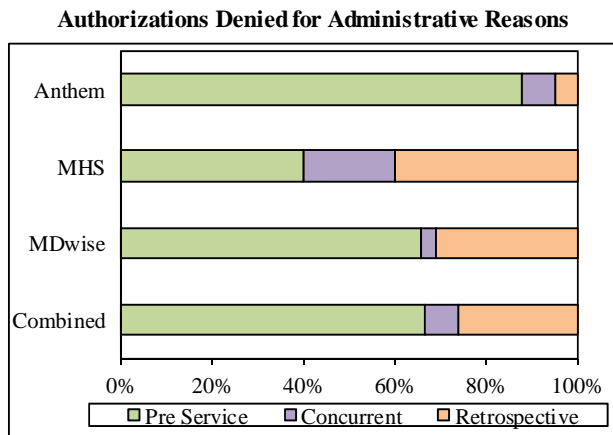
Exhibit V.17
Service Authorizations Reviewed in the Sample, by Authorization Type



	Type of Authorization		
	Pre Service	Concurrent	Retrospective
Anthem	205	57	11
MHS	167	82	21
MDwise	214	10	47
Combined	586	149	79

	Type of Authorization		
	Pre Service	Concurrent	Retrospective
Anthem	62	24	4
MHS	35	19	1
MDwise	51	4	9
Combined	148	47	14

*4 additional MDwise auths were reviewed but auth type could not be determined.



	Type of Authorization		
	Pre Service	Concurrent	Retrospective
Anthem	36	3	2
MHS	12	6	12
MDwise	62	3	29
Combined	110	12	43

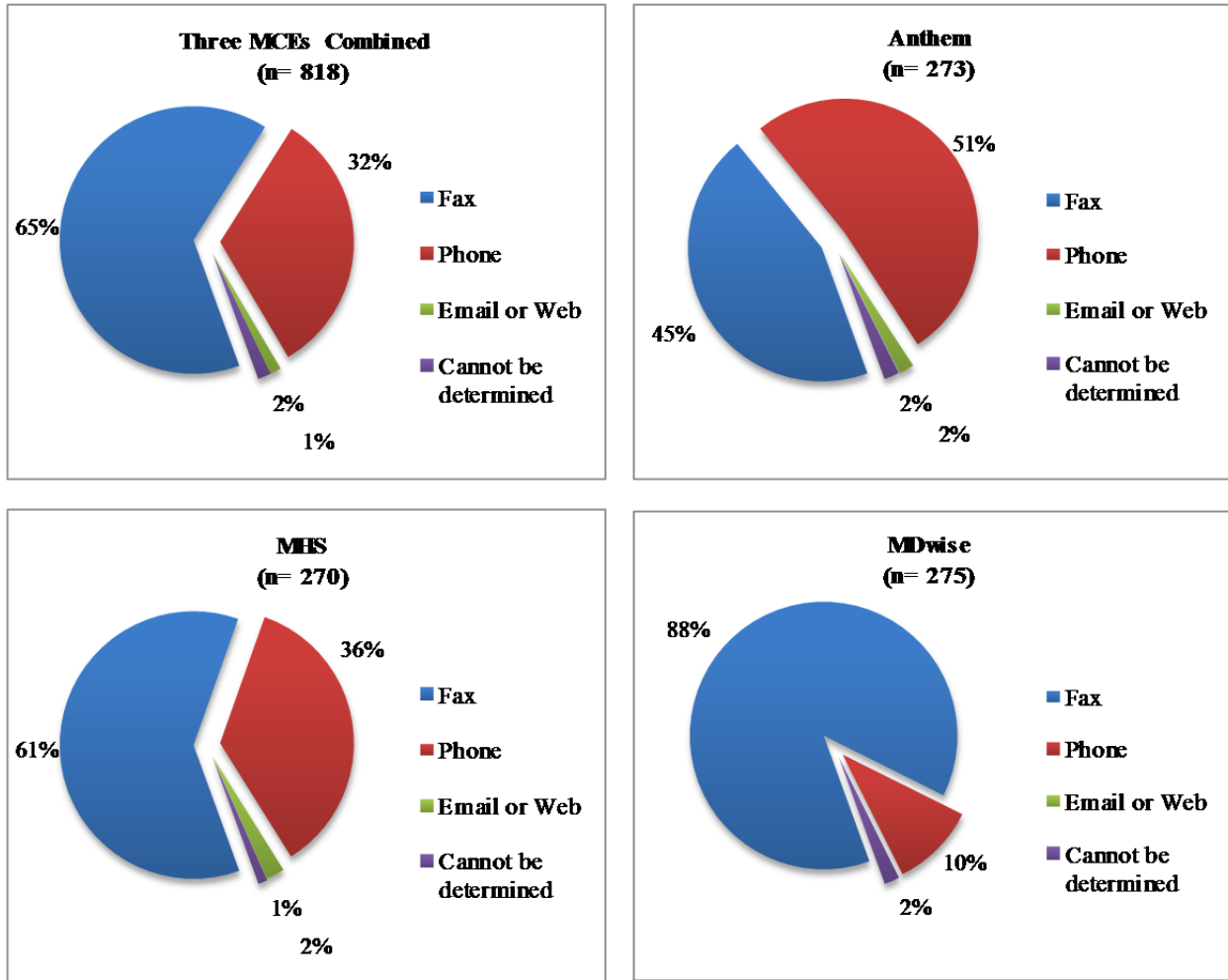
	Type of Authorization		
	Pre Service	Concurrent	Retrospective
Anthem	99	29	5
MHS	115	56	8
MDwise	100	3	8
Combined	314	88	21

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Exhibit V.18 shows that two-thirds of the sample authorizations were submitted by fax and one-third were submitted by phone. MDwise had more authorizations submitted by fax (88%) than the statewide average while Anthem had less than the statewide average (45%). MHS was near the statewide average with respect to the mode in which the authorizations were submitted to the MCE.

Exhibit V.18
Mode in which Service Authorizations in the Sample were Submitted to the MCE



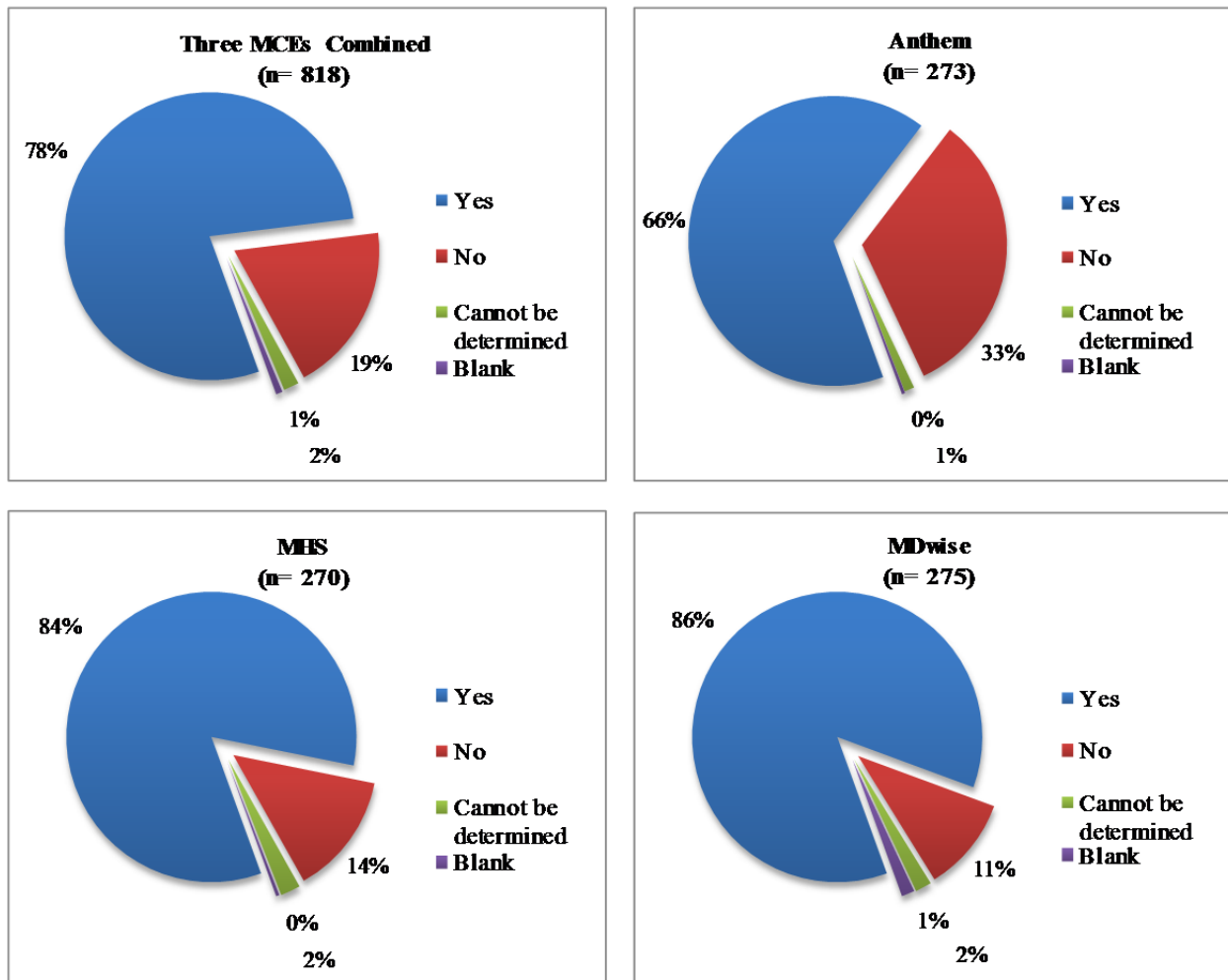
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The MCEs request that clinical documentation be submitted with every authorization request. This notice is on the standard authorization form created by the OMPP that is used by all MCEs. Within the sample studied, 78 percent of authorizations contained clinical documentation with the initial request. Anthem had a lower rate of submissions than the statewide average and MHS and Anthem received a greater percentage of authorizations with clinical information than the statewide average. This trend may be related to the fact that both MHS and MDwise receive more authorizations by fax than by phone (refer back to Exhibit V.18). Regardless, all of the MCEs outreach to the requesting provider whenever they see that clinical information was not submitted with the initial request.

Exhibit V.19

Clinical Documentation Submitted with Service Authorization Initial Request in the Sample



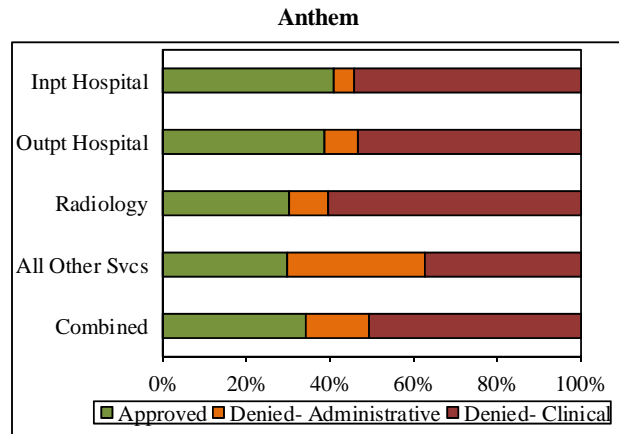
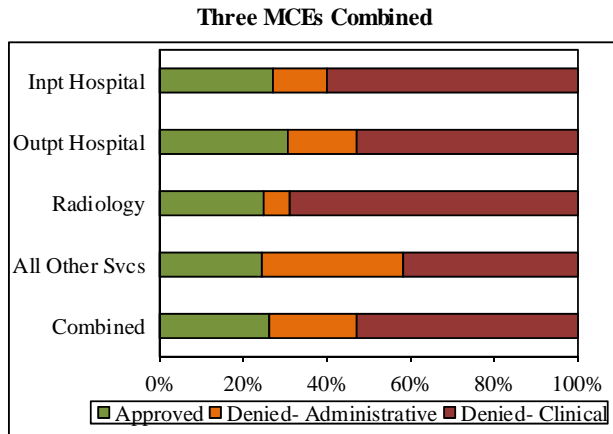
The final determination of the authorizations in the sample was analyzed. Exhibit V.20 shows that 210 out of 815⁹ were approved, 167 were denied for administrative reasons, and 424 were denied for clinical reasons. An additional 14 were given modified status. It should be noted that 39 of the approved authorizations were initially denied. The usual reason is due to lack of clinical documentation provided. Clinically related denials were common in the inpatient hospital and radiology categories, whereas administrative denials are more common in services in other categories.

⁹ Three out of the 818 authorizations were excluded because the final determination could not be determined.

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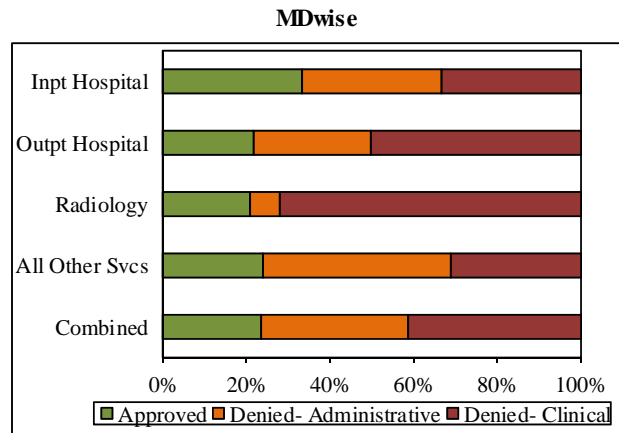
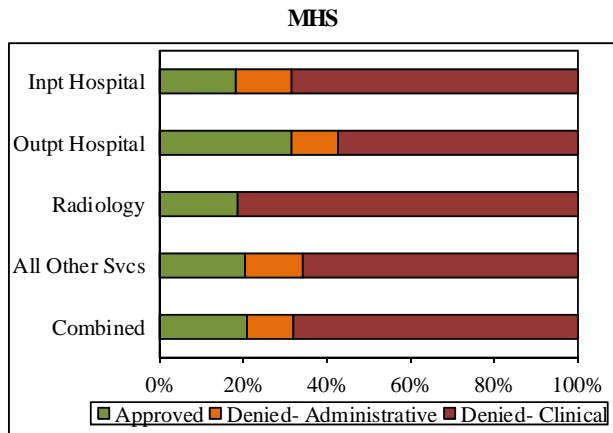
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**Exhibit V.20
Service Authorizations Reviewed in the Sample, by Final MCE Determination**



	Final Determination of Authorization		
	Approved	Denied-Administrative	Denied-Clinical
Inpt Hospital	50	23	110
Outpt Hospital	41	22	71
Radiology	38	10	105
All Other Svcs	81	112	138
Combined	210	167	424

	Final Determination of Authorization		
	Approved	Denied-Administrative	Denied-Clinical
Inpt Hospital	25	3	33
Outpt Hospital	19	4	26
Radiology	22	7	44
All Other Svcs	24	27	30
Combined	90	41	133



	Final Determination of Authorization		
	Approved	Denied-Administrative	Denied-Clinical
Inpt Hospital	19	14	71
Outpt Hospital	11	4	20
Radiology	7	0	30
All Other Svcs	18	12	58
Combined	55	30	179

	Final Determination of Authorization		
	Approved	Denied-Administrative	Denied-Clinical
Inpt Hospital	6	6	6
Outpt Hospital	11	14	25
Radiology	9	3	31
All Other Svcs	39	73	50
Combined	65	96	112

Note: In addition to these, 14 auths with a determination of 'Modified' were reviewed but are not shown in this exhibit. Also, 3 auths were reviewed but the disposition could be not determined from the data provided in the review.

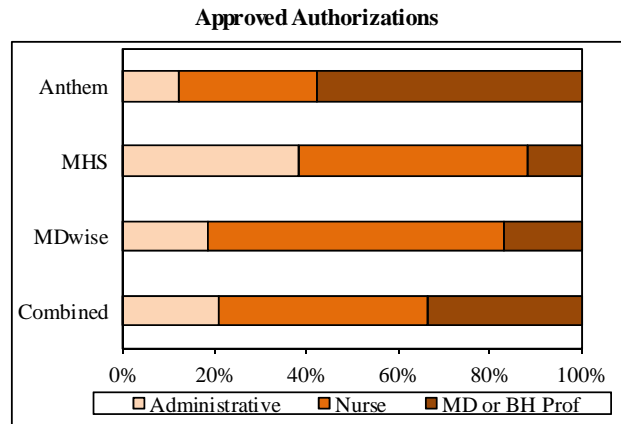
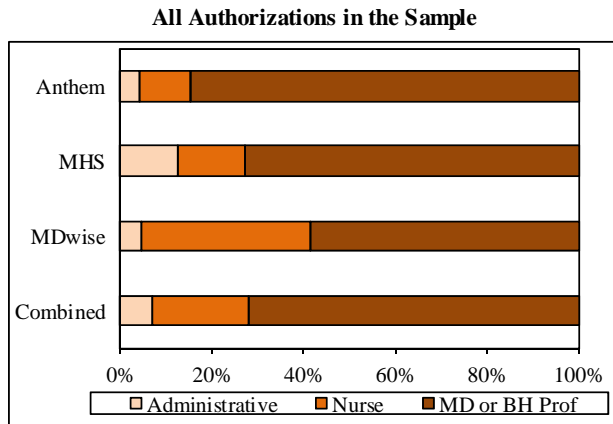
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For the assessment of the highest personnel level reviewing the authorization, 71 percent of the sample was reviewed by a physician or a mental health professional. Another 21 percent were reviewed by a nurse as the highest level. Anthem had the largest sample reviewed by a physician (84%), then MHS (72%), then MDwise (57%). All authorizations denied for clinical reasons, however, were reviewed by a physician or mental health professional.

Exhibit V.21

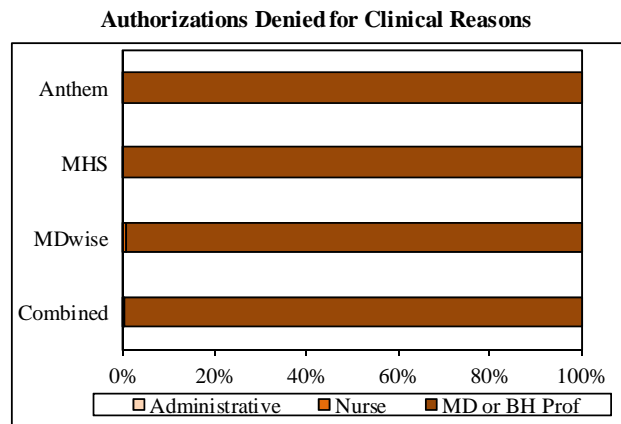
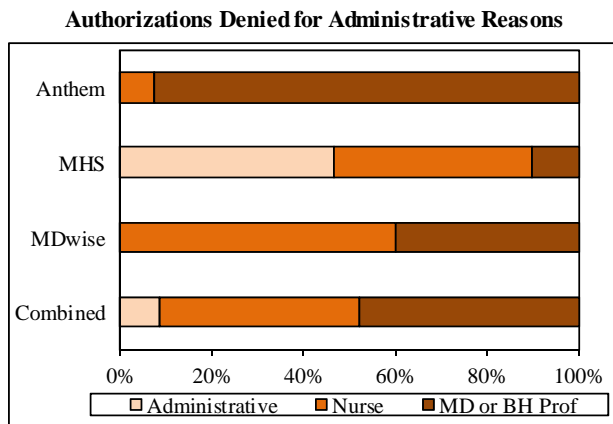
Highest Level MCE Personnel Reviewer of Service Authorizations Reviewed in the Sample



	Highest Level Reviewer		
	Administrative	Nurse	MD or BH Prof
Anthem	11	30	228
MHS	34	39	194
MDwise	12	99	156
Combined	57	168	578

	Highest Level Reviewer		
	Administrative	Nurse	MD or BH Prof
Anthem	11	27	52
MHS	20	26	6
MDwise	12	42	11
Combined	43	95	69

*15 auths were excluded because reviewer could not be determined.



	Highest Level Reviewer		
	Administrative	Nurse	MD or BH Prof
Anthem	0	3	38
MHS	14	13	3
MDwise	0	54	36
Combined	14	70	77

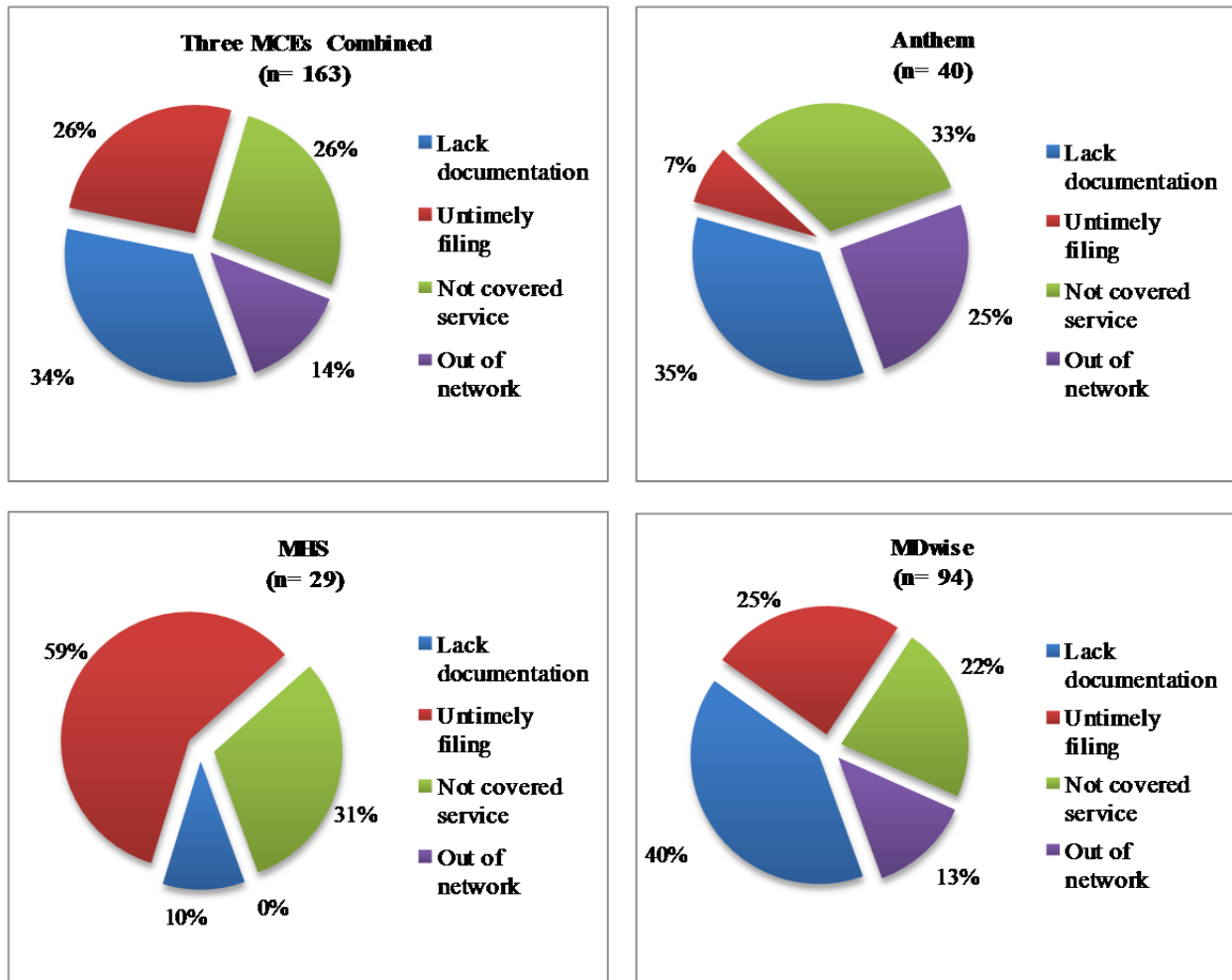
	Highest Level Reviewer		
	Administrative	Nurse	MD or BH Prof
Anthem	0	0	130
MHS	0	0	179
MDwise	0	1	109
Combined	0	1	418

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B&A asked the MCEs to provide the reason for the administrative denials in this review (refer to Exhibit V.22 below). The most common reasons which were evenly split included lack of documentation, untimely filing, and not a covered service. At the MCE level, however, out of network was the reason for one-quarter of Anthem’s administrative denials, untimely filing was the reason in 59 percent of MHS’s administrative denials, and MDwise cited lack of documentation 40 percent of the time.

Exhibit V.22
Reason for Administrative Denial Among Service Authorizations in the Sample

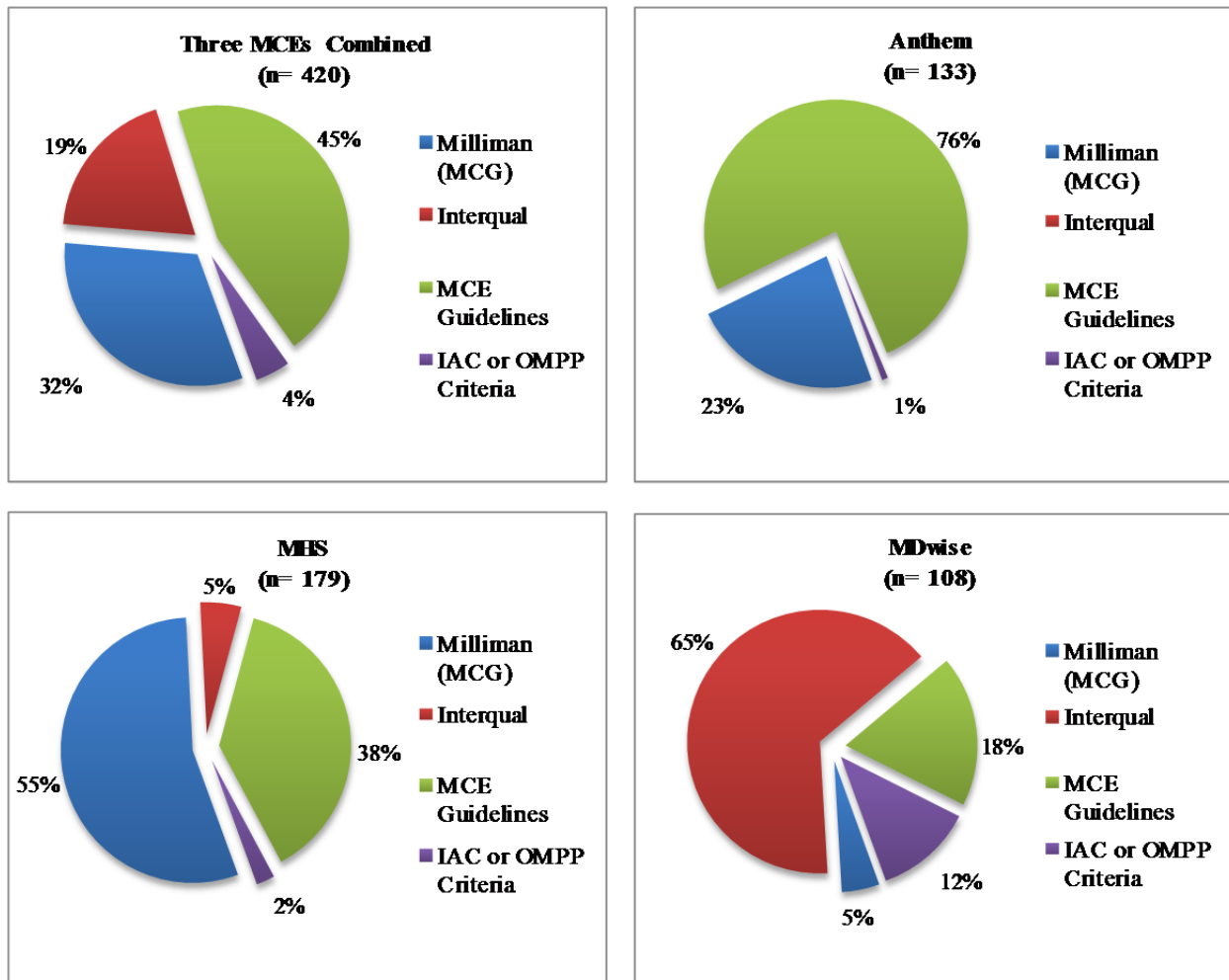


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In 420 of the 818 sample cases, lack of medical necessity was cited as the reason for denial of the authorization request. In every case, the EQR Review Team found that clinical criteria was cited, although the type varied by MCE. Exhibit V.23 shows that statewide MCE specific guidelines were used 45 percent of the time, followed by Milliman Care Guidelines (MCG) was used 32 percent of the time, followed by Interqual used 19 percent of the time. Anthem cited MCE guidelines 76 percent of the time, while MHS used MCG in over half of the clinical denials (55%) and MDwise used Interqual two-thirds of the time. The type of guidelines is often driven by which national guidelines each MCE chooses to subscribe to. MCE guidelines were found to be centered on radiology procedures and some mental health services.

**Exhibit V.23
Clinical Criteria Used to Justify Medical Necessity Denial Among Service Authorizations in the Sample**



Analytics on the overall dataset showed that all three MCEs were in compliance with required turnaround time (TAT) for each authorization type, based on their own self-reported data. Exhibit V.24 highlights the results that the EQR Review Team found in its own study. B&A found that 69 percent of pre-service authorization requests were reviewed within three days and 99 percent were reviewed within 14 days. Among concurrent review requests, 40 percent were determined in the same day and 86 percent were determined either in the same day or within one day. Among retrospective authorizations, 91 percent were determined within 7 days and 100 percent were reviewed within 30 days. MDwise lagged slightly

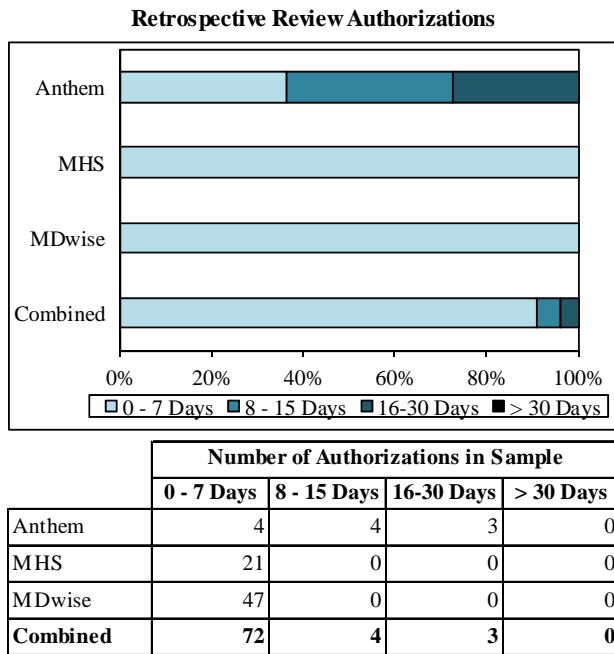
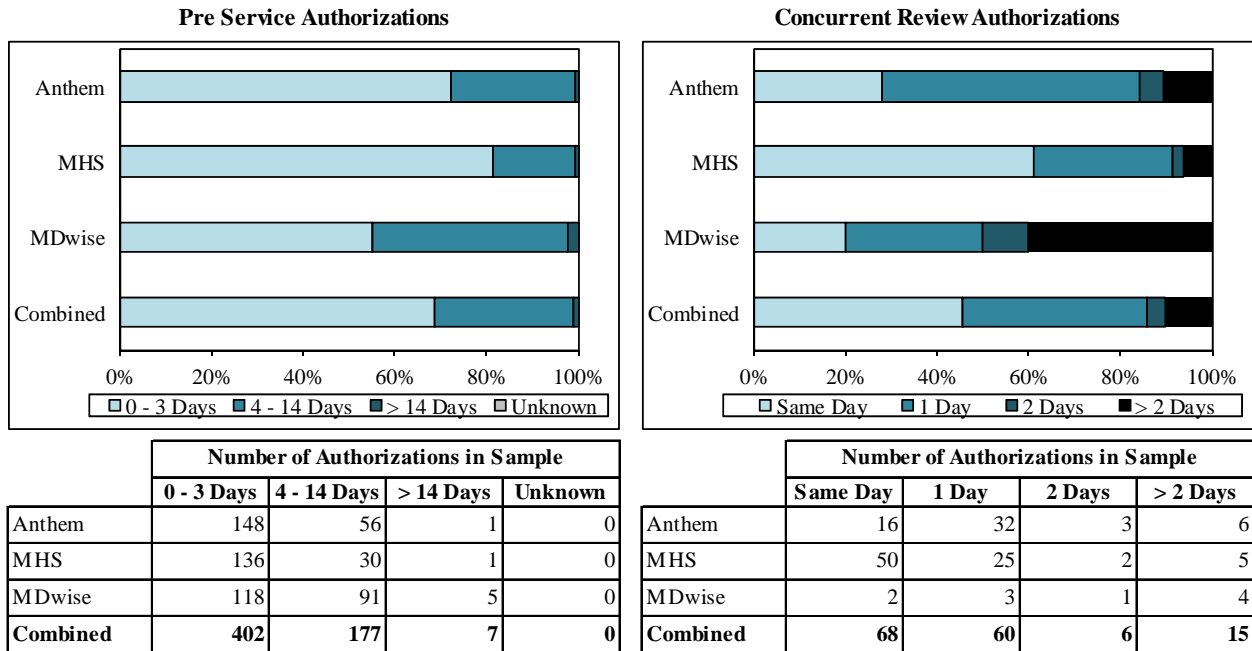
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behind Anthem and MHS for TAT for pre-service authorizations but was still within the target TAT. On concurrent reviews, MDwise also lagged behind on some of these authorizations (40 percent were three days or more), but this may have been a mislabeling of these auths as concurrent review since MDwise characterizes some non-inpatient, recurring service requests (e.g., therapies) as concurrent reviews.

Exhibit V.24

Average Turnaround Time for Service Authorizations Reviewed in the Sample, by Type of Auth



The EQR Review Team did observe differences in the TAT depending upon the disposition of the authorization. Almost 80 percent of denials for clinical reasons had a TAT of three days or less. This is

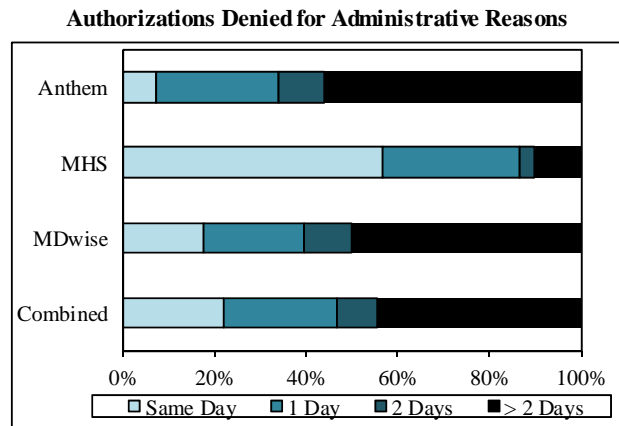
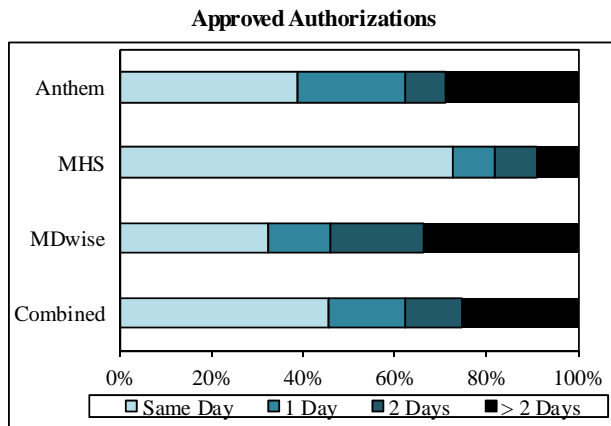
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logical since it was observed that more of the clinically-denied authorizations were for hospital services. Denials for administrative reasons had the longest TAT. As explained to the review team and seen in the sample records, the MCEs are giving requesting providers as much time as possible (e.g. up to the 7th day on a pre-service request) to submit additional required information before denying the request for lack of documentation. Among approved authorizations, 75 percent were determined within two days.

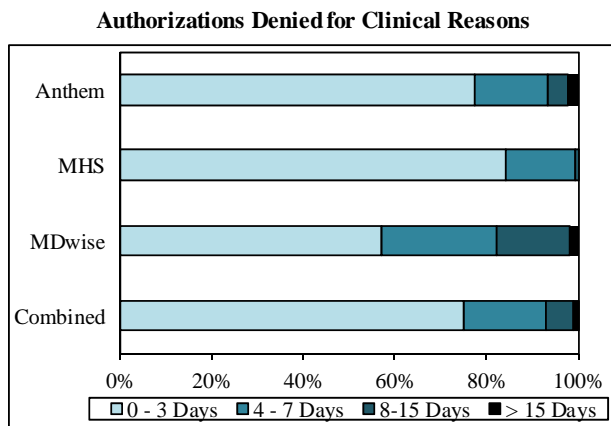
Exhibit V.25

Average Turnaround Time for Service Authorizations Reviewed in the Sample, by Auth Disposition



	Number of Authorizations in Sample			
	Same Day	1 Day	2 Days	> 2 Days
Anthem	35	21	8	26
MHS	40	5	5	5
MDwise	21	9	13	22
Combined	96	35	26	53

	Number of Authorizations in Sample			
	Same Day	1 Day	2 Days	> 2 Days
Anthem	3	11	4	23
MHS	17	9	1	3
MDwise	17	21	10	48
Combined	37	41	15	74



	Number of Authorizations in Sample			
	0 - 3 Days	4 - 7 Days	8-15 Days	> 15 Days
Anthem	103	21	6	3
MHS	151	27	1	0
MDwise	64	28	18	2
Combined	318	76	25	5

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Summary of Findings

After our review of the information collected on the authorization review tool for the 818 sample cases and our visual review of the records in each MCE's online systems, the EQR Review Team can summarize its findings related to MCE authorization review processes as follows.

1. With few exceptions, all three MCEs appear to be in compliance with turnaround time requirements for pre-service, concurrent and retrospective authorization reviews. This includes compliance with the OMPP's contractual requirement of seven days TAT for pre-service which is stricter than the national standard of fourteen days.
2. In 420 cases out of 818 reviewed, the reason for denial that was cited was lack of medical necessity. In each one of these cases, the rationale for determination of medically unnecessary was documented in the records. In 96 percent of these cases, the specific citation of the clinical guideline applied was stated in the denial letters to the requesting provider and the member.
3. When MCEs used clinical guidelines to make their determination, the resources used most often were MCG, Interqual, ASAM, or MCE nationally peer-reviewed guidelines (specifically in the case of radiology for Anthem). In other instances, the MCEs have created their own guidelines for specific services based on current literature in the field (two examples found were for enteral nutrition and wheelchairs).
4. Clinical documentation was submitted in 78 percent of the cases in our sample, but much more so for MHS and MDwise than Anthem. However, correspondence notes in the files reviewed showed evidence by the MCE to obtain clinical information or to seek more complete clinical information when the original documentation submitted by the requesting provider was incomplete.
5. In 33 percent of the cases reviewed in which an administrative denial was determined (n=167), the reason was lack of documentation because the time expired for the requesting provider to fulfill the MCE's request for more clinical information.
6. There was evidence in the files where peer to peer reviews were conducted between medical professionals regarding an authorization request. When a request was denied for medical necessity, the denial letter to the provider offered a peer-to-peer consultation.
7. The proactive work of obtaining clinical information and utilizing clinical guidelines in assessing denials for lack of medical necessity appears to have had a positive effect on the rate of appeals. When compared to a similar study of MCE authorizations that B&A conducted in 2009 with these same MCEs, the appeals rate has decreased significantly.
8. MHS in particular has the MCG guideline checklist embedded in its authorization software to show exactly how the case does not meet medical necessity if asked by the provider.
9. Since the 2009 EQR, there has been noticeable improvement in the outbound letters sent by all three MCEs related to authorizations. In particular,
 - a. Anthem conducted a rigorous test to ensure its letters are written at a 5th grade reading level (the letters sent out are the same for both the provider and member). Anthem used the same letter for both previously, but they were at a higher reading level.

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- b. MHS amended language so that specific clinical guidance which had been found in 2009 is no longer given. Instead, generalities about the standard of care are provided which is customary for an MCE notification to a provider.
10. In a few cases in the sample studied, the denial letters were either not generated by the MCE or not available to the reviewers. In particular, this was true of the cases reviewed under MDwise's Eskenazi delivery system and MHS's Cenpatico (behavioral health) unit.
11. Internal controls (via login and password) are in place in the authorization software so that the physician decision and text is locked and cannot be changed by other users. For Anthem and MHS, this physician text field is copied directly into the outbound denial letter.
12. Another recommendation made in the 2009 study that was implemented is the internal control to automatically attach the nurse/doctor name and suffix next to any notes in the record. This is now a feature of each MCE's software (with a few exceptions at MDwise and MHS for its behavioral health cases reviewed by Cenpatico where the name appeared but not the suffix).
13. The OMPP has a requirement in its scope of work that signatures are required on denial letters. The MCEs reported that this is not an NCQA requirement. Anthem does affix its Medical Director's signature on its denial letters related to medical necessity (in a few cases it was another doctor), whereas MHS and MDwise just sign the letter from "Medical Management". For administrative denials, a nurse or administrative team member's signature was often found.
14. Also in the 2009 study, the EQR Review Team cited the preponderance of cases where Anthem and MHS denied inpatient stays for less than 72 hours but would offer observation payment in lieu of the inpatient DRG case payment. This was still found to be true for these MCEs and for MDwise as well in this year's review, but in each of the cases reviewed where this occurred the clinical guideline was cited referencing the reason why an inpatient level of care was not medically necessary.
15. When the inpatient/observation scenario occurs, Anthem offers observation payment status in its inpatient denial letter. MHS offers observation payment status upon request only.
16. There is still terminology/process differences used in specific scenarios across the MCEs. With respect to terminology differences, using the inpatient denied/observation approved scenario cited above:
 - a. Anthem will assign a denied status to the inpatient authorization. The observation authorization may be created (although not required) and, if so, is deemed approved.
 - b. MHS will assign a denied status to the inpatient authorization and the observation authorization is deemed approved.
 - c. MDwise will assign a modified status to the inpatient authorization and the observation status is deemed approved.
17. With respect to differences in processes:
 - a. The authorizations reviewed by MDwise delivery systems that use the CMCS platform cannot be modified. If the decision is to allow for a modified approval, the original authorization is broken into two authorizations—one which has an approved status and one which has a denied status.
 - b. Anthem cited NCQA guidance in which any authorization that contains a primary diagnosis must be considered for medical necessity, even if the documentation is lacking.

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This process change occurred in April 2014. Therefore, many Anthem denials that had previously been administrative denials with lack of documentation as the reason are now classified as clinical denials with not medically necessary as the reason. This means that nurses and physicians are now reviewing these authorizations where before physicians were not reviewing them. MHS and MDwise did not cite this as a required process.

- c. When there are multiple auth requests (lines) on a single request, since Anthem considers each of these separately, each line will have its own denial letter sent out (if the request was denied).
18. For approved authorizations, Anthem and MHS do not send out written notifications of the decision, but they do make verbal contact with the provider. MDwise makes both written notification to the member and provider and verbal notification to the provider.
 19. MDwise is unique among the MCEs in that many authorizations are denied for being out of network where this term means that the provider is outside of the specific delivery system that the member is enrolled with.

Recommendations to the MCEs and the OMPP Related to Service Authorization Processes

Since our review of this MCE function in CY 2009, the EQR Review Team observed considerable improvement in the processes outlined for authorization reviews and the manner in which these processes were used day-to-day through our review in the onsite study sample. Additionally, two of the three MCEs (MHS and MDwise) have upgraded their information systems for tracking authorization requests and reviews. The third MCE (Anthem) has a robust system as well, although it is not as integrated as the other MCEs' platforms. A system upgrade at Anthem is scheduled.

With this in mind, the following recommendations are offered to the MCEs and the OMPP in effort to instill continuous quality improvement in this functional area.

Recommendations to Specific MCEs

1. Anthem should consider finding a way to capture the date of receipt and date of determination for the authorizations reviewed by its delegated entity, AIM, who is responsible for reviewing selected radiology requests. All other information on these requests is sufficiently stored in Anthem's authorization system. If this is not possible, then oversight through a standard report for Anthem to track turnaround time for these authorization requests is advised.
2. MHS should ensure that its Centene partner, Cenpatico, has denial letters on file for all behavioral health-related authorization denials.
3. MDwise should ensure that its delegated delivery system, Eskenazi, has denial letters on file for all of its authorization denials.
4. Recognizing that each MCE may have certain requirements for claims processing, since MHS and MDwise require an authorization number for inpatient maternity stays even though prior authorization is not required, both MCEs should develop a method to tag these records so that they are not counted in the true counts of authorization requests that are reported to the OMPP.
5. Likewise, when all the MCEs deny an inpatient hospital authorization based on medical necessity but then auto-generate an observation payment authorization related to this request, these auto-

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generated authorizations should be separately tagged since they are not truly the original authorization requests from the provider.

6. MDwise does not require its delivery systems to have a formal training of its authorization review staff which would be subject to passing a competency test at the end of the training. The delivery systems are supposed to conduct inter-rater reliability testing annually with their staff, but this is not memorialized in policy (it is in the Medical Management Training Manual). MDwise should consider instituting greater assurances of nurse training on the use of guidelines on the front end of the process as well as through the IRR process on the back end at the delivery system level.
7. MHS should require that its Cenpatico partners conduct an inter-rater reliability process with its authorization review staff and ensure that its subcontracted psychiatrists at BHM also go through a periodic IRR process.

Recommendations to the OMPP

1. Since the OMPP requires its MCEs to be NCQA-certified, the OMPP should clarify its guidance on items that appear to be in conflict with NCQA requirements, specifically as it relates to:
 - a. Whether notification letters are required to be sent for approvals (this is not an NCQA requirement)
 - b. Whether specific signatures are required on denial letters for medical necessity as opposed to just signing the letter from "Medical Management" (specific signatures are not required by NCQA, although the EQRO agrees that this may be helpful to instill better provider communications and foster more peer-to-peer contact)
2. The use of, and application of, terminology can be confusing in some instances. In particular, when and how the use of the term "modified" or "modified approval" is being applied. The use of the term "cancelled" also was used differently (or not at all) across the MCEs. The OMPP may want to consider releasing working definitions for the use of these terms in the HHW and HIP programs, at least with respect to data reporting. To the extent that NCQA already provides guidance on these definitions, the OMPP should consider using NCQA definitions for consistency. This would be especially helpful in better understanding the frequent inpatient denials that are approved for observation and how these specific requests are handled and tracked in each MCE's authorization system.
3. As discussed in our findings of the validation of performance measures in Section III, B&A was not able to validate the counts of authorization requests in CY 2014 that were submitted to us by the MCEs for this study with the actual results submitted by the MCEs in quarterly reports to the OMPP. Presumably, the information for both submissions came from the same data source at the MCE. Compounding this are the differences in definitions related to approved/denied, levels of appeals, and the counting of actual requests (e.g., if therapy sessions over two months count as one authorization or potentially four separate authorizations in two-week increments). To that end, if the OMPP is going to continue requiring a quarterly report on MCE service authorization requests, it may want to consider more specific definitions around:
 - a. Specific service categories (e.g., mapping CPT/HCPCS codes to categories)
 - b. Counting header-level vs. detail-level requests
 - c. How to capture continuous, ongoing requests (e.g., therapies, enteral nutrition, extended inpatient hospital stays)

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- d. Terminology for classifying authorization type (pre-service, concurrent, retrospective)
 - e. Terminology for classifying authorization determination (approved, denied, modified)
4. The MCEs had mentioned that there is interest in conducting provider education around the expectations and requirements for submitting authorization requests in the HHW and HIP programs. This is in addition to potential updates to the universal authorization form currently in use. B&A supports this proposal and recommends that the OMPP participate in facilitating this outreach so that the provider base recognizes that this is a program-wide initiative and not just MCE-specific requirements.

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SECTION VI: FOCUS STUDY ON POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS

Hospital readmission rates are often used as a measure to assess the quality of care delivered to patients in the inpatient hospital setting and are often publicly reported as a means to encourage hospitals and their community health care partners to work closer together both prior to admission to the hospital and at the time of discharge.

There are a variety of ways in which readmissions are currently being defined and used. The Centers for Medicare and Medicaid (CMS) has defined its own readmission rate measure that is used as part of payment policy in its inpatient prospective payment system (IPPS) in the Medicare program. The National Committee for Quality Assurance (NCQA) also has an All Cause Readmission measure in its portfolio of the Healthcare Effectiveness Data and Information Set (HEDIS) to benchmark health plans against each other and national averages.

Burns & Associates, Inc. (B&A) has been working with 3M in the application of its Core Grouping Software which contains a suite of modules aimed at identifying potentially preventable events (PPEs). Among these modules is an application to identify what 3M defines as potentially preventable readmissions (PPRs). As part of this year's External Quality Review (EQR), Burns & Associates (B&A) utilized this software to assist the Office of Medicaid Policy and Planning (OMPP) and its managed care entities (MCEs) serving Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) members in measuring the rate of PPRs within these populations for inpatient stays that occurred in Calendar Years (CYs) 2013 and 2014.

Background on Potentially Preventable Readmissions (PPRs)

It is important to note upfront the distinction between all cause readmission rates and PPR rates. The PPR rate is more nuanced than many all cause readmission rates in the field because the 3M software examines the clinical relationship between the initial hospital stay and the subsequent readmission. For example, a patient may have been hospitalized for knee replacement surgery, was discharged, then subsequently readmitted three weeks later for a COPD-related condition. The COPD condition was not exacerbated by the knee replacement surgery. If, on the other hand, the initial stay was for pneumonia, then the subsequent stay for COPD may be clinically related to the pneumonia. In the calculation of an all cause readmission rate (for example, examining stays that spanned less than 30 days apart), both of these scenarios would be counted in an all cause readmission rate for a hospital or a health plan. In the calculation of a PPR rate, only the latter scenario would be counted in the PPR rate.

One way to think about PPRs is that they are a subset of all readmissions. Specifically, PPRs as defined by 3M:

- Are unplanned (e.g., a planned angioplasty after an initial admission for angina would not be counted as a PPR);
- Are clinically related to the initial admission (such as the example cited above); and
- Are deemed to be preventable (e.g., an alteration of consciousness after an admission for a brain tumor is not deemed as preventable)

The basis for making the decision on whether a readmission is a PPR or not utilizes the category assigned to each case in the APR-DRG software and the clinical judgement that is programmed into 3M's PPR software. The APR-DRG (All Payer Refined Diagnosis Related Group) is 3M's proprietary 3M grouper that contains categories intended for all payers—Medicare, Medicaid and commercial. Unlike the Medicare Multiple Severity DRG grouper (MS-DRG), the APR-DRG has many more discrete categories

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for newborns and maternity cases, so it is well suited for use by a Medicaid program. Indiana's OMPP is migrating to using the APR-DRG effective October 1, 2015.

Patients who readmit to the hospital and the APR-DRG assignment is the same as their first admission would, by definition, be deemed PPRs since the diagnosis is the same in the readmission as the first. On an annual basis, 3M's team of clinicians also review the association between different APR-DRGs to make a decision if the two APR-DRGs are clinically related and, if a readmission were to occur, then the second stay APR-DRG *could* have been prevented. Since there are 312 unique APR-DRGs, there are over 100,000 possible combinations of two DRGs to consider. In their most recent review, the 3M clinicians determined that approximately 22.5 percent of all combinations are both clinically related and potentially preventable. The decision on PPR assignment is made annually and includes the review of the latest literature, feedback from clinical experts, feedback from payers who are using the software, and a two-tier peer review process.

It is also important to note the use of *potentially* preventable. The assignment of a readmission to potentially preventable status is based on the information presented to the PPR software, namely, information that is regularly stored on a claim. Data that is considered on a claim includes the age and gender of the patient, all of the diagnoses codes reported on the claim, the discharge status of the original admission and, if the user specifies it, information recorded in the Present on Admission field on the claim. Medical record information could also inform the status of a PPR, but since the software is limited to use only information presented on a standard claim, 3M cautions that their matching only suggests situations where the two cases are potentially preventable. In the end, the PPR attempts to identify problems in the quality of care in the initial hospitalization and discharge planning or follow-up.

To this end, it is important to remember when reviewing the data that results should be reviewed in higher levels of categorization, for example, the overall PPR rate for a hospital, a PPR rate for a diagnostic category, or a region-wide PPR rate. This is to understand trends in PPR rates over time. An examination of individual patient cases where the readmission was tagged as a PPR may be helpful to use as case studies, but the higher level trends can identify opportunities for improvement in hospital discharge planning or service delivery while the individual is an inpatient.

Within the 3M software, there are other indicators that can assist the end user to better understand the root cause of why a readmission was tagged as a PPR. For example, each PPR is tagged with a clinical reason code which indicates what the clinical reason that the software tagged the case as a PPR. Some examples of clinical reasons will be shown in the findings section that appears later in this section. Additionally, since the software is scanning all diagnosis codes on a claim, it also considers comorbidities, particularly mental health conditions that are reported on acute care stays. The 3M PPR software provides a major mental health indicator flag (yes/no) on each case. Not every case that has mental health conditions reported is assigned a yes on this flag. In fact, even some cases mapped to psychiatric DRGs are not given the major mental health indicator flag. Conversely, some acute care cases are given this flag if the diagnoses reported merit the assignment (e.g., a diagnosis of schizophrenia that is also reported on a Crohn's disease case).

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Methodology for Defining the Study Sample

An extract of encounters and enrollment information was provided to B&A by OMPP's data warehouse vendor, Optum, in July 2015 for information received from the MCEs through June 2015 to use as the basis for analytics in this study. For this EQR, B&A considered all inpatient stays that were reported by the three MCEs as encounters to OMPP with dates of discharge in CY 2013 and CY 2014 (n= 173,075 cases). Users of the software can limit the dataset for their own needs by deciding what cases are submitted to the software to obtain a PPR assignment. The software also has a preferences screen where users can decide on specific preferences they would like the software to consider as it runs the algorithm. Lastly, there is logic built within the software that runs behind the scenes in order to make the PPR determination.

B&A has been utilizing the PPR software for another State Medicaid Agency (SMA) and we have studied how other Medicaid programs have been using the PPR software. The methodology described below has been used by other SMAs as well to apply the logic from the PPR software. If the OMPP chose to calculate PPR rates on a regular basis, the State has the option to make adjustments to a number of the steps in this methodology.

Step 1: Assign APR-DRG and pre-screen the data to identify excluded admissions and incomplete data

By design, B&A excluded all newborn and maternity cases as well as all transplant cases. Although many of these cases would be excluded through logic built into the software, as an initial step all cases reported in these DRGs were removed and not submitted to the PPR software. Normal newborns and maternity cases were excluded because of their high volume in any Medicaid dataset and their very low PPR rate. By including these cases, a health plan or hospital overall PPR rate will be weighted down. To control for variances in PPR rates due solely to different mother/baby DRG volume across hospitals/health plans, all of these cases were removed.

On the other end, all neonatal intensive care (NICU) cases were removed due to the unpredictability to determine whether any readmissions within this set of patients would be preventable or not without having more information on the case (such as the medical record). For the same reason, transplant cases were removed. In total, there were 119,759 cases removed because they were assigned to the DRGs named above.

After this pre-screening of the dataset, B&A checked to ensure that all remaining cases contained valid data in the fields required by the software to run the program, such as missing patient IDs or cases that could not group to an APR-DRG due to invalid diagnosis codes. In all, 3,897 cases were removed for these reasons. Finally, 522 duplicate claims were removed.

The result of these steps reduced the original two-year dataset of 173,075 cases down to 48,897 cases.

Step 2: Remove cases determined by the PPR software to be excluded from calculations

A number of other tests are run by the software on the 48,897 cases to remove some from consideration for the PPR test. Specific criteria checked to remove cases from consideration include:

- Discharges where the patient left against medical advice
- Admissions to a non-acute facility
- Admission to an acute care hospital for rehabilitation or convalescence
- Same day transfers to an acute care facility for non-acute care (e.g., hospice)
- Selected malignancy cases

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- Selected cases with diagnoses with radiotherapy and chemotherapy codes

After this process was completed, an additional 115 cases were removed from the study.

Step 3: Identify readmission chains and reclassify those readmissions and initial readmissions that are not clinically related

In the preferences screen, the user specifies the time period within two inpatient cases to test for readmission. For this study, a 30-day window was selected. Therefore, all cases are placed in date order from earliest to latest by date of discharge. The software computes those cases where the inpatient admission date was 30 days or less from a previous discharge date. When cases are found that meet this criteria, a readmission *chain* is built. Readmission chains continue to be built upon until the date span is “broken”.

- *Example:* If there was a third case for the patient that was an admission within 30 days of the second case's discharge date, then this would be also be added to the same readmission chain.
- *Example:* If there was a third case for the patient but it occurred 40 days after the second case's discharge date, then the case would not be added to the original chain. It may start a new chain or be considered an Only Admission.

It should be noted that readmission chains are built around the patient, not the hospital. If a patient had an initial admission at Hospital A and then readmitted 20 days after their discharge from Hospital A but was admitted to Hospital B, a readmission chain is still created. The hospital with the initial admission in the chain “owns” the chain and this information is used to calculate its PPR rate.

Provisionally, each case in the dataset is assigned to one of the following categories:

- Initial Admission indicates the case that starts a readmission chain
- Readmission indicates any subsequent case in a readmission chain after the Initial Admission
- Only Admission indicates those cases that stand alone with no readmission within 30 days
- Transfer Admission indicates cases where the hospital received the case from another hospital

The PPR software assesses each case in a readmission chain to determine if the readmission is clinically related to the Initial Admission. Once this is complete, the total readmissions originally identified are subdivided into two groups—Clinically Related Chains and Disregarded Readmission Chains (meaning that they won't count in the PPR calculations).

Therefore, some cases get reassigned from their provision flag as follows:

- Readmissions that are deemed clinically related to the prior admission are renamed Potentially Preventable Readmissions
- Readmissions that are not deemed clinically related to the prior admission are effectively “broken” from the chain. For the purposes of PPR assignment, these are reassigned either as Only Admissions (if there was not a third admission to consider for the patient) or Initial Admission (if there is a third admission and case #2 substitutes as the Initial Admission from case #1).
- When readmission chains are broken up, the case assigned as the Initial Admission is reclassified as an Only Admission.
- Readmissions can also be reassigned as Transfer Admissions in this process.

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Step 4: Compute the hospital's or MCE's PPR Rate

The final PPR rate is simply the formula of:
$$\frac{\text{Total Number of Clinically Related Chains}}{\text{Total (Initial Admissions + Only Admissions)}}$$

Step 5: Apply risk adjustment logic to compute an Expected PPR Rate

The value computed in Step 4 above can also be called the Actual PPR Rate for a hospital or an MCE. It is strongly suggested, however, that each entity's Actual PPR rate be risk adjusted to account for variations in the mix of patients that the hospital or MCE has when compared to a norm (e.g., the statewide average).

B&A computed an Expected PPR Rate for each hospital (which can then be rolled up to the MCE level or a regional level) by using two sets of criteria:

1. Whether the patient is pediatric (defined as 18 years of age or younger) or adult; and
2. Whether the patient has the major mental health indicator assigned to his/her claims

Therefore, four risk adjustment groups were defined. The PPR rates were first computed for each DRG within the statewide population. Then, a PPR rate for each DRG was computed within each risk group. When all DRGs are combined, the overall Actual PPR rate for the specific risk group was compared to the statewide average Actual PPR rate. The variance of the risk group's Actual PPR Rate compared to the statewide PPR rate is the risk adjustment factor.

Because of the large number of exclusions that were discussed previously, the sample of cases within a calendar year decreased significantly. Therefore, for this study, the HHW and HIP claims experience was combined to compute the average statewide PPR rate. But, as is seen below, the HIP population only contributes to two of the four risk groups since there are only adult members in HIP.

B&A computed all Actual PPR rates first for the cases in CY 2013 in isolation and then all of the CY 2014 cases in isolation. This was to measure the change in any hospital's PPR rate from one year to the next. Therefore, there are also different risk adjustment factors for CY 2013 and CY 2014. These are shown in Exhibit VI.1 below.

Exhibit VI.1
Risk Adjustment Factors Computed in CY 2013 and CY 2014

	Group 1 Major MH Indicator- Adult	Group 2 Major MH Indicator- Pediatric	Group 3 No MH Indicator- Adult	Group 4 No MH Indicator- Pediatric
CY 2013	1.9308	1.7537	0.9817	0.8866
CY 2014	1.9083	1.5540	0.9115	0.9104

For example, this exhibit tells us that in CY 2013, the individuals in Group 1 (adults with the major mental health indicator) were 1.93 more times likely to readmit than all HHW and HIP members in the statewide average. This risk factor did not change much for Group 1 from CY 2013 to CY 2014. Alternatively, the adults without the major mental health indicator were 0.98 times as likely (or less

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likely) to readmit than all HHW and HIP members in the statewide average. The pediatric groups (Group 2 and 4) follow similar trends to their related adult risk groups.

When computing the risk adjustment factors, low volume DRGs are not factored into the analysis. Under each of the 312 DRGs there are four subgroups based on a severity of illness (SOI) level. Even in the case of the statewide database, some of these DRG/SOI combinations have very low sample size. Although it will not contribute significantly to an overall PPR rate (due to the low volume these DRG/SOIs represent), it is appropriate to exclude low volume DRG/SOIs from the risk adjustment factor calculations. B&A decided to exclude any DRG/SOI where the statewide volume of Initial Admissions in a given DRG/SOI was ten cases or less. These cases stay in for calculation of Actual PPR rates, but not when the Expected (risk adjusted) PPR rate is computed.

Although 596 DRG/SOI combinations are excluded from risk adjustment in CY 2014 when applying this logic, the cases in these DRG/SOIs represent only 9.8 percent of the Initial Admissions and 12.6 percent of the Clinically Related Chains in the CY 2014 dataset.

The complete risk adjustment process can be summarized in the steps below.

1. Identify the cases that will be considered in the risk adjustment factor calculation by excluding cases in DRG/SOI where there are 10 or less cases statewide.
2. Tag each DRG/SOI as "in" or "out" for risk adjustment purposes.
3. For those DRG/SOIs that are "in", compute the statewide Actual PPR rate for each DRG/SOI.
4. Subdivide the cases in Step 3 into the four risk groups.
5. Multiply the number of At Risk Admissions for a risk group within a DRG/SOI by the statewide PPR rate for the SOI. These are called Expected Values.
6. Sum the Expected Values computed for all DRG/SOIs separately for Risk Groups 1, 2, 3 and 4.
7. Sum the Clinically Related Chains for Risk Groups 1, 2, 3 and 4 separately.
8. For each Risk Group individually, divide the Clinically Related Chains by the sum of the Expected Values. This is the Risk Adjustment Factor for the Risk Group.
9. For a specific hospital, repeat Steps 4, 5 and 6 from above.
10. For a Risk Group within a hospital, multiply the Expected Values (Step 6) by the Risk Adjustment Factor (Step 8). The risk adjustment factors were shown in Exhibit VI.1.
11. Sum the values derived in Step 10 from all four risk groups.
12. The Expected PPR rate for a hospital is the value in Step 11 divided by the Total (Initial Admissions + Only Admissions).

Step 6: Compute Actual-to-Expected Ratios

Because of changes in a hospital's mix of cases, population served and external factors such as changes in statewide rates, B&A recommends that OMPP and the MCEs not focus as much on a hospital's or MCE's Actual PPR rate as much its Actual-to-Expected Ratio. This ratio is simply
$$\frac{\text{Actual PPR Rate}}{\text{Expected PPR Rate}}$$

An Actual-to-Expected Ratio of 1.0 means that the hospital or MCE had PPRs as expected against the statewide benchmark that year. A ratio that is less than 1.0 means that the hospital/MCE performed better than expected when compared to the statewide average on expected readmissions. A ratio that is greater than 1.0 means that the hospital/MCE performed worse than expected.

It is important to note that the statewide PPR rates and risk adjustment factors were calculated separately for CY 2013 and CY 2014. This means that the Actual-to-Expected Ratios for a hospital or MCE take into account the inpatient utilization experience for each year in isolation.

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The Actual PPR rates computed were the same for CYs 2013 and 2014 at 5.4 percent. Approximately 1,150 readmission chains were found that appeared to have readmissions that were clinically related to the patient's original discharge. This contrasts with an all cause readmission rate of approximately 9.1 percent each year that factors in all readmission chains, including those not deemed to be clinically related according to the 3M software.

Exhibit VL2

Comparing All Cause and Potentially Preventable Readmission Rates, CY 2013 and 2014

	A	B	C	D	E
Calendar Year	Initial Admissions (includes Only Admissions)	Total Number of Readmission Chains	Total Number of Clinically Related Chains	All Cause Readmission Rate (Col B / Col A)	Potentially Preventable Readmission Rate (Col C / Col A)
2013	21,242	1,922	1,143	9.05%	5.38%
2014	21,406	1,963	1,154	9.17%	5.39%

When stratified by age group, teens/pre-teens and older adults have slightly higher PPR rates than other age groups and the statewide.

Exhibit VL3

Comparing All Cause and Potentially Preventable Readmission Rates, CY 2013 and 2014 By Age Group

Age Group	Initial Admissions (includes Only Admissions)	Total Number of Readmission Chains	Total Number of Clinically Related Chains	All Cause Readmission Rate	Potentially Preventable Readmission Rate
CY 2013					
Total	21,242	1,922	1,143	9.05%	5.38%
Age 0	2,656	226	101	8.51%	3.80%
Age 1 - 9	3,894	303	176	7.78%	4.52%
Age 10 - 19	4,624	420	310	9.08%	6.70%
Age 20 - 39	7,044	632	352	8.97%	5.00%
Age 40+	3,024	341	204	11.28%	6.75%
CY 2014					
Total	21,406	1,963	1,154	9.17%	5.39%
Age 0	2,154	152	70	7.06%	3.25%
Age 1 - 9	3,190	204	123	6.39%	3.86%
Age 10 - 19	4,374	412	308	9.42%	7.04%
Age 20 - 39	7,246	632	342	8.72%	4.72%
Age 40+	4,442	563	311	12.67%	7.00%

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PPR rates do vary by major diagnostic category. Adult Circulatory and Gastroenterology cases as well as Mental Health cases (adult and pediatric combined) had higher PPR rates than the statewide average PPR rates. From CY 2013 to CY 2014, these adult DRG groups saw slight reduction in the PPR rate; for the Mental Health domain, the PPR rate had a slight increase.

Exhibit VI.4
Comparing All Cause and Potentially Preventable Readmission Rates, CY 2013 and 2014
By Major Diagnostic Category

Diagnostic Category	Initial Admissions (includes Only Admissions)	Total Number of Readmission Chains	Total Number of Clinically Related Chains	All Cause Readmission Rate	Potentially Preventable Readmission Rate
CY 2013					
All	21,242	1,922	1,143	9.05%	5.38%
Adult Circulatory	671	91	58	13.56%	8.64%
Adult Gastroenterology	1,648	204	138	12.38%	8.37%
Adult Respiratory	1,868	143	81	7.66%	4.34%
Adult All Other	4,879	563	280	11.48%	5.76%
Gynecology	2,863	133	25	4.65%	0.87%
Pediatric Respiratory	1,711	67	42	3.92%	2.45%
Pediatric All Other	3,302	326	157	9.87%	4.75%
Mental Health	4,300	395	362	9.19%	8.42%

CY 2014					
All	21,406	1,963	1,154	9.17%	5.39%
Adult Circulatory	809	92	50	11.37%	6.18%
Adult Gastroenterology	2,004	230	148	11.48%	7.39%
Adult Respiratory	1,581	158	88	9.99%	5.57%
Adult All Other	5,444	582	269	10.66%	4.94%
Gynecology	2,523	118	20	4.68%	0.79%
Pediatric Respiratory	1,452	48	26	3.31%	1.79%
Pediatric All Other	2,594	232	102	8.87%	3.93%
Mental Health	4,999	503	451	10.06%	9.02%

The clinical reasons why specific cases within a readmission chain were tagged as PPRs by the software was also examined. Exhibit VI.5 on the next page displays the various reasons that may be provided as rationale for identifying the cases in a chain as clinically related. In both CY 2013 and CY 2014, about one-quarter of all cases were deemed clinically related because the readmission was for the same acute care reason as the original admission (reason code 1). Another quarter of cases were deemed clinically related because the subsequent admission was related to—but not the same as—the acute care condition from the original admission (reason code 3). Approximately one-third of cases in both years were deemed clinically related because the readmission was for a mental health or substance abuse condition and so was the original admission (reason code 6C).

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Exhibit VL5

Clinical Reason Assigned to Claims in Clinically Related Chains in Calendar Years 2013 and 2014

		CY 2013		CY 2014	
		Claims	% of Claims	Claims	% of Claims
Total Claims in Clinically Related Chains in the Year		1,340	100.0%	1,533	100.0%
Clinical Relationship Code and Description					
1	Medical readmission for a continuation or recurrence of the reason for the initial admission, or for a closely related condition.	344	25.7%	344	22.4%
2A	Ambulatory care sensitive conditions as designated by ARHQ.	35	2.6%	50	3.3%
2B	All other readmissions for a chronic problem that may be related to care either during or after the initial admission.	83	6.2%	103	6.7%
3	Medical readmission for an acute medical condition or complication that may be related to or may have resulted from care during the initial admission or in the post-discharge period after the initial admission.	360	26.9%	349	22.8%
4	Readmission for a surgical procedure to address a continuation or a recurrence of the problem causing the initial admission.	17	1.3%	16	1.0%
5	Readmission for surgical procedure to address a complication that may be related to or may have resulted from care during the initial admission.	23	1.7%	32	2.1%
6A	Readmission for mental health reasons following an initial admission for a non-mental health, non-substance abuse reason.	53	4.0%	62	4.0%
6B	Readmission for a substance abuse diagnosis reason following an initial admission for a non-mental health, non-substance abuse reason.	8	0.6%	17	1.1%
6C	Mental health or substance abuse readmission following an initial admission for a substance abuse or mental health diagnosis.	417	31.1%	560	36.5%

Using the risk adjustment logic described in the methodology section described above, B&A computed Actual PPR rates and Expected PPR rates for CY 2013 and CY 2014 separately under multiple levels of aggregation:

- Statewide rates (average will be = 1.000)
- MCE rates, using statewide data
- Regional rates, using statewide data
- MCE rates, using regional data
- Rates by hospital, using statewide data
- Rates by hospital, using MCE-specific data

The exclusion of maternity and neonate claims significantly reduced the total inpatient stays in the study in each year. Because the HIP population in CY 2013 and 2014 was just 10 percent of the HHW population, it was not possible to compute HIP-specific PPR rates due to low sample size. With the introduction of HIP 2.0 in CY 2015, this will not be an issue going forward. For this study, however, all Actual-to-Expected ratios shown reflect the combined inpatient claims experience of the HHW and HIP populations (excluding maternity, newborns, and transplants).

Each MCE has been provided with files specific to their populations to show the impact of PPR rates at the hospital level, region level, and DRG level. Results of the Actual-to-Expected ratios for the other cohorts of populations appear below.

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Exhibit VI.6 shows how each of the cohort populations compares to the statewide average Actual-to-Expected ratio of 1.0 in CY 2014. On the top line, it was found that MHS exceeded expectations after risk adjustment with a ratio of 0.969. Both Anthem and MDwise performed slightly worse than expected after risk adjustment with ratios of 1.011 and 1.012, respectively. When B&A has analyzed these metrics in the past, we generally define “as expected” as a ratio between 0.980 and 1.020. Using this working definition, both Anthem and MDwise performed “as expected”.

When examining the Actual-to-Expected ratios using statewide data but at the regional level (the column next to the region names), there was wide variation found across the eight regions. Four regions (Northeast, Central, Southwest and Southeast) exceeded the expectations after risk adjustment of their PPR rates since all have ratios below 1.0. The Southwest Region far exceeded expectations with the lowest ratio of 0.845. Alternatively, the other four regions (Northwest, North Central, West Central and East Central) did not meet expectations since their ratios were all above 1.0. The West Central region had the worst Actual-to-Expected ratio among regions of 1.285; however, it should be noted that this region had the fewest admissions in the study (5.0%) of any region examined.

When the results by region were examined in more detail at the MCE level, in general it was found that if a region had an Actual-to-Expected (A-to-E) ratio that was above 1.0 statewide, then this was also true for each MCE. Likewise, regions with Actual-to-Expected ratios below 1.0 statewide had similar findings at the MCE level. The exceptions to this rule are as follows:

- Northwest Region: Statewide A-to-E ratio of 1.048, but Anthem’s ratio specifically was 0.855
- Northeast Region: Statewide A-to-E ratio of 0.935, but MDwise’s ratio specifically was 1.173
- Central Region: Statewide A-to-E ratio of 0.965, but Anthem’s ratio specifically was 1.041
- Southeast Region: Statewide A-to-E ratio of 0.981, but Anthem’s ratio specifically was 1.043

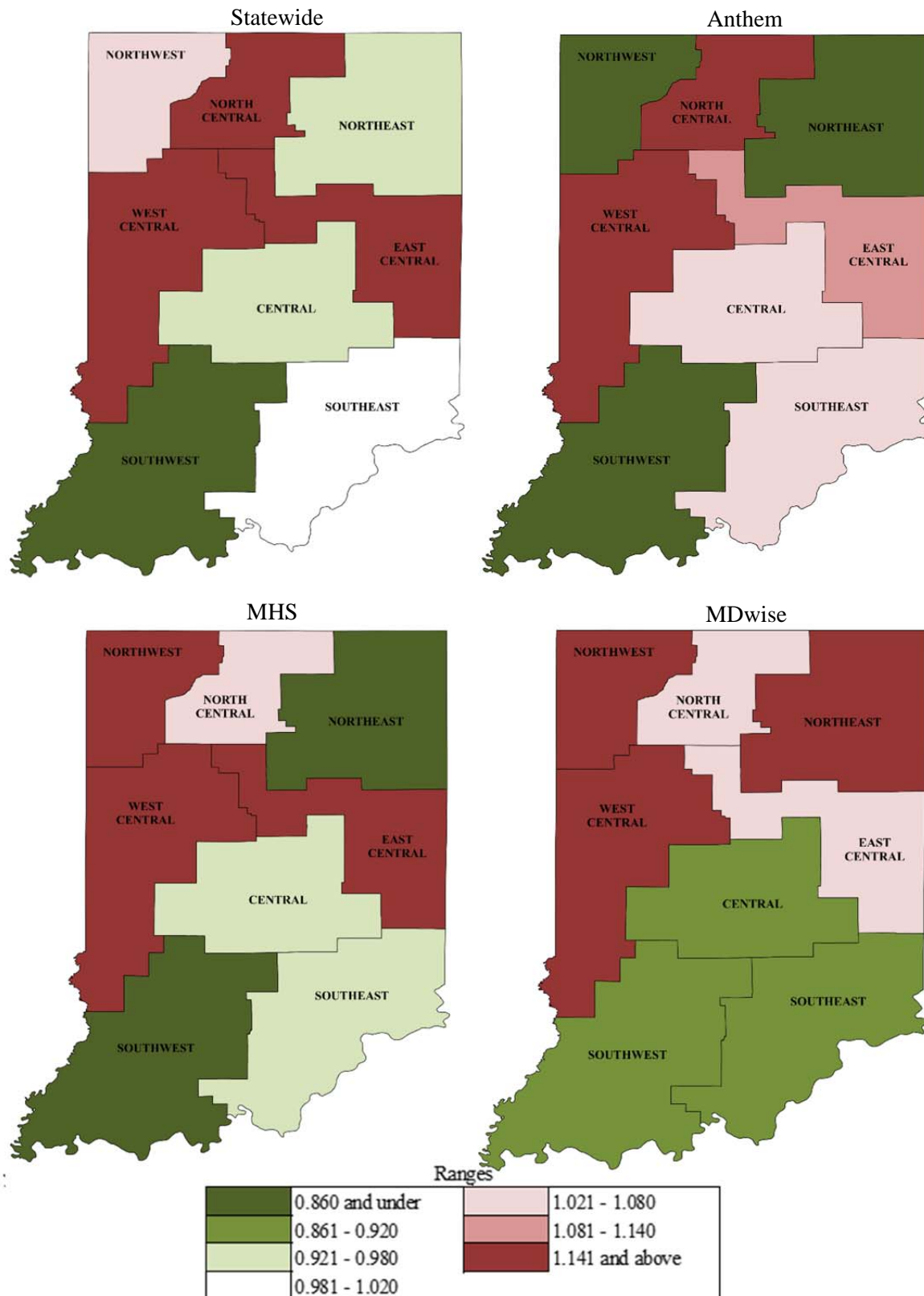
**Exhibit VI.6
Actual-to-Expected Ratios Related to PPRs in CY 2014, by Region**

			The values below by MCE are for HHW and HIP combined.		
	Region	HHW and HIP Combined	Anthem	MHS	MDwise
	Statewide	1.000	1.011	0.969	1.012
1	Northwest	1.048	0.855	1.195	1.215
2	North Central	1.173	1.460	1.021	1.056
3	Northeast	0.935	0.796	0.804	1.173
4	West Central	1.285	1.398	1.193	1.227
5	Central	0.965	1.041	0.938	0.898
6	East Central	1.160	1.102	1.360	1.076
7	Southwest	0.845	0.853	0.814	0.873
8	Southeast	0.981	1.043	0.925	0.912

All of the information shown in Exhibit VI.6 above is also shown graphically in the maps on the next page in Exhibit VI.7.

Exhibit VI.7

Actual-to-Expected PPR Ratios for Hoosier Healthwise and Healthy Indiana Plan Combined



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On the next page in Exhibit VI.8, scatter plots are shown where each circle on the scatter plot represents the value of an Actual-to-Expected ratio in CY 2014 for a specific hospital. To account for low volume, in the statewide plot (upper left), only those hospitals that had a minimum of 50 initial + only admissions (the denominator in the PPR calculation) are shown (n= 80 hospitals). At the MCE level (the remaining three boxes), only a subset of the hospitals that are shown in the statewide box are represented. Specifically, only those hospitals that had at least 50 admissions statewide but also had a minimum of 20 admissions with the MCE are plotted. This varied from 52 hospitals plotted on the MDwise box to 71 hospitals plotted on the Anthem box.

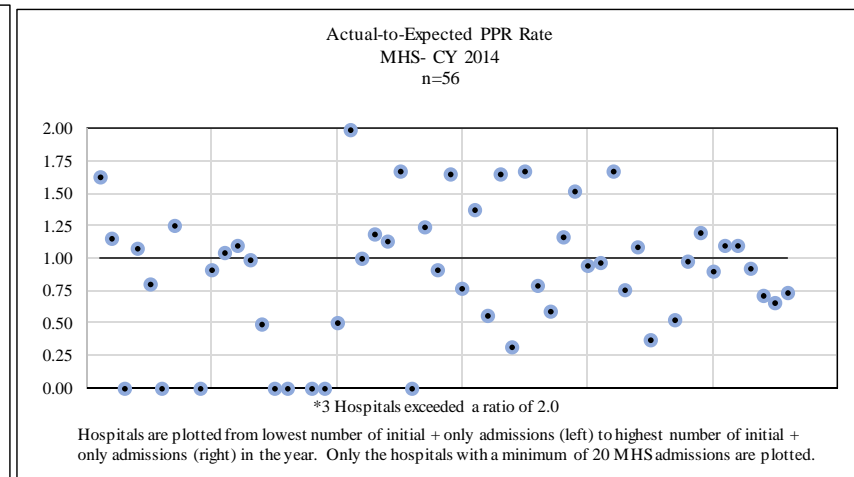
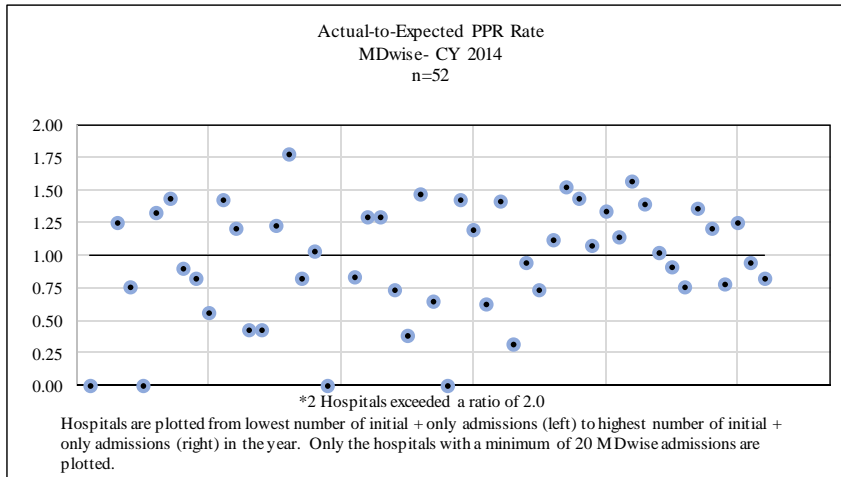
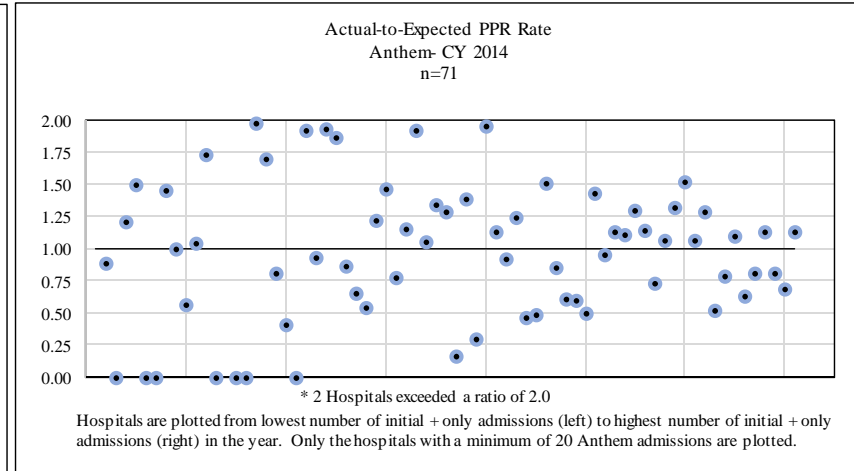
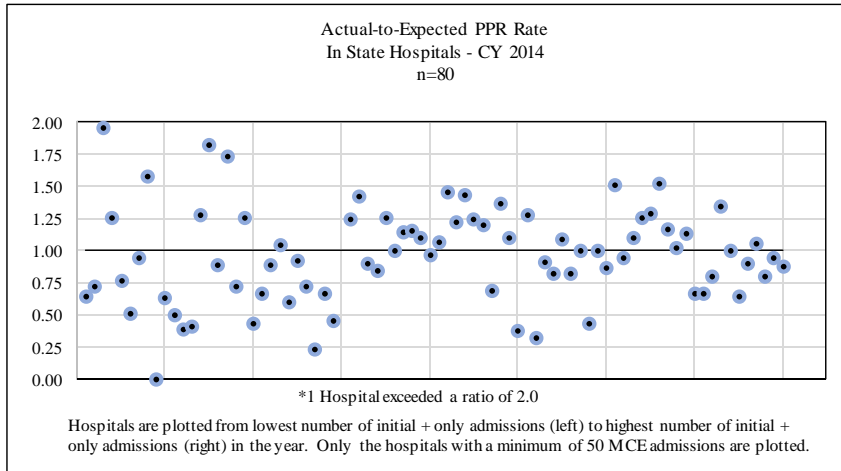
In each box, the plotting of the hospital values is displayed from left to right, with the lowest volume hospitals plotted on the left across to the highest volume hospital to the far right. The data was plotted this way because it is anticipated that the Actual-to-Expected ratios will be more volatile with lower-volume hospitals.

In general, the scatter plots do show that there is wide variation in the Actual-to-Expected ratios at the hospital level. There is some centering around the average ratio of 1.0 with the higher-volume hospitals, but even among these hospitals there is variation with some hospitals that have an Actual-to-Expected ratio above 1.0 while others are below 1.0. Hospitals with no clinically-related readmissions in the study have an Actual-to-Expected ratio of 0.0.

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Exhibit VI.8

Actual-to-Expected Values in CY 2014 Plotted at the Hospital Level, for High Volume Hospitals, Statewide and By MCE



The Statewide Average Actual-to-Expected Ratio is set at 1.0.

The Actual Ratio is the hospital's actual clinically related readmission chains divided by the hospital's total 'at risk' admissions (excludes some DRGs).

The Expected Ratio risk adjusts the number of clinically related readmission chains (the numerator) to account for how the hospital's profile of cases varies from the statewide average.

The information used to risk adjust a hospital's ratio includes the distribution by Severity of Illness within a DRG, the mix of adult and pediatric cases, and presence of a major MH comorbidity.

Hospitals with an Actual-to-Expected ratio less than 1.0 beat expectations given their case mix. Hospitals with a ratio above 1.0 did worse than expected given their case mix.

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Recommendations to the MCEs and the OMPP Related to PPRs

This is the first review of analyzing potentially preventable readmissions using the 3M PPR grouper in the HHW and HIP programs. In general, the trends at the statewide level and the MCE level were consistent over the two year period studied. B&A offers the following recommendations to explore where PPR trends differed among more discrete cohorts.

1. The Actual-to-Expected ratios were greater than 1.0 in four regions of the state, but less than 1.0 in the other four regions. The OMPP and the MCEs may want to explore if the reasons for the ratios being greater than 1.0 are consistent across these regions. For example, the root cause may be specific diagnostic conditions or specific hospitals.
2. At the major diagnostic level, Adult Circulatory, Adult Gastroenterology and Mental Health diagnoses had Actual PPR rates that were greater than other conditions and higher than the statewide average of 5.39 percent in CY 2014. With the addition of more adults entering the HIP 2.0 program in CY 2015, the MCEs should consider conducting a drill down into these results to assess opportunities for hospital-specific or regional-specific interventions that may curtail potentially preventable readmissions from continuing as the volume of adult inpatient admissions increases.
3. The Actual-to-Expected ratios varied significantly at the hospital level. This may partially be driven by volume (i.e., lower volume hospitals can have more volatile ratios year-to-year given the uncertain mix of services). The MCEs are encouraged to work specifically with higher-volume hospitals that have Actual-to-Expected ratios greater than 1.0 in both CY 2013 and CY 2014 to better understand the root cause of these results for each hospital.
4. Related to Recommendation #3 above, the OMPP may want to encourage the MCEs to develop quality-based initiatives specifically to high-volume hospitals that have Actual-to-Expected ratios greater than 1.0 not only in both CY 2013 and CY 2014 statewide, but also those that consistently have Actual-to-Expected ratios greater than 1.0 at the MCE level.

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SECTION VII: FOCUS STUDY ON POTENTIALLY PREVENTABLE EMERGENCY DEPARTMENT VISITS

In addition to the potentially preventable hospital readmissions (PPRs) discussed in the last section, the 3M Core Grouping Software also contains a module to assist in identifying potentially preventable emergency department visits (PPVs). As another aspect of this year's External Quality Review (EQR), Burns & Associates (B&A) utilized this software to assist the Office of Medicaid Policy and Planning (OMPP) and its managed care entities (MCEs) serving Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) members understand the rate of PPVs within these populations for emergency department (ED) visits that occurred in Calendar Year (CY) 2014.

Background on Potentially Preventable Emergency Department Visits (PPVs)

It is important to note upfront the distinction between what may be classified as a non-emergent ED visit and a PPV. Although many ED visits may meet the criteria under both definitions, the two terms are not necessarily synonymous.

PPVs are ED visits that may result from a lack of adequate access to care or ambulatory care coordination. PPVs are ambulatory sensitive conditions (e.g., asthma) in which adequate patient monitoring and follow-up (e.g., medication management) should be able to reduce or eliminate.

The basis upon which ED visits are assessed to determine if they are PPVs are 3M's Enhanced Ambulatory Patient Groupings (EAPGs). The EAPGs are the classification system used in 3M's proprietary outpatient payment classification system. It should be noted that there are 555 different EAPGs, but not all of them are considered for testing as a PPV. Since the EAPGs include everything from outpatient surgeries to lab and x-rays to chemotherapies to medical equipment, only those EAPGs which are related to ambulatory sensitive conditions are tested for PPVs. When submitted to the PPV software, these cases are given a flag that is called a medical visit indicator. For purposes of testing for PPV, a claim may have both a medical visit indicator and another significant procedure (e.g., an outpatient surgery code) on the claim. Only those cases that solely have the medical visit indicator with no other significant procedure are considered for the PPV test.

As was mentioned in Section VI pertaining to readmissions, the term used to flag cases in the software is *potentially* preventable visit. There may be other information not submitted on the claim (e.g., the medical record) that would disqualify the visit from being classified as preventable. The software is limited to standard information submitted on a claim, so the assessment made is that the case was potentially preventable given the information provided to make the determination.

Methodology for Defining the Study Sample

An extract of encounters and enrollment information was provided to B&A by OMPP's data warehouse vendor, Optum, in July 2015 for information received from the MCEs through June 2015 to use to conduct the analytics for this study. In general, the computation of PPV rates is more straightforward than what was described for potentially preventable readmissions (PPRs), but the number of risk groups that 3M suggests is greater. B&A followed one of 3M's suggested approaches for risk adjusting the PPV rates which we have also completed for another State Medicaid Agency (SMA). This is described in detail a bit later. If the OMPP chose to calculate PPV rates on a regular basis, the State has the option to make adjustments to a number of the steps in this methodology much like it does in the PPR methodology.

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For this EQR, B&A considered all outpatient stays that were reported by the three MCEs as encounters to OMPP with dates of service in CY 2014.

Step 1: Submit outpatient claims from the defined time period to the grouper and obtain the EAPG assignment.

All outpatient cases from CY 2014 were submitted to obtain the EAPG assignment. At the same time, the software also provides the medical visit indicator on the claim. It should be noted that each detail line on a claim is given an EAPG assignment, but the medical visit indicator considers all data lines reported on the claim. The EAPG assignment itself is driven off of the CPT or HCPCS code reported on the line. For those lines that do not contain a CPT or HCPCS and only a revenue code, the detail line was assigned EAPG 999 (unassigned).

Step 2: Identify potential cases as medical visits and which should be included in the PPV test.

Any claim which contains either CPT 99281-99285 or a 45x revenue code is initially considered for the PPV test. As stated previously, if a claim has both a medical visit indicator and a significant procedure, then these are excluded from the PPV test.

The total number of visits in CY 2014 that remained after this exclusion is 487,101—of these, 448,962 are for HHW members and 38,139 are for HIP members.

Step 3: The PPV software determines the PPV status of each visit on a case-by-case basis.

A flag of PPV = Yes or No is given to each visit uniquely.

Step 4: Compute the hospital's or MCE's PPV Rate

The final PPV rate is simply the formula of:

$$\frac{\text{Total Number of ED Visits Considered with a PPV Flag = Yes}}{\text{Total Number of ED Visits Considered (Yes and No PPV Flag)}}$$

Step 5: Apply risk adjustment logic to compute an Expected PPV Rate

The concept of risk adjusting the PPV rates is similar to what was described for risk adjusting the PPR rates in that the total population studied is segmented into discrete risk groups. A PPV rate is computed for each risk group. If a hospital has a population of patients that are in risk groups with higher PPV rates than the norm (e.g., the statewide average), then the hospital is given credit for this by adjusting its Expected PPV to be higher than the norm (statewide) rate.

Embedded in the PPV software is the classification of clinical risk groups (CRGs) as well. 3M's CRGs are a categorical clinical model which assigns each member of a population to a single mutually exclusive risk category. CRG assignment is based on age, gender, interaction of diseases, persistence and recurrence. To obtain a CRG assignment for each individual, claims experience from a baseline period are submitted. Since B&A used CY 2014 as the study period for PPVs, the baseline period of CY 2013 was used to obtain the CRG assignment for each individual. All institutional, professional and pharmacy claims are submitted from the historical period in order to obtain the person's CRG assignment. 3M focuses on all services before and after a health care event, but time limited acute care diseases are given less significance. Additionally, the recency of a person's experience (such as the latest six months) is given more weight in the assignment.

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The CRG software first assigns the patient to one of nine high-level statuses:

1. Healthy
2. Significant Acute
3. Single Minor Chronic
4. Multiple Minor Chronic
5. Single Dominant or Moderate Chronic
6. Multiple Significant Chronic
7. Three Dominant Chronic
8. Dominant, Metastatic and Complicated Malignancies
9. Catastrophic

Under these categories, patients are assigned to one of 272 base CRGs each of which can have up to six severity of illness levels. Because this can lead to as many as 1,080 risk groups, 3M has developed Aggregated Clinical Risk Groups (ACRGs) in classification groups of 416, 151 and 38. For this project, B&A is using the 38 ACRG classifications. In addition, 3M recommends that any patient that is classified in high level status 8 or 9 listed above should be excluded from PPV calculations for risk adjustment. This means, in essence, that the 38 ACRGs are further reduced to 27. B&A followed this suggestion, so 27 PPV rates were computed for each ACRG. These are the risk adjustment factors that are used in the calculation of the Expected PPV rate. This is similar to the four risk adjustment factors derived for computing the hospital's Expected PPR rate.

The complete risk adjustment process can be summarized in the steps below.

1. Obtain the CRG assignment for each individual in the statewide dataset.
2. Compute the PPV rate for each CRG category using the statewide study period ED experience of the individuals in the specific CRG.
3. For the hospital/MCE/region under study, identify just their patients and divide them into the 27 ACRG categories.
4. The cases for the hospital/MCE/region have already been determined as PPV or not. Therefore, within each of the 27 ACRGs for the hospital/MCE/region, the Actual PPV rate can be computed for each ACRG.
5. Multiply the total countable ED visits within the hospital/MCE/region's ACRG risk group by the statewide PPV rate for the ACRG. These are called Expected Values.
6. Sum the Expected Values computed for all 27 ACRGs.
7. Sum the Actual PPV visits for all 27 ACRGs.

Step 6: Compute Actual-to-Expected Ratios

The concept of an Actual-to-Expected Ratio here is similar to what was discussed for PPRs. The ratio used for PPVs is simply
$$\frac{\text{Sum of the Expected Values in all 27 ACRGs (Step 6 above)}}{\text{Sum of the Actual PPV Visits in all 27 ACRGs (Step 7 above)}}$$

An Actual-to-Expected Ratio of 1.0 means that the hospital or MCE had PPVs as expected against the statewide benchmark that year. A ratio that is less than 1.0 means that the hospital/MCE beat the statewide average on expected preventable ED visits. A ratio that is greater than 1.0 means that the hospital/MCE did worse than the statewide average.

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Findings from the Review of the Study Sample

The Actual PPV rates varied in CY 2014 between the HHW and HIP programs, with the HHW program at a PPV rate of 69.5 percent and the HIP program at a PPV rate of 81.1 percent. Whereas the total ED claims per 1,000 member months were similar between HHW and HIP, the PPV claims per 1,000 member months were different between the two programs. In HHW, the rate of PPV claims was 38 per 1,000 member months in CY 2014; in HIP, it was 51 per 1,000 member months.

Despite differences across the two programs, within each program the PPV rates at the MCE level are very consistent. The spread of the MCE PPV rates in HHW is two percentage points (from 68.3% to 70.2%); in HIP, the spread is one percent (from 80.3% to 81.4%).

Exhibit VII.1

Distribution of PPV and Non-PPV ED Visits in Calendar Year 2014, by Program and MCE

PPV Status	Hoosier Healthwise				Healthy Indiana Plan				
	Anthem	MHS	MDwise	All 3 MCEs	Anthem	MHS	MDwise	All 3 MCEs	
PPV	101,208	89,128	121,503	311,839	17,222	6,568	7,150	30,940	
Non-PPV	44,116	41,430	51,577	137,123	3,934	1,514	1,751	7,199	
Total	145,324	130,558	173,080	448,962	21,156	8,082	8,901	38,139	
Member Months of Enrollees:				8,146,372	Member Months of Enrollees:				603,305
ED Claims / 1,000 Member Months:				55	ED Claims / 1,000 Member Months:				63
PPV Claims / 1,000 Member Months:				38	PPV Claims / 1,000 Member Months:				51

PPV Status	Anthem	MHS	MDwise	All 3 MCEs	Anthem	MHS	MDwise	All 3 MCEs
PPV	69.6%	68.3%	70.2%	69.5%	81.4%	81.3%	80.3%	81.1%
Non-PPV	30.4%	31.7%	29.8%	30.5%	18.6%	18.7%	19.7%	18.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

PPV rates vary to some degree within specific age groups in HHW. Infants have the highest PPV rate among the age groups studied at 77.0 percent. The adults in HHW have the lowest rate at 66.4 percent. This rate, however, is much lower than their peers in HIP where the PPV rate is 81.1 percent.

Exhibit VII.2

Distribution of PPV and Non-PPV ED Visits in CY 2014, by Program and Age Group

PPV Status	Hoosier Healthwise					HIP Age 19 and Above
	Age < 1	Age 1 - 5	Age 6 - 18	Age 19 and Above	All Ages in HHW	
PPV	20,055	86,885	107,787	97,112	311,839	30,940
Non-PPV	5,999	36,054	46,018	49,052	137,123	7,199
Total	26,054	122,939	153,805	146,164	448,962	38,139

PPV Status	Age < 1	Age 1 - 5	Age 6 - 18	Age 19 and Above	All Ages in HHW	Age 19 and Above
PPV	77.0%	70.7%	70.1%	66.4%	69.5%	81.1%
Non-PPV	23.0%	29.3%	29.9%	33.6%	30.5%	18.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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In addition to examining PPV rates by age group, B&A also analyzed to see if there was a relationship between the PPV rate and the ED Visit CPT code that was billed on the claim. The five CPT codes 99281 through 99285 are intended to indicate the level of emergency department care required. These CPT codes are self-reported by the hospital. 3M also recommends including other service lines billed where there is not an ED CPT code billed but, rather, 450-459 revenue codes which are the common revenue codes billed for the ED.

B&A stratified the results of the PPV rates by CPT code as well as those services where a 45x revenue code was billed without a CPT code. The data was further segmented between HHW and HIP and also by MCE within each program. The results are shown on the next page in Exhibit VII.3.

Looking at the percentages in the far right column of the exhibit, the PPV rates follow a logic trend in that the highest PPV rate of 88 percent is in CPT 99281 which is the lowest level ED visit. The higher the CPT code (and therefore the likely the greater the resource intensity), the lower the PPV rate which indicates that higher-level coded ED claims (such as in CPT 99285) are less potentially preventable. This trend also applies to HHW and the HIP as a whole as well as trends within HHW and HIP at the MCE level.

The area that is different is among services where the hospital billed a 45x revenue code without a 99281-99285 CPT code. The exhibit shows that, in the aggregate, the PPV among this cohort of visits is only 17 percent. This trend is influencing the overall average PPV rate reported for HHW in particular. The values shown below summarize the PPV rates with and without the ED-defined codes without CPT 99281-99285:

- For HHW
 - PPV rate with 45x rev code and no 99281-99285 included: 69.5 percent
 - PPV rate with 45x rev code and no 99281-99285 excluded: 81.2 percent

- For HIP
 - PPV rate with 45x rev code and no 99281-99285 included: 81.1 percent
 - PPV rate with 45x rev code and no 99281-99285 excluded: 82.6 percent

Therefore, it can be inferred from this data that the finding in Exhibit VII.2 where the PPV rates among adults in HHW and HIP were different may be less about ED utilization patterns between the adults in both programs and more related to the presence (or lack of) a CPT code on the claim when the ED revenue code was present.

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Exhibit VII.3

PPV Rates in CY 2014 Based on ED Billing Type, By MCE and Program

ED Type	PPV Status	Anthem				MHS				MDwise				Total	
		HHW	HIP	HHW	HIP	HHW	HIP	HHW	HIP						
CPT 99281	PPV	3,335	88%	336	91%	3,898	88%	121	92%	4,432	88%	184	91%	12,306	88%
	Non-PPV	439	12%	34	9%	544	12%	11	8%	582	12%	18	9%	1,628	12%
	Total	3,774		370		4,442		132		5,014		202		13,934	
CPT 99282	PPV	18,692	87%	2,078	86%	18,221	84%	797	89%	25,319	87%	865	87%	65,972	86%
	Non-PPV	2,915	13%	346	14%	3,592	16%	98	11%	3,663	13%	126	13%	10,740	14%
	Total	21,607		2,424		21,813		895		28,982		991		76,712	
CPT 99283	PPV	48,337	84%	6,796	84%	44,842	81%	2,483	85%	61,663	85%	2,591	85%	166,712	84%
	Non-PPV	9,196	16%	1,279	16%	10,461	19%	450	15%	10,461	15%	471	15%	32,318	16%
	Total	57,533		8,075		55,303		2,933		72,124		3,062		199,030	
CPT 99284	PPV	21,079	74%	5,439	84%	15,686	71%	2,053	83%	22,620	77%	2,260	81%	69,137	75%
	Non-PPV	7,525	26%	1,046	16%	6,287	29%	426	17%	6,893	23%	517	19%	22,694	25%
	Total	28,604		6,485		21,973		2,479		29,513		2,777		91,831	
CPT 99285	PPV	3,914	64%	2,021	73%	2,918	55%	932	72%	4,237	68%	989	72%	15,011	65%
	Non-PPV	2,223	36%	740	27%	2,348	45%	358	28%	2,008	32%	387	28%	8,064	35%
	Total	6,137		2,761		5,266		1,290		6,245		1,376		23,075	
Revenue Code 45x but no CPT reported	PPV	5,851	21%	552	53%	3,563	16%	182	52%	3,232	10%	261	53%	13,641	17%
	Non-PPV	21,818	79%	489	47%	18,198	84%	171	48%	27,970	90%	232	47%	68,878	83%
	Total	27,669		1,041		21,761		353		31,202		493		82,519	
All ED Visits Combined	PPV	101,208	70%	17,222	81%	89,128	68%	6,568	81%	121,503	70%	7,150	80%	342,779	70%
	Non-PPV	44,116	30%	3,934	19%	41,430	32%	1,514	19%	51,577	30%	1,751	20%	144,322	30%
	Total	145,324		21,156		130,558		8,082		173,080		8,901		487,101	
Excluding ED Visits that do not have 99281-99285	PPV	95,357	81%	16,670	83%	85,565	79%	6,386	83%	118,271	83%	6,889	82%	329,138	81%
	Non-PPV	22,298	19%	3,445	17%	23,232	21%	1,343	17%	23,607	17%	1,519	18%	75,444	19%
	Total	117,655		20,115		108,797		7,729		141,878		8,408		404,582	

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PPVs were examined at the EAPG level to determine if certain types of ED visits were more likely to be identified as PPVs than others. Exhibit VII.4 on the next page displays the top 10 EAPGs (based on the volume of PPVs) within age groups. When data is not shown for an EAPG beneath a certain age group, it does not mean that there were no PPVs in that EAPG; rather, it means that the EAPG was not in the top 10 for that age group.

For the youngest members in HHW (age < 1 and age 1-5), more than 80 percent of all of their PPVs are captured in the top 10 EAPGs. For other children (age 6-18), 69 percent of all PPVs are in the top 10 EAPGs. For adults in HHW and HIP, the volume is spread over more EAPG categories since the top 10 EAPGs represent just 58 and 55 percent, respectively, of all PPVs.

The EAPG with the most PPVs statewide is the same for all three pediatric age groups. EAPG 562 Infections of Upper Respiratory Tract & Otitis Media contains 32 percent, 31 percent and 19 percent of the PPVs among children < age 1, children age 1-5, and children age 6-18, respectively. Another high volume EAPG is 871 Signs, Symptoms & Other Factors Influencing Health Status. Among the adult population, two EAPGs each comprise about 10 percent of all PPVs in HHW and two EAPGs each also comprise about 10 percent of all PPVs in HIP. One EAPG is the same in both HHW and HIP, namely, 628 Abdominal Pain. The other high volume EAPG in HHW for adults is the same as found with the pediatric population—562 Infections of Upper Respiratory Tract & Otitis Media. The other high volume EAPG in HIP for adults is 661 Level II Other Musculoskeletal System & Connective Tissue Disease.

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Exhibit VII.4
Top 10 EAPGs in CY 2014 with Potentially Preventable ED Visits, by Age Group

	Age < 1		Age 1 to 5		Age 6 to 18		Age 19 and Above		Total HHW		Total HIP	
	PPVs	Pct in Top 10	PPVs	Pct in Top 10	PPVs	Pct in Top 10	PPVs	Pct in Top 10	PPVs	Pct in Top 10	PPVs	Pct in Top 10
Total	20,055	87.9%	86,885	81.8%	107,787	69.2%	97,112	57.6%	311,839	66.0%	30,940	55.3%
Ambulatory Patient Group (EAPG)												
00040 SPLINT, STRAPPING AND CAST REMOVAL					4,315	4.0%						
00530 HEADACHES OTHER THAN MIGRAINE											1,036	3.3%
00562 INFECTIONS OF UPPER RESPIRATORY TRACT & OTITIS MEDIA	6,421	32.0%	26,591	30.6%	20,400	18.9%	9,439	9.7%	62,851	20.2%	2,112	6.8%
00564 LEVEL I OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSIS	815	4.1%	4,360	5.0%	4,463	4.1%			11,557	3.7%		
00572 BRONCHIOLITIS & RSV PNEUMONIA	796	4.0%										
00573 COMMUNITY ACQUIRED PNEUMONIA	444	2.2%	1,719	2.0%								
00576 LEVEL I OTHER RESPIRATORY DIAGNOSES	876	4.4%	2,215	2.5%								
00604 CHEST PAIN							4,075	4.2%			1,969	6.4%
00627 NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	2,126	10.6%	7,462	8.6%	5,015	4.7%	3,794	3.9%	18,397	5.9%	1,209	3.9%
00628 ABDOMINAL PAIN					6,665	6.2%	9,659	9.9%	17,555	5.6%	2,824	9.1%
00656 BACK & NECK DISORDERS EXCEPT LUMBAR DISC DISEASE											1,000	3.2%
00657 LUMBAR DISC DISEASE							4,693	4.8%			1,836	5.9%
00661 LEVEL II OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DISEASE					10,476	9.7%	8,072	8.3%	20,203	6.5%	2,887	9.3%
00673 CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS			2,284	2.6%								
00674 CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS	519	2.6%	4,058	4.7%	8,052	7.5%	3,798	3.9%	16,427	5.3%	1,145	3.7%
00675 OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS	1,662	8.3%	8,358	9.6%	8,609	8.0%	3,952	4.1%	22,581	7.2%	1,092	3.5%
00727 ACUTE LOWER URINARY TRACT INFECTIONS					3,072	2.9%	4,627	4.8%	9,317	3.0%		
00752 LEVEL I MENSTRUAL AND OTHER FEMALE DIAGNOSES							3,792	3.9%				
00808 VIRAL ILLNESS	1,226	6.1%	5,503	6.3%					10,179	3.3%		
00871 SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	2,748	13.7%	8,556	9.8%	3,558	3.3%			16,853	5.4%		

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The top 10 EAPGs based on PPV volume were also examined at the MCE level. In Exhibit VII.5, the top 10 EAPGs for HHW were reviewed. The exhibit shows that the PPV volume is very consistent across all three MCEs. The top 10 EAPGs comprise two-thirds of all PPVs both statewide and within each MCE. Further, the top 10 EAPGs are the same for all three MCEs. The top EAPG for all MCEs is what was found to be high volume within each age group in the previous exhibit, 562 Infections of Upper Respiratory Tract & Otitis Media.

Exhibit VII.5
Top 10 EAPGs in Hoosier Healthwise in CY 2014 with Potentially Preventable ED Visits, by MCE

	Anthem		MHS		MDwise		All 3 MCEs	
	PPVs	Pct in Top 10	PPVs	Pct in Top 10	PPVs	Pct in Top 10	PPVs	Pct in Top 10
Total	101,208	65.1%	89,128	66.5%	121,503	66.5%	311,839	66.0%
Ambulatory Patient Group (EAPG)								
00562 INFECTIONS OF UPPER RESPIRATORY TRACT & OTITIS MEDIA	19,503	19.3%	18,480	20.7%	24,868	20.5%	62,851	20.2%
00564 LEVEL I OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSIS	3,533	3.5%	3,268	3.7%	4,756	3.9%	11,557	3.7%
00627 NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	6,069	6.0%	5,314	6.0%	7,014	5.8%	18,397	5.9%
00628 ABDOMINAL PAIN	6,155	6.1%	5,261	5.9%	6,139	5.1%	17,555	5.6%
00661 LEVEL II OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DISEASE	6,552	6.5%	5,700	6.4%	7,951	6.5%	20,203	6.5%
00674 CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS	5,116	5.1%	4,855	5.4%	6,456	5.3%	16,427	5.3%
00675 OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS	7,142	7.1%	6,396	7.2%	9,043	7.4%	22,581	7.2%
00727 ACUTE LOWER URINARY TRACT INFECTIONS	3,114	3.1%	2,572	2.9%	3,631	3.0%	9,317	3.0%
00808 VIRAL ILLNESS	3,100	3.1%	2,888	3.2%	4,191	3.4%	10,179	3.3%
00871 SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	5,639	5.6%	4,503	5.1%	6,711	5.5%	16,853	5.4%

When the high-volume EAPGs were examined in the HIP program, six of the top 10 EAPGs were also found to be in the top 10 in the HHW program. Among the other four, two are in the top 5 EAPGs for HIP—604 Chest Pain and 657 Lumbar Disc Disease.

There is a slight difference in the top 10 EAPGs for PPVs in HIP when examined by MCE, but still seven of the top 10 EAPGs are common to all three MCEs. Only two EAPGs—563 Dental & Oral Diseases & Injuries and 727 Acute Lower Urinary Tract Infections—are not in the top 10 EAPGs for HIP statewide when measuring the volume of PPVs in the program.

Refer to Exhibit VII.6 on the next page for complete details.

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Exhibit VII.6

Top 10 EAPGs in Healthy Indiana Plan in CY 2014 with Potentially Preventable ED Visits, by MCE

	Anthem		MHS		MDwise		All 3 MCEs	
	PPVs	Pct in Top 10	PPVs	Pct in Top 10	PPVs	Pct in Top 10	PPVs	Pct in Top 10
Total	17,222	56.3%	6,568	54.8%	7,150	55.1%	30,940	55.3%
Ambulatory Patient Group (EAPG)								
00530 HEADACHES OTHER THAN MIGRAINE	590	3.4%			243	3.4%	1,036	3.3%
00562 INFECTIONS OF UPPER RESPIRATORY TRACT & OTITIS MEDIA	1,205	7.0%	411	6.3%	496	6.9%	2,112	6.8%
00563 DENTAL & ORAL DISEASES & INJURIES			274	4.2%	260	3.6%		
00604 CHEST PAIN	1,067	6.2%	389	5.9%	513	7.2%	1,969	6.4%
00627 NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	672	3.9%	275	4.2%	262	3.7%	1,209	3.9%
00628 ABDOMINAL PAIN	1,526	8.9%	607	9.2%	691	9.7%	2,824	9.1%
00656 BACK & NECK DISORDERS EXCEPT LUMBAR DISC DISEASE	570	3.3%	213	3.2%			1,000	3.2%
00657 LUMBAR DISC DISEASE	1,068	6.2%	399	6.1%	369	5.2%	1,836	5.9%
00661 LEVEL II OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DISEASE	1,659	9.6%	589	9.0%	639	8.9%	2,887	9.3%
00674 CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS	674	3.9%	230	3.5%	241	3.4%	1,145	3.7%
00675 OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS	661	3.8%	212	3.2%			1,092	3.5%
00727 ACUTE LOWER URINARY TRACT INFECTIONS					226	3.2%		

PPV rates vary quite a bit by region within HHW, but less so within HIP. In HHW, the PPV rates range from a low of 62.9 percent in the East Central Region to 77.2 percent in the North Central Region. In HIP, the PPV rates range from a low of 79.6 percent in the Northeast Region to 83.7 percent in the Southeast Region.

Exhibit VII.7

PPV Rates for Hoosier Healthwise and Healthy Indiana Plan in CY 2014, by Region

	Region	Hoosier Healthwise				Healthy Indiana Plan			
		PPVs	PPV Rate	Non-PPVs	Non-PPV Rate	PPVs	PPV Rate	Non-PPVs	Non-PPV Rate
1	Northwest	35,571	63.3%	20,591	36.7%	3,237	80.4%	791	19.6%
2	North Central	30,504	77.2%	8,996	22.8%	2,162	81.1%	504	18.9%
3	Northeast	42,220	78.6%	11,480	21.4%	3,269	79.6%	836	20.4%
4	West Central	26,635	67.9%	12,573	32.1%	2,657	80.1%	661	19.9%
5	Central	86,426	65.3%	46,023	34.7%	8,442	81.5%	1,922	18.5%
6	East Central	25,887	62.9%	15,283	37.1%	3,755	81.7%	839	18.3%
7	Southwest	35,769	74.4%	12,287	25.6%	5,133	81.0%	1,201	19.0%
8	Southeast	28,827	74.5%	9,890	25.5%	2,285	83.7%	445	16.3%
	ALL Regions	311,839	69.5%	137,123	30.5%	30,940	81.1%	7,199	18.9%

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In order to risk adjust the PPV rates, B&A computed the PPV rates for the 27 aggregated clinical risk groups (ACRGs) for HHW and HIP separately. These are shown in Exhibit VII.7 on the next page. It should be noted that some of the ACRGs have low sample size which can cause greater variance in the PPV rates. For example, out of 310,698 PPVs found in CY 2014 in HHW that were considered in the risk adjustment process across the 27 ACRGs¹⁰, 17 out of 27 ACRGs contained less than one percent of all PPVs statewide in the HHW population. Out of 30,840 PPVs found in CY 2014 in HIP that were considered in the risk adjustment process¹¹, 13 out of 27 ACRGs contained less than one percent of all PPVs statewide in the HIP population.

Among the ACRGs with more than one percent of all PPVs in HHW, the PPV rate was steady between 65 percent (ACRG 11 Healthy Non-User) and 72 percent (ACRG 20 History of Significant Acute Disease). Similarly, among the ACRGs with more than one percent of all PPVs in HIP, the PPV rate was steady between 79 percent (ACRG 32 Single Minor Chronic Disease Level- 2) and 84 percent (ACRG 20 History of Significant Acute Disease).

The proportion of PPVs is steady at the MCE level within the higher volume ACRGs. In other words, when comparing the percentage of statewide PPVs for Anthem, MHS and MDwise in total for HHW against these same percentages at the ACRG level, there is general consistency, at least among the ACRGs comprising at least one percent of all PPVs statewide. There is more variation in these statistics at the MCE/ACRG level in HIP, but this is because the volume is much lower overall in HIP since the program only contained one-tenth of the HHW membership in CY 2014.

¹⁰ There were 311,839 PPVs identified in HHW overall in CY 2014, but 1,141 were PPVs in ACRG status levels 8 and 9 which are not considered in risk adjustment.

¹¹ There were 30,940 PPVs identified in HIP overall in CY 2014, but 100 were PPVs in ACRG status levels 8 and 9 which are not considered in risk adjustment.

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Exhibit VII.8
Distribution of PPVs in CY 2014, HHW and HIP
By Statewide and MCE and Crosstabulated by ACRG

ACRG	Aggregated Clinical Risk Group Description	Hoosier Healthwise Results for CY 2014					Healthy Indiana Plan Results for CY 2014				
		PPV Rate Statewide	Total Number of PPVs Statewide	Percent of Statewide PPVs-Anthem	Percent of Statewide PPVs-MHS	Percent of Statewide PPVs-MDwise	PPV Rate Statewide	Total Number of PPVs Statewide	Percent of Statewide PPVs-Anthem	Percent of Statewide PPVs-MHS	Percent of Statewide PPVs-MDwise
	Total	69%	310,698	32%	29%	39%	81%	30,840	56%	21%	23%
10	Healthy	70%	141,213	32%	28%	39%	81%	2,438	59%	15%	26%
11	Healthy Non-User	65%	41,614	36%	28%	37%	81%	16,784	49%	28%	22%
20	History Of Significant Acute Disease	72%	31,544	31%	29%	40%	84%	953	59%	12%	28%
31	Single Minor Chronic Disease Level -1	71%	17,866	31%	29%	39%	84%	1,164	65%	11%	25%
32	Single Minor Chronic Disease Level -2	71%	6,248	33%	28%	39%	79%	315	63%	12%	24%
41	Minor Chronic Disease In Multiple Organ Systems Level -1	71%	2,098	31%	32%	37%	82%	352	66%	15%	19%
42	Minor Chronic Disease In Multiple Organ Systems Level -2	75%	332	32%	30%	39%	76%	83	70%	8%	22%
43	Minor Chronic Disease In Multiple Organ Systems Level -3	71%	1,876	37%	31%	32%	81%	353	65%	10%	24%
44	Minor Chronic Disease In Multiple Organ Systems Level -4	73%	706	40%	21%	40%	87%	103	63%	7%	30%
51	Single Dominant Or Moderate Chronic Disease Level -1	69%	21,123	31%	28%	41%	80%	1,543	62%	14%	24%
52	Single Dominant Or Moderate Chronic Disease Level -2	69%	17,789	32%	28%	40%	84%	1,227	65%	10%	25%
53	Single Dominant Or Moderate Chronic Disease Level -3	68%	2,623	32%	31%	37%	77%	175	58%	14%	28%
54	Single Dominant Or Moderate Chronic Disease Level -4	68%	392	36%	24%	40%	83%	29	38%	34%	28%
55	Single Dominant Or Moderate Chronic Disease Level -5	70%	201	27%	34%	39%	67%	2	0%	0%	100%
56	Single Dominant Or Moderate Chronic Disease Level -6	63%	38	18%	71%	11%	100%	1	0%	0%	100%
61	Significant Chronic Disease In Multiple Organ Sys Level -1	70%	8,878	30%	28%	41%	82%	1,595	66%	11%	23%
62	Significant Chronic Disease In Multiple Organ Sys Level -2	71%	7,012	31%	29%	40%	81%	1,330	63%	15%	22%
63	Significant Chronic Disease In Multiple Organ Sys Level -3	70%	4,495	32%	32%	37%	81%	965	68%	15%	17%
64	Significant Chronic Disease In Multiple Organ Sys Level -4	72%	2,664	36%	31%	33%	83%	698	70%	6%	24%
65	Significant Chronic Disease In Multiple Organ Sys Level -5	65%	1,102	38%	26%	36%	81%	345	61%	14%	24%
66	Significant Chronic Disease In Multiple Organ Sys Level -6	76%	277	22%	29%	49%	93%	69	55%	42%	3%
71	Dominant Chronic Disease In 3+ Organ Systems Level -1	68%	57	44%	32%	25%	91%	49	47%	4%	49%
72	Dominant Chronic Disease In 3+ Organ Systems Level -2	81%	124	15%	39%	46%	75%	36	69%	28%	3%
73	Dominant Chronic Disease In 3+ Organ Systems Level -3	64%	200	27%	42%	31%	72%	129	66%	3%	31%
74	Dominant Chronic Disease In 3+ Organ Systems Level -4	73%	75	27%	27%	47%	88%	52	48%	19%	33%
75	Dominant Chronic Disease In 3+ Organ Systems Level -5	68%	119	36%	45%	19%	78%	38	79%	0%	21%
76	Dominant Chronic Disease In 3+ Organ Systems Level -6	56%	32	44%	41%	16%	80%	12	8%	17%	75%

Note: Cases in ACRGs Level 8 and 9 have been removed from the analysis.

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After risk adjustment was completed, B&A computed the Actual-to-Expected ratios across multiple cohort populations. These results are shown in Exhibit VII.9. Each cohort population is compared to the statewide average Actual-to-Expected ratio of 1.0 in CY 2014 in either HHW or HIP. On the top line, it was found that MHS performed near expectations after risk adjustment with a ratio of 0.983 in HHW. Both Anthem and MDwise generally performed as expected after risk adjustment with ratios of 1.004 and 1.010, respectively. (B&A generally defines “as expected” as a ratio between 0.980 and 1.020.) In the HIP program, all three MCEs performed as expected.

When examining the Actual-to-Expected ratios using statewide data but at the regional level (the columns next to the region names), there was wide variation found across the eight regions for HHW but not for HIP. Four regions (Northwest, West Central, Central, and East Central) in HHW exceeded the expectations after risk adjustment of their PPR rates since all have ratios below 1.0. Alternatively, the other four regions in HHW (North Central, Northeast, Southwest and Southeast) did not meet expectations since their ratios were all above 1.0. The ratios in the eight regions range from a low of .904 in the East Central region to a high of 1.131 in the Northeast Region.

When the results by region were examined in more detail at the MCE level, the lower volume in HIP required us to combine HHW and HIP data for this analysis. In general, it was found that if a region had an Actual-to-Expected (A-to-E) ratio that was above 1.0 statewide in HHW, then this was also true for each MCE. Likewise, regions with Actual-to-Expected ratios below 1.0 statewide in HHW (where most of the volume is) had similar findings at the MCE level. The exceptions to this rule are as follows:

- Northwest Region: Statewide A-to-E ratio of 0.912, but MDwise’s ratio specifically was 1.005
- West Central Region: Statewide A-to-E ratio of 0.978, but MHS ratio specifically was 1.047
- East Central Region: Statewide A-to-E ratio of 0.904, but Anthem and MHS had ratios above 1.0

**Exhibit VII.9
Actual-to-Expected Ratios Related to PPVs in CY 2014, by Region**

Region	HHW All MCEs	HIP All MCEs	Anthem	MHS	MDwise
Statewide HHW	1.000	1.000	1.004	0.983	1.010
Statewide HIP	1.000	1.000	1.003	1.004	0.990

The values below by MCE are for HHW and HIP combined.						
1	Northwest	0.912	0.990	0.918	0.764	1.005
2	North Central	1.112	0.999	1.125	1.081	1.129
3	Northeast	1.131	0.980	1.095	1.076	1.149
4	West Central	0.978	0.988	0.999	1.047	0.943
5	Central	0.940	1.004	0.963	0.894	0.960
6	East Central	0.904	1.007	1.036	1.071	0.826
7	Southwest	1.071	0.999	1.057	1.071	1.104
8	Southeast	1.073	1.032	1.072	1.055	1.073

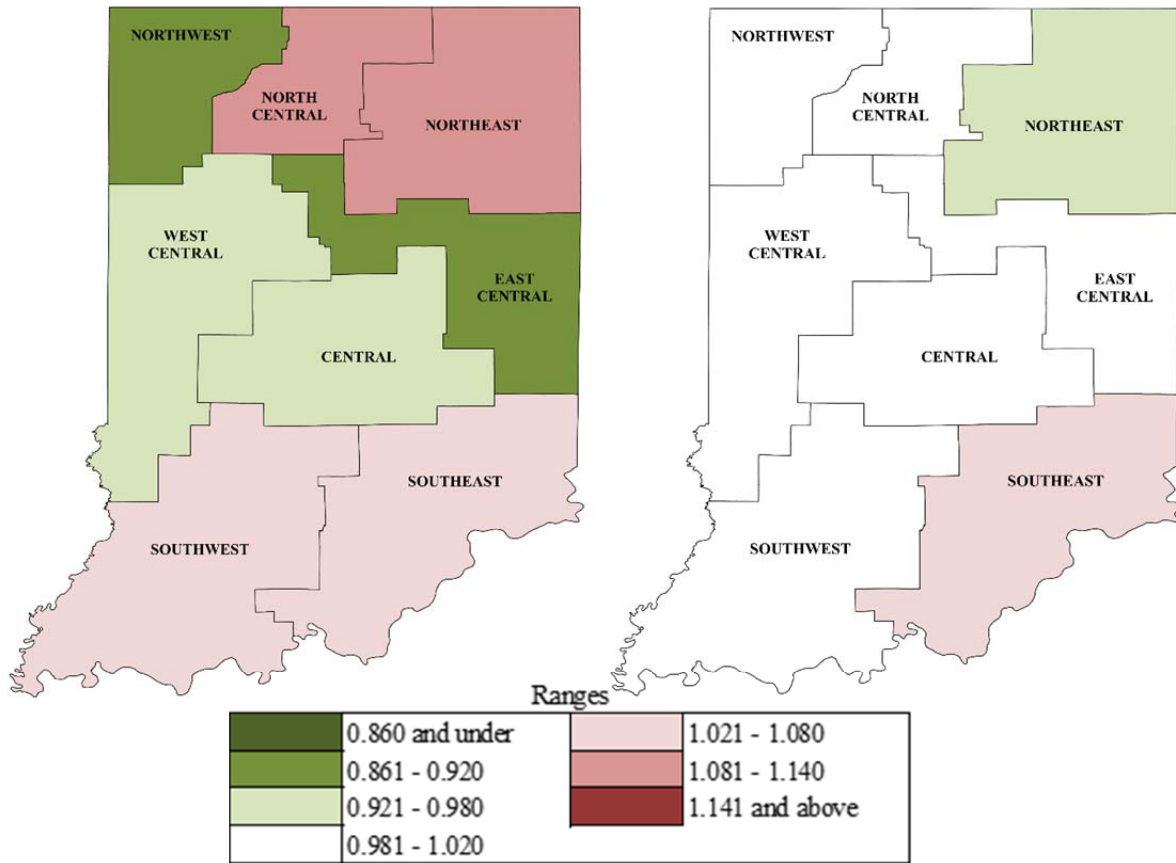
All of the information shown in Exhibit VII.9 above is also shown graphically in the maps starting on the next page in Exhibits VII.10 and Exhibit VI.11.

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Exhibit VII.10

Actual-to-Expected PPV Ratios for Hoosier Healthwise and Healthy Indiana Plan, by Region

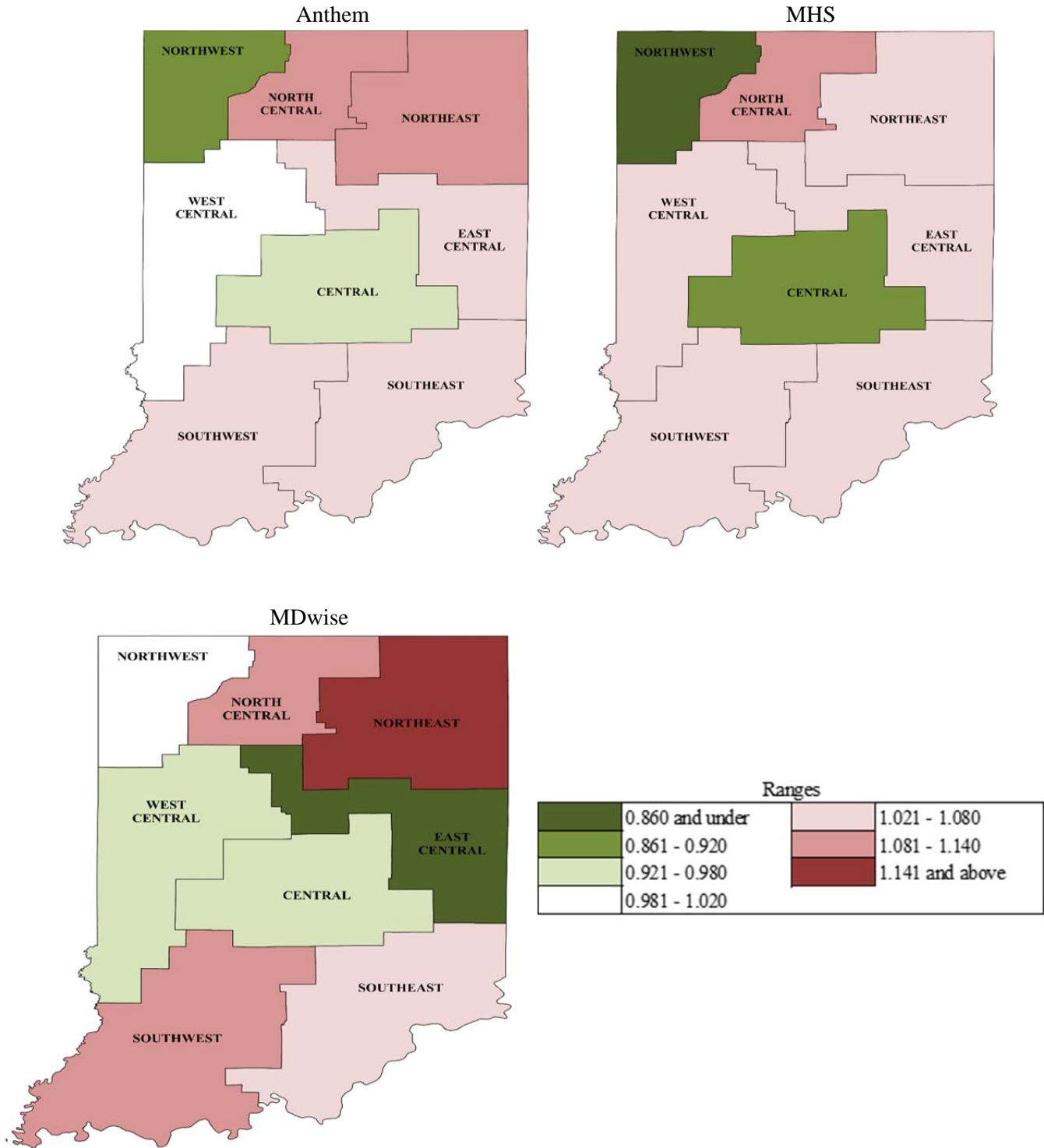


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Exhibit VII.11

Actual-to-Expected PPV Ratios for Hoosier Healthwise and Healthy Indiana Plan Combined, by MCE



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Recommendations to the MCEs and the OMPP Related to PPVs

This is the first review of analyzing potentially preventable ED visits using the 3M PPV grouper in the HHW and HIP programs. In general, if the study was limited to include only ED visits with CPT codes 99281-99285, then the PPV rates between HHW and HIP were similar (81 to 83 percent). Although there was little variation seen in the PPR rates among the three MCEs, there are opportunities to reduce this PPV rate for all populations. There was variation seen in the Actual-to-Expected ratios at the regional level. B&A offers the following recommendations to explore how to use the PPV data to inform ways to reduce unnecessary ED use.

1. The Actual-to-Expected ratios were greater than 1.0 in four regions of the state for HHW, but less than 1.0 in the other four regions. The OMPP and the MCEs may want to explore if the reasons for the ratios being greater than 1.0 are consistent across these regions. One option would be to focus on the highest volume EAPGs statewide (top 10) and determine if these EAPGs were the root cause or possibly examine hospital-specific results.
2. Two-thirds of all PPVs in HHW were in ten EAPGs and six of these were also in the top 10 for HIP. With the addition of more adults entering the HIP 2.0 program in CY 2015, the MCEs should consider conducting a drill down into these results to assess opportunities for hospital-specific or regional-specific interventions that may curtail potentially preventable ED visits within this list of ED visits.
3. When examining the ACRGs (risk groups), 59 percent of all PPVs in HHW and 62 percent of all PPVs in HIP were visits from members in ACRGs 10 and 11 (Healthy and Healthy Non-User). Another area of educational opportunity for the MCEs to consider is among appropriate use of the ED particularly among the MCE's healthiest members.

APPENDIX A
2015 EQR GUIDE

**2015 EXTERNAL QUALITY REVIEW GUIDE FOR THE HOOSIER HEALTHWISE
AND HEALTHY INDIANA PLAN PROGRAMS
(Review of CY 2014 Operations)**

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Separate Excel File Contains Tabs for

- Request for preferred meeting time form (to be remitted back to B&A)
- MCE Responses to Data Elements Related to Service Authorization Requests (to be completed and remitted back to B&A)
- Template for Submission of Data Elements Related to Service Authorization Requests (to be completed and remitted back to B&A)
- Template for Submission of Data Elements Related to Service Authorization Appeals (to be completed and remitted back to B&A)

A. Summary of This Year's Topics, Timeline and Review Team

Overview

Burns & Associates, Inc. (B&A) was hired by Indiana's Office of Medicaid Policy and Planning (OMPP) 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) 2014.

The Centers for Medicare and Medicaid (CMS) require that EQROs complete three mandatory activities on a regular basis as part of the EQR:

- 1) A review to determine MCE compliance with federal Medicaid managed care regulations;
- 2) Validation of performance measures produced by an MCE; and
- 3) Validation of performance improvement projects undertaken by the MCEs

There are many optional activities that EQROs may also complete. A comprehensive review of Activity #1 was completed in CY 2012. Therefore, for this year's EQR, B&A met with the OMPP to determine the topics selected for this year's EQR which include the following:

- Validation of Performance Measures (10 quarterly reports from the 2014 HHW and HIP Reporting Manuals have been selected)
- Validation of MCE Quality Improvement Projects (Emergency Room Utilization, Postpartum Care and Tobacco Cessation for Pregnant Women)
- Optional EQR Activity: Examine Service Authorization Processes (this is a follow-up to a review conducted in CY 2009 as part of the EQR)
- Optional EQR Activity: Examine Potentially Preventable Readmissions
- Optional EQR Activity: Examine Potentially Preventable Emergency Department Visits

All topics will be reviewed for both the HHW and HIP populations.

Timeline

The OMPP is requesting that B&A deliver the draft report for this EQR by September 30. The final report is due October 31. The schedule effectively begins with the release of this EQR Guide. The items that are being requested from the MCEs are due June 25. Onsite meetings are scheduled during the weeks of July 6, July 27, August 10 and August 17, 2015. A full schedule may be found in Section C of this Guide.

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

The OMPP has customarily asked B&A to offer a debriefing session with each MCE. The dates for these sessions are tentatively scheduled for October 20 and 21. Each MCE/health plan will also receive a copy of the final EQR report that will be delivered to CMS once it has been reviewed by the OMPP.

The B&A Review Team

This year's EQR Review Team consists of the following members:

- Mark Podrazik, Project Director, B&A: Mark has previously conducted nine EQRs of the HHW program, six EQRs of the HIP and an external review of the Care Select program. He will oversee the entire project and final report.
- Jesse Eng, SAS Programmer, B&A: Jesse will be the lead programmer/analyst on the Potentially Preventable Readmissions study. He has been conducting a similar study and created a hospital report card for Ohio's Medicaid program. The Ohio Medicaid Managed Care Plan Report Card will be released in July 2015. Jesse has participated in conducting analytics for B&A's Independent Evaluation of Indiana's CHIP since 2010.
- James Maedke, SAS Programmer, B&A: James will be the lead programmer/analyst on the Potentially Preventable Emergency Department Visit study. He has been conducting a similar study for Ohio's Medicaid program. James was the principal analyst on last year's EQR and B&A's Independent Evaluation of Indiana's CHIP for the last two years.
- Barry Smith, Data Analyst, B&A: Barry has over 10 years of experience with financial analysis and data mining. He has assisted in analytics for B&A's Independent Evaluation of Indiana's CHIP as well as the External Quality Reviews in Indiana since 2009.
- Dr. Linda Gunn, PhD, Subcontractor: Linda has assisted B&A on six previous HHW EQRs, five HIP EQRs and the Care Select review. She will participate in the examination of service authorizations.
- Kristy Lawrance, Subcontractor: Kristy assisted on the 2013 and 2014 EQRs of the HHW and HIP programs and has previous experience working for the OMPP on various projects as well as for Advantage under its contract with the OMPP for Care Select. She will participate in the validation of quality improvement projects and performance measures as well as the examination of service authorizations.

B. Details on Topics in this Year's EQR

Topic #1— Validation of Performance Measures

The purpose for this review is to validate the results of quarterly report submissions for the reporting periods in CY 2014 from the MCEs to the OMPP. B&A will use the CMS EQR Protocol 2, Attachment A (updated September 2012)¹ to report our findings related to the validation of these measures. This will be accompanied by a brief writeup in the EQR report.

The measures that are being validated include:

- QR-PA1: Prior Authorization Report
- QR-U1: Service Utilization (only the items under the headings Emergency Room and Inpatient Hospital)
- QR-GSU3: ER Bounce Back
- QR-GSU4: Inpatient Utilization – General Hospital/Acute Care Discharges
- QR-GSU5: Inpatient Utilization – General Hospital/Acute Care ALOS
- QR-GSU6: Inpatient Readmission Rate
- QR-GSU7: Type of Emergency Room Utilization
- QR-GSU8: Frequency of Emergency Room Utilization
- QR-MN4: Maternity Reports
- QR-PCC2: Preventive Exam (rollover related)

The measures will be computed for the HHW and HIP populations with the exception of QR-MN4 which will be computed for HHW only and QR-PCC2 which will be computed for HIP only.

When applicable, B&A is using the encounters reported to the OMPP and stored in the OMPP data warehouse, FSSA Enterprise Data Warehouse, as of June 1, 2015 as the source data for this analysis. When source data is not stored in the OMPP data warehouse, B&A will request the source data from the MCEs (e.g., information on the QR-PA1 report). It is B&A's intention to share our results with each MCE individually and compare to what the MCE submitted. If large differences are found, we will work with the MCE to determine the root cause of the differences.

The discussion of preliminary findings is scheduled in one-on-one onsite meetings with each MCE during the week of July 27 which will be led by Mark Podrazik. Because of the number of reports being reviewed this year, we will carve out an entire day for this discussion, if necessary, at each MCE. As we get closer to the meeting date, B&A will provide information in advance with respect to the reports that will be discussed in depth and the types of questions that will be asked related to each report. We will also give each MCE an anticipated estimate of the amount of time that will be required for the onsite meeting once our initial desk review validation has been completed.

¹ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>

Topic #2— Validation of Performance Improvement Projects

The purpose for this review is to fulfill our requirement to validate the results of selected performance improvement projects, or PIPs, as they are called by CMS in its protocol. For our purposes, PIPs are synonymous with Quality Improvement Projects, or QIPs, as defined by the OMPP. B&A will utilize CMS EQR Protocol 3, Attachment A (updated September 2012) as the basis for reporting our validation of three PIPs (QIPs) at each MCE. This will be accompanied by a brief writeup in the EQR report.

As you are aware, considerable time was spent last year in collective meetings with all MCEs and OMPP as well as individually between B&A and each MCE over the design of the new QIP form and the data elements that will be reported. It was agreed that the first complete submission for QIPs after this discussion are due to the OMPP by August 1, 2015. B&A will review these final QIPs, as well as the quarterly updates that each MCE provided to the OMPP, as the basis for the validation process.

Although each MCE may have selected a variety of QIPs, in an effort to encourage our continuous quality improvement process, the actual QIPs selected for this year's EQR are the same for each MCE and are the same as those from last year, with one minor exception. The three QIPs to be validated are:

- Postpartum Care (HHW program only)
- ER Utilization (HHW and HIP programs)
- Tobacco Cessation (HHW and HIP programs); for Tobacco Cessation, however, the primary focus will be on items in the QIP related to tobacco cessation for pregnant women

During the week of August 10, Mark Podrazik and Kristy Lawrence will conduct onsite meetings with each MCE to go over the QIPs under review. This will include follow-up questions from our desk review as well as a discussion with the relevant staff who had primary responsibility for the interventions that were put in place for the QIPs that were selected. It is expected that the B&A Review Team will spend a half-day with each MCE (about one hour to discuss each QIP). If additional information is required, the MCEs will have the opportunity to provide this information to B&A by August 21.

Topic #3— Optional EQR Activity: Examine Service Authorization Processes

In CY 2009, at the request of the OMPP, B&A conducted an extensive review of service authorization policies and procedures. As part of this study, over 800 individual authorization requests were also examined to assess how each MCE's policies and procedures were being used in actual operations. From this review, a number of recommendations were made to each MCE and to the OMPP with respect to areas in which policies and procedures could be refined and made clearer to the providers who are requesting services on behalf of HHW and HIP members.

The OMPP has asked B&A to revisit this topic in this year's EQR as a means to assess how the recommendations that were made in CY 2009 were implemented and to assess the consistency of processes in service authorizations overall in the HHW and HIP.

This focus study will examine:

- MCE policies and procedures for the authorization of services
- MCE process flows for service authorizations, both internally and as requested externally for their contracted providers
- Staffing at each MCE for the service authorization function
- Training and monitoring of staff performing service authorization functions
- How policies, procedures and processes stated by the MCE are utilized "real time" through a process review of a sample of service authorizations

As such, the study has three main components which include:

- A desk review of MCE policies, procedures, and other documentation;
- A quantitative analysis of service authorization requests made to each MCE in CY 2014;
- An onsite interview to discuss policies and procedures and the quantitative analysis conducted; and
- An onsite review of a sample of service authorizations (which may include reviews of cases in an online system and/or hard copy case file documentation) to validate policies and procedures. At this time, it is anticipated that the sample drawn for each MCE will be 250 authorization requests that are inclusive of HHW and HIP.

It should be noted that this year's study will be process oriented. We will not be conducting a clinical review of the disposition of each authorization request in our sample.

Steps of Review

1. B&A will request documents from each MCE for a desk review that will be conducted in anticipation of our onsite interview with each MCE. These documents will be due back to B&A by June 19.
2. B&A will submit proposed data elements and file layouts to receive relevant information about every service authorization request made to the MCE in CY 2014. As we learned in the prior review in CY 2009, one of the stumbling blocks of the study was the consistency in reporting. As such, before we finalize any data request tool, B&A's lead Mark Podrazik will conduct a brief phone call with each MCE about their ability to report data to B&A in the format requested so that the quantitative portion of the study analyzes data consistently across MCEs. These calls will be scheduled for either June 2 or June 3. The MCEs should be aware that, after completing these

conversations, the templates for the data requested as they appear in this EQR Guide may change based on MCE feedback. The intent is for B&A to release final versions of these templates by June 5. The completion and submission of the final templates will be due to B&A by June 26.

3. B&A's team members Mark Podrazik, Linda Gunn and Kristy Lawrance will meet with each MCE in half-day sessions scheduled for July 7 and 8 to discuss authorization policies, procedures and processes. Additionally, this team will also be the ones conducting the review of sample cases. As such, we will also request that each MCE provide us with a tutorial on this day on the capabilities of any online tools used in the authorization process at the MCE. Finally, any follow-up that may be required from the files submitted related to service authorizations on June 26 will be discussed at this session.
4. B&A will draw a sample of cases to give to each MCE in anticipation of the onsite review that will be conducted in August. Provided that any outstanding items are resolved with respect to the data provided by each MCE at the July 7/8 meeting, our intent is to release the sample of 275 service authorizations (250 in sample plus a 10% oversample rate) by July 17.
5. B&A will create a review tool to capture information about each service authorization that will be reviewed in the sample. In an effort to test the review tool, the members of the review team will meet with each MCE on July 28 to pilot the tool. We anticipate that on this day we will be at each MCE for no more than two hours. We will ask that each MCE have six of the cases in the sample ready for us to review (two for each of the three team members). We will walk through the process that will be completed when the full review is conducted using these six cases as a test of the process and our ability to find and record information on our review tool.
6. The onsite sessions to complete the review of the remainder of the cases will be scheduled for the week of August 17. It is our intent for all three team members to conduct this review and to spend a full day at each MCE. We are also allocating two days in this week as placeholder days if we find that we need to finish any work that was not completed in the day assigned to your MCE. If we find that even more time than this is necessary, we will schedule additional meeting times with each MCE on a case-by-case basis.

The results of the quantitative analysis, the qualitative review, and the review of sample cases will be summarized in a report specific to this focus study.

Throughout this year's EQR period, on an as needed basis, B&A will consult with each MCE about our findings. We would discuss findings with an MCE if we found that the results for an MCE differed greatly from the other MCEs. We will give each MCE notice of items we intend to cover in advance of any discussion so that the appropriate staff can be available to answer questions.

**Topic #4— Optional EQR Activity: Examine Potentially Preventable Readmissions (PPRs) AND
Topic #5— Optional EQR Activity: Examine Potentially Preventable ER Visits (PPVs)**

The B&A team has been utilizing 3M's Core Grouping Software in support of studying the impact of PPRs, PPVs and potentially preventable hospital admissions (PPAs) for quality-based initiatives in Ohio's Medicaid program. A hospital report card is available on the Ohio Department of Medicaid's website at <http://www.medicaid.ohio.gov/RESOURCES/ReportsandResearch/ModernizeHospitalPayments.aspx>. This hospital report card will be updated with more current data in July 2015. In addition, a managed care plan report card will also be released in July.

Additionally, B&A has been analyzing PPV rates within specific geographic areas in Ohio to assess opportunities for Ohio Medicaid to employ specific interventions in these regions. The PPV identifies not only whether the ER visit was potentially preventable but also the type of visit (using diagnosis codes). Information on this study is not yet publicly available.

B&A intends to use the methodologies developed in our work on the projects named above to assess PPR and PPV rates for each Indiana MCE for the review year CY 2014. For the PPR study in particular, we may find that due to claims submission lag from the hospital to the MCE we may need to move the study period back to State Fiscal Year 2014 instead of CY 2014. B&A will be making a specific data request of encounters reported to the OMPP and stored in the OMPP data warehouse, FSSA Enterprise Data Warehouse, as of June 1, 2015 as the source data for this analysis. Assuming that there will be no issues with the receipt of this data, B&A does not foresee a separate data request from the MCEs for either of these focus studies.

It is our intent to report PPR and PPV rates for each MCE overall and within geographic regions with comparisons to rates using an all-MCE average. For the PPR rates, results will also be tabulated for each contracted in state hospital, both an all-MCE average for the hospital and the PPR rate for the hospital for its patients within each MCE. A tolerance level is factored in for low sample size so that findings for discrete MCE/hospital combinations may not be reported if the sample size does not support this.

Through consultations that B&A has had and continues to have with the 3M team that supports this software, one of the key factors to consider in any findings reported is how these findings need to be risk adjusted to consider differences in the populations being compared across MCEs. For the PPR results, B&A risk adjusts each hospital's rate (and ultimately, the MCE rate) using age (pediatric and adult) and presence of a major mental health indicator (which may be found on both acute care and behavioral health-related DRG cases) to risk adjust the PPR rates. For the PPV results, the risk adjustment is done by assessing clinical risk groups (CRGs) that an MCE's membership falls into. The CRGs are also derived from the 3M software. In effect, PPV rates are determined for each CRG and then an MCE's PPV rate is weighted by its population within each CRG.

B&A intends to introduce the concepts related to the PPR and PPV methodology in an all-MCE meeting that will also be attended by OMPP staff on July 7. At the conclusion of the EQR this year, B&A will once again convene an all-MCE meeting to share the results of the study. This is anticipated to occur the week of October 19. MCE-specific findings will also be shared during the customary MCE debrief meetings that will once again be held this year. These are also tentatively scheduled to occur the week of October 19.

C. Detailed Schedule and Document Request

The table below presents all information requests of the MCEs as well as all meetings scheduled for this year's EQR. We have some flexibility as to which day we visit each MCE. As has been done in prior years, we are happy to accommodate specific MCE staff schedules wherever we can. Therefore, we ask you to indicate your preferences for the onsite meetings in the form that accompanies this EQR Guide. Please provide feedback to us about your preferences no later than **June 19**. We will confirm all onsite meeting appointments by **June 26**. Specific times for meetings on each day will be scheduled with the MCE in advance of each meeting.

Unless specifically requested by B&A in advance of the meeting, MCE staff do not need to bring any materials to the interview sessions.

Please note that all onsite interviews will cover both the HHW and HIP programs. If the staff in a functional area differs between the two programs, we ask that representatives from each program attend the interview.

Date	Participants or Responsible Party	EQR Item
May 27	B&A	EQR Guide released to the MCEs
June 2	MCEs	Email to B&A Document 'MCE Responses to Data Elements Related to Service Authorization Requests'
June 2-3	B&A, MCEs	Conference call related to submission of 'MCE Responses to Data Elements Related to Service Authorization Requests'
June 5	B&A	Release of final version of templates related to request for data elements related to service authorization requests and appeals
June 19	MCEs	Documents requested for the desk review of service authorization policies, procedures and processes are due back to B&A via OMPP's Sharepoint site. Preferred meeting times for onsite sessions due back.
June 26	MCEs	Submission of the completed final version of templates related to request for data elements related service authorization requests and appeals are due back to B&A via OMPP's Sharepoint site
July 7	B&A, MCEs, OMPP 9:00 – 11:30	Educational session on the methodology and application of 3M's PPR and PPV software
July 7 & 8	MCEs, B&A	Onsite interviews with each MCE to discuss service authorization policies, procedures and processes. Also, MCE will provide tutorial to B&A on any online tools used by service authorization staff.
	July 7, 1:30 - 4:30	Meeting with MCE #1
	July 8, 9:00 - 12:00	Meeting with MCE #2
	July 8, 1:30 - 4:30	Meeting with MCE #3
July 17	B&A	Full sample of service auths sent to each MCE
July 28	MCEs, B&A	Onsite meeting to test authorization pilot tool (6 cases per MCE will be reviewed in the pilot)
	9:00 - 11:00	Meeting with MCE #1
	12:00 - 2:00	Meeting with MCE #2
	2:30 - 4:30	Meeting with MCE #3

Date	Participants or Responsible Party	EQR Item
July 29 - 31	MCEs, B&A	Onsite interviews with each MCE to discuss validation of performance measures
	July 29, 8:30 - 4:30	Meeting with MCE #1
	July 30, 8:30 - 4:30	Meeting with MCE #2
	July 31, 8:30 - 4:30	Meeting with MCE #3
Aug 11 & 13	MCEs, B&A	Onsite interviews with each MCE to discuss QIPs
	Aug 11, 1:00 - 4:00	Meeting with MCE #1
	Aug 13, 9:00 - 12:00	Meeting with MCE #2
	Aug 13, 1:00 - 4:00	Meeting with MCE #3
Aug 17 - 21	MCEs, B&A	Onsite review of sample of service authorizations
	Aug 17, 8:30 – 4:30	MCE #1
	Aug 18, 8:30 – 4:30	MCE #2
	Aug 19, 8:30 – 4:30	Placeholder day, if needed
	Aug 20, 8:30 – 4:30	MCE #3
	Aug 21, 8:30 – 4:30	Placeholder day, if needed
August 21	MCEs	Any follow-up materials requested from the MCEs from the meetings on QIPs that occurred August 10 and 11 are delivered to B&A.
	MCEs	Any follow-up materials requested from the MCEs from the meetings on Performance Measures that occurred July 29-31 are delivered to B&A.
October 1	B&A	Draft EQR report due to OMPP
October 20 and 21 (tentative)	B&A, MCEs, OMPP	All-MCE debriefing on results of PPR and PPV studies. Individual MCE debriefs with B&A and OMPP will occur.

Document Request

Please email the following documents directly to Mark Podrazik at mpodrazik@burnshealthpolicy.com

- MCE Responses to Data Elements Related to Service Authorization Requests – **due June 2**
- Spreadsheet of preferred meeting times for onsite sessions – **due June 19**

All other documents are due back to B&A either on June 19, June 26 or August 21. B&A requests that all remaining documents requested are transmitted through one of the following methods:

- (a) via the MCE's secure email system; or
- (b) via the OMPP SharePoint site. If using OMPP's SharePoint, please upload your data under the \2015\EQR directory under your MCE name. ***Please place HHW-specific and HIP-specific information in the same location under the HHW section of SharePoint.***

Please email Mark Podrazik whenever you have uploaded files to the SharePoint site.

Because the desk review items are more MCE-specific this year, we are not requiring the use of standardized naming conventions as we have done in prior years. Please retain for any policies and procedures you submit the name you use internally so that if we need to discuss it we are using common nomenclature. For other items requested, a naming convention is not required but please use file descriptions that clearly indicate what the file contains.

Data to be submitted to SharePoint by **June 19**:

- Current policies and procedures related to service authorizations; although not an exhaustive list, we are expecting to see the following topics covered in your submission:
 - Policy and procedure for pre-service authorizations
 - Policy and procedure for concurrent reviews
 - Policy and procedure for retrospective reviews
 - Self-referable services
 - Emergency services and post-stabilization care
 - Application of prudent layperson policy
 - Timeliness of decisions (if not in policies above)
 - Appropriate professionals for medical management decisions
 - Separation of financial and medical necessity decision making
 - Training of utilization management staff
 - Inter rater reliability testing of utilization management staff
 - Any other audit policy related to utilization management
- An organizational chart of the number and location of staff that support the service authorization function at your MCE; if behavioral health is separate from acute care, be sure to include them
- Any training materials used to train authorization staff
- The MCE's Provider Manual from CY 2014; if there is a different manual for HHW and HIP, please submit both.
- Any information given to providers regarding a 'Gold Star' or 'Preferred Provider Program' with respect to service authorizations
- High level statistics on the number of service providers and the percentage of all authorizations requested in CY 2014 that they represent in your Preferred Provider Program, if you have one
- A sample of actual letters (personal identifiable information blacked out) of:
 - Approval of service authorization to the requesting provider
 - Denial of service authorization to the requesting provider
 - Denial of service authorization to the hospital for inpatient services
 - Denial of service authorization to the member
 - Modified approval of service authorization to the requesting provider (if differs from full denial)
 - Modified approval of service authorization to the member (if differs from full denial)
- Other information that you believe would be relevant to the review of service authorization policies, procedures and processes that are not listed above

Data to be submitted to SharePoint by **June 19**:

- Completed final version of the template for request for data elements related service authorization requests
- Completed final version of the template for request for data elements related service authorization appeals

Data to be submitted to SharePoint by **August 21**: Will be determined on an as-needed basis in consultation with each MCE with respect to information on QIPs and performance measure data.

APPENDIX B

REVIEW TOOL FOR AUTHORIZATION SAMPLE

AUTHORIZATION REVIEW TOOL EQR 2015

B&A Reviewer Initials _____

Date B&A Reviewed _____

MCE Auth ID _____

Member RID _____

1. Indicate MCE
 Anthem MHS MDwise

2. Place an X in the most appropriate box to indicate the service category for auth request.

<input type="checkbox"/> Inpatient acute care	<input type="checkbox"/> Inpatient beh health	<input type="checkbox"/> Outpatient surgery	<input type="checkbox"/> Other outpatient hosp
<input type="checkbox"/> PT / OT / ST	<input type="checkbox"/> Specialist referral	<input type="checkbox"/> Radiology	<input type="checkbox"/> Laboratory
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Home health visit	<input type="checkbox"/> Orthotics	<input type="checkbox"/> Enteral nutrition
<input type="checkbox"/> Wheelchair, wheelchair accessories or repairs	<input type="checkbox"/> Other DME not specified already in other categories		
<input type="checkbox"/> Other medical (non BH) not specified above	<input type="checkbox"/> Community-based behavioral health service		

3. Assumption is that MCE Corporate Office reviewed the auth unless one of the following is checked:

<input type="checkbox"/> For Anthem: AIM/St F	<input type="checkbox"/> For MHS: Cenpatico	<input type="checkbox"/> For MDwise: CMCS	<input type="checkbox"/> For MDwise: Hoosier Alliance
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4. Provider Category that submitted auth
 PAR (contracted) Non PAR (not contracted) Cannot be determined

5. Type of Auth Request? (place an X in only 1 box)
 Pre Service Concurrent Review Retrospective Cannot be determined

6. Mode of Auth Request? (place an X in only 1 box)
 Fax Phone Email Cannot be determined

7. Who is the highest level staff member to reviewed the Auth Request? (place an X in only 1 box)
 Non-clinical staff *only* Nurse Physician/MH Professional Cannot be determined

8. Record relevant dates related to this authorization (mm/dd/yy)
 a. Date Auth was Requested _____ b. Date of Final Determination _____

9. Clinical documentation was supplied with the initial auth request by the provider (either via fax or by phone and recorded by MCE)
 Yes No Cannot be determined

10. What was the *Initial* Determination for the Auth Request? (place an X in only 1 box)
 Approved Denied Modified Cannot be determined

11. Check if evidence in file that requesting provider asked for reconsideration after initial determination was made.

12. Check if evidence in file that a physician peer-to-peer was conducted (either before or after determination made).

13. If answer to #11 or #12 is Yes, what was the *Final* Determination for the Auth Request? (place an X in only 1 box)
 Approved Denied Modified Cannot be determined

Complete Questions 14-19 only if the authorization request was denied or modified.

14. Reason Category for MCE denial or modification Administrative Clinical

15. If reason for denial or modification was administrative, indicate MCE rationale or check if Cannot be determined
 Lack of documentation Untimely filing Not covered service Other

16. If reason for denial or modification was clinical, indicate MCE rationale or check if Cannot be determined
 Service request not deemed medically necessary Other (describe) _____

17. If reason for denial was "not deemed medically necessary", what criteria was used to justify this? (check all that apply)
 Milliman (MCG) Interqual MCE Clinical Guidelines IAC or OMPP criteria

18. Who signed the denial/modified disposition letter to the requesting provider? (Check only 1) No written letter found
 MD signed the letter RN signed the letter No signature (generic such as "from Medical Management")

19. Indicate the level of detail provided in the letter pertaining to clinical criteria. MCE Guideline stated
 Specific citation for Milliman or Interqual stated Specific citation not provided, just general reference

If in Q2 (service category), 'Inpatient acute care' or 'Inpatient beh health' checked, answer Questions 20-21.

20. Length of stay < 48 hours Length of stay 48-72 hrs Length of stay > 72 hours

21. Yes, observation days approved If Yes, indicate number of days _____ No, observation not approved