Indiana Health Coverage Programs 2024-2026 Quality Strategy Plan

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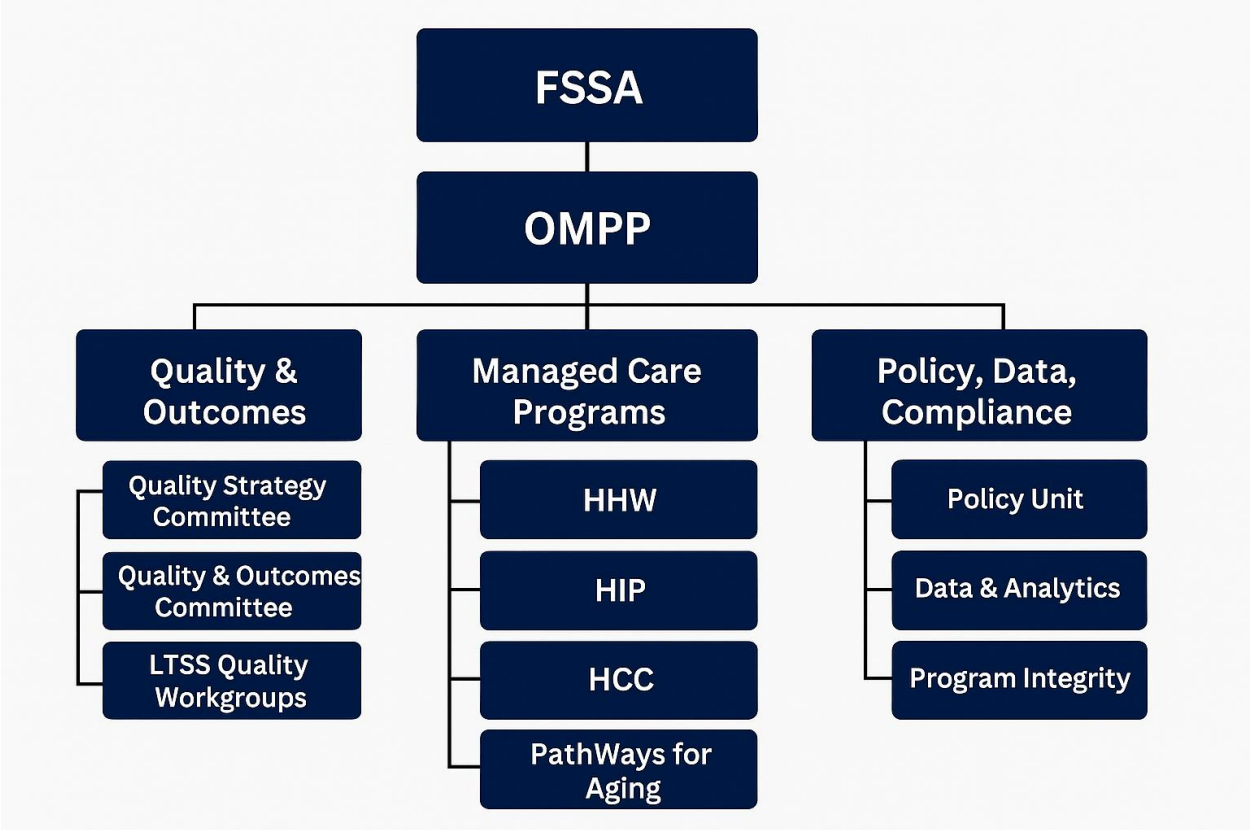
SECTION I. Introduction and Overview

Introduction

The Indiana Family and Social Services Administration (FSSA) is the state agency responsible for administering the **Indiana Health Coverage Programs (IHCP)** under Medicaid and the **Dual Eligible Special Needs Plan (D-SNP)**. FSSA's vision is to build a healthier Indiana where vulnerable Hoosiers thrive through an innovative and accountable system. Its mission is to provide essential Medicaid coverage to eligible Hoosiers through programs that are efficient, sustainable, and improve health outcomes and community well-being.

Under FSSA's direction, the **Office of Medicaid Policy and Planning (OMPP)** administers Medicaid and D-SNP for Indiana. OMPP partners with managed care entities (MCOs) to deliver services for IHCP across four programs: **Hoosier Healthwise (HHW)**, **Hoosier Care Connect (HCC)**, **Healthy Indiana Plan (HIP)**, and **Indiana PathWays for Aging (PathWays)** (which includes D-SNP alignment). Indiana provides **Children's Health Insurance Program (CHIP)** benefits through managed care under HHW as a combination Medicaid expansion and separate CHIP program.

Figure 1.1. FSSA IHCP Organizational Structure



In accordance with **42 CFR 438.340** and **42 CFR 457.1240(e)**, Indiana implements and maintains a **Quality Strategy Plan (QSP)** establishing methods to improve the delivery of Medicaid and D-SNP services statewide. The QSP aligns with agency objectives to enhance the emotional, mental, and physical wellness of Hoosiers. It defines statewide managed care quality priorities, goals, and objectives, and serves as guidance for MCOs to plan and conduct quality improvement. The QSP frames the state's approach to: the Final Medicaid Managed Care Rule implementation, Quality Assessment and Performance Improvement (QAPI), Performance Improvement Projects (PIPs), annual External Quality Review (EQR), State Directed Payments, use of Core Measure Sets, and other quality management activities.

This QSP is a 1-year update (effective through 2026) that sets top priorities, areas for improvement, and performance metrics. It is being revised under 42 CFR 438.340(b)(10) to address significant changes, including incorporation of the D-SNP population into PathWays (effective Jan 1, 2026), the termination of one MCO, and revisions to quality metrics (pay for outcomes, performance measures, and PIPs).

Overview of Indiana Health Coverage Programs

Indiana is actively enhancing the lives of Medicaid managed care members by focusing on timely access, quality improvement, and cost management. Based on the U.S. Census Bureau 2023 estimate, Indiana's population was 6,862,199; as of December 2023, 1,666,337 individuals were enrolled in Indiana Medicaid (including CHIP) — about 1 in 3 Hoosiers. Of those, 1,444,799 (86.7%) were enrolled with an MCO.

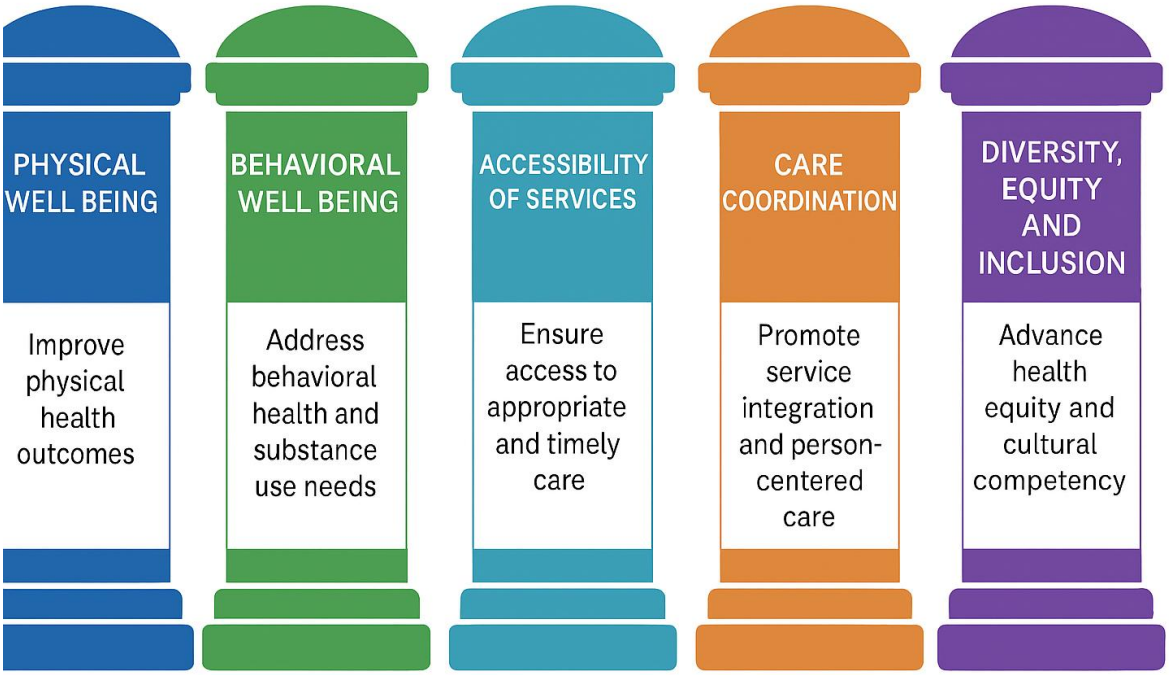
As of **January 1, 2026**, Indiana contracts with five risk-based MCOs to administer IHCP programs: **Elevance Health d/b/a Anthem Blue Cross and Blue Shield (Anthem)**, **Arcadian Health Plan d/b/a Humana Healthy Horizons in Indiana (Humana)**, **CareSource Indiana, Inc.**, **Coordinated Care Corporation d/b/a Managed Health Services (MHS)**, and **UnitedHealthcare Insurance Company d/b/a UnitedHealthcare Community Plan**. Effective **July 1, 2024**, Indiana began delivering **Long-Term Services and Supports (LTSS)** through managed care in **PathWays for Aging**. PathWays MCOs must cover the full range of Medicaid services and operate a **companion D-SNP** exclusively aligned in calendar year **2026**; until then, MCOs and D-SNPs are aligned. **MDwise** is no longer participating in Indiana Medicaid as of **January 1, 2026,** and is transitioning out through mid/late 2026.

Table 1. Indiana Medicaid Health Coverage Programs

Program Name	Populations Served	Managed Care Authority	Managed Care Entities	Services Covered
Children's Health Insurance Program (CHIP)	Children up to age 19	1115(a); 1932(a)	Anthem; Managed Health Services; CareSource	Physical health; behavioral health; vision; dental; pharmacy
Hoosier Healthwise (HHW)	Children up to age 19; pregnant individuals; parents and caretakers	1115(a); 1932(a); 1931	Anthem; Managed Health Services; CareSource	Physical health; behavioral health; vision; dental; pharmacy; non-emergent transportation
Healthy Indiana Plan (HIP)	Adults ages 19–64 who meet income eligibility criteria	1115(a)	Anthem; Managed Health Services; CareSource	Physical health; behavioral health; vision; dental; pharmacy; non-emergent transportation
Hoosier Care Connect (HCC)	Individuals aged <65 who are aged, blind, or disabled and not Medicare eligible; includes some foster care populations	1915(b)(1), (b)(4)	Anthem; Managed Health Services; UnitedHealthcare	Physical health; behavioral health; vision; dental; pharmacy; non-emergent transportation
Indiana PathWays for Aging	Individuals aged 60 or older, blind, or disabled; includes members with or without Medicare (including D-SNP members)	1915(b)(1), (b)(4); 1915(c)	Anthem; Humana; UnitedHealthcare	Physical health; behavioral health; vision; dental; pharmacy; non-emergent transportation; long-term services and supports (LTSS)

*There is one federally recognized tribe in Indiana, the **Pokagon Band of Potawatomi**. Individuals who are **American Indian/Alaska Native (AI/AN)** may elect to enroll into managed care (voluntary enrollment).

Figure 1 — Five Pillars of Well Being



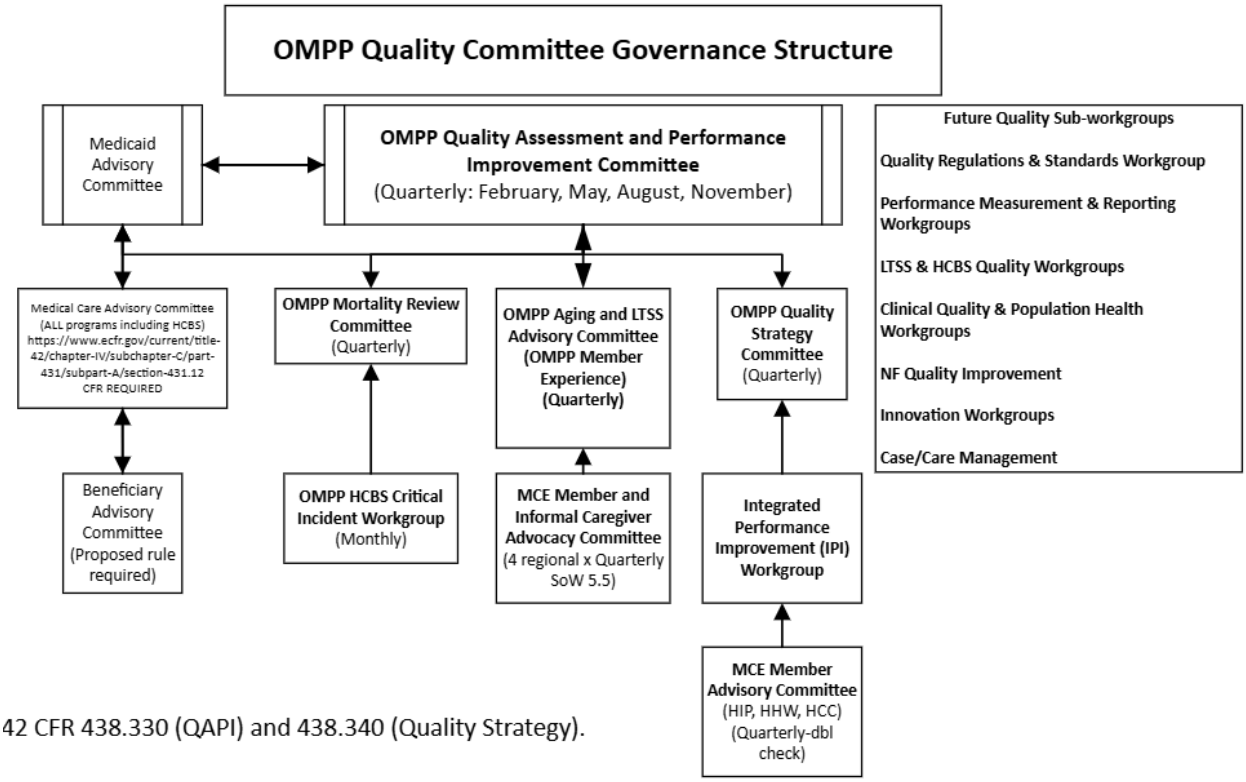
SECTION II. OMPP Quality Management Structure

Quality Management Structure

The Office of Medicaid Policy and Planning (OMPP) administers the Indiana Health Coverage Programs (IHCP) and oversees statewide quality management activities. OMPP's quality structure ensures that services delivered through managed care entities (MCOs) meet federal requirements and support improved member outcomes across physical health, behavioral health, LTSS, dental, vision, pharmacy, and care management programs.

OMPP coordinates quality strategy implementation across Medicaid programs—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP), Hoosier Care Connect (HCC), and Indiana PathWays for Aging (PathWays)—including aligned Dual Eligible Special Needs Plan (D-SNP) operations beginning calendar year 2026.

Figure 2.1. OMPP Quality Committee Governance Structure



42 CFR 438.330 (QAPI) and 438.340 (Quality Strategy).

OMPP's quality structure is composed of multiple Committees working together to support oversight, quality measurement, evaluation, and continuous improvement. These committees coordinate with MCOs, the External Quality Review Organization (EQRO), CMS, sister agencies, and stakeholders.

Figure 2.1 Sources of Input to the Quality Management Improvement Workplan

OMPP uses standardized processes for performance measurement, ensuring that quality results are accurate, comparable, and aligned with federal and state requirements.

Major Quality Oversight Responsibilities

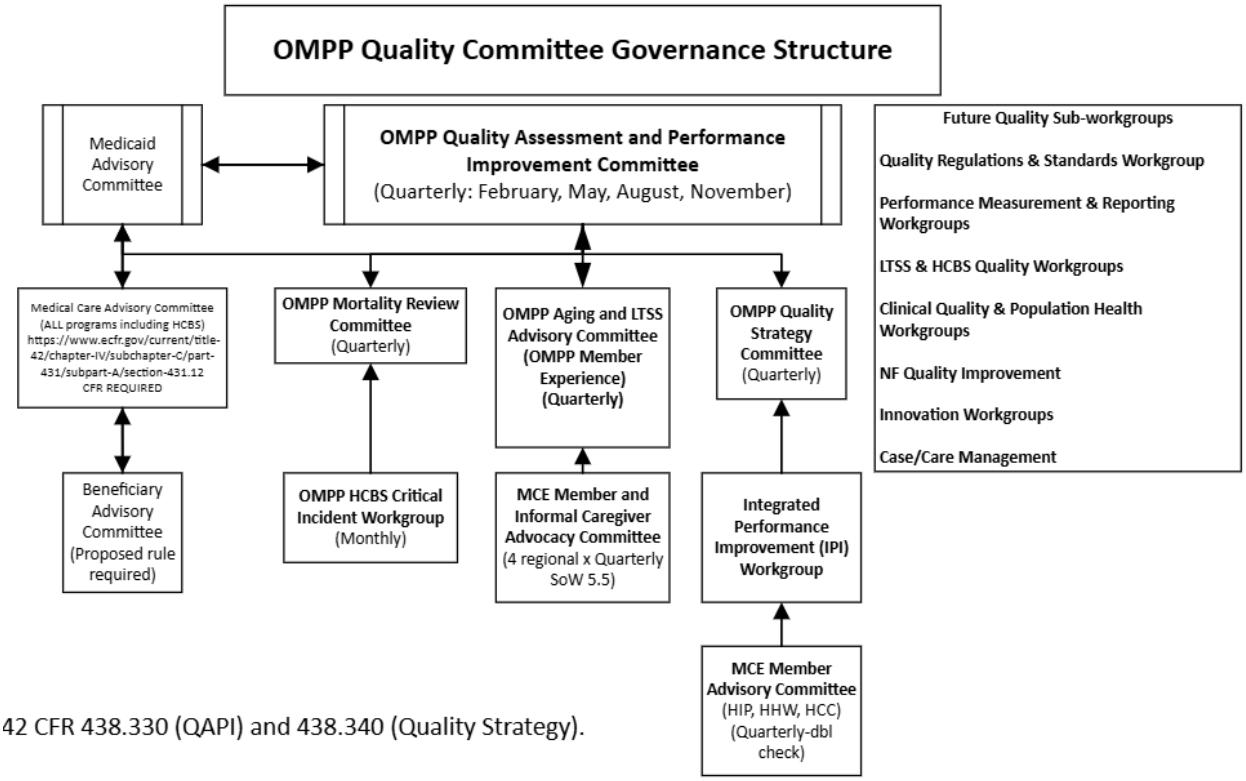
OMPP's Quality Division carries out the following statewide oversight responsibilities:

- Administers and updates the **Quality Strategy Plan**
- Leads **quality measurement**, including performance measures, pay-for-outcomes (P4O), and Core Measure Sets
- Directs and monitors **Performance Improvement Projects (PIPs)**
- Coordinates data submission, validation, and reporting across programs
- Supports **State Directed Payments (SDPs)** tied to quality
- Oversees **External Quality Review (EQR)** and implements corrective actions
- Coordinates quality-related contract requirements with MCOs
- Manages **population health** and **health equity** strategies
- Leads LTSS quality oversight under the **PathWays** program
- Oversees **member experience**, appeals, and grievances processes
- Ensures compliance with **42 CFR 438 Subpart E** and **42 CFR 457** reporting requirements

SECTION II.A - Quality Committees and Oversight Bodies

OMPP maintains a multi-layered governance structure to coordinate quality activities across Medicaid programs, and the D-SNP aligned population.

Figure 2.2 Quality Committee Governance Structure



42 CFR 438.330 (QAPI) and 438.340 (Quality Strategy).

OMPP Quality Committee (OQC)

The OQC provides strategic direction for all quality-related initiatives across IHCP programs. Primary functions include:

- Approving annual quality priorities and goals
- Reviewing MCO performance against required metrics
- Reviewing PIP progress, barriers, and outcomes
- Reviewing EQR findings and recommending corrective action
- Monitoring health equity initiatives
- Reviewing annual CMS submissions

Membership includes leadership from:

- OMPP Director's Office
- Quality Division
- Care Management & LTSS
- Behavioral Health
- Data & Analytics
- Managed Care Oversight

Meetings occur at minimum **quarterly**.

Managed Care Clinical Advisory Group (MCCAG)

The MCCAG supports clinical policy decisions relevant to OMPP and MCO performance. Functions include:

- Reviewing care management policy changes
- Monitoring quality trends for high-risk populations
- Reviewing behavioral health and physical health integration efforts
- Providing clinical input on P4O, PIPs, and emerging quality topics

Membership includes medical directors from all contracted MCOs and OMPP clinical leadership.

MCO Quality Leadership Collaborative

A cross-MCO collaborative that supports statewide measurement consistency and shared practices. Topics include:

- Data validation and performance measurement
- Standardized reporting
- PIP methodology alignment
- Health equity improvement strategies

This group meets **monthly**.

SECTION II.B – Quality Reporting & Data Infrastructure

OMPP oversees all quality reporting and data validation related to Medicaid managed care and D-SNP alignment.

Key responsibilities include:

- Managing annual quality measure submissions
- Overseeing hybrid medical record review activities
- Maintaining data validation protocols
- Coordinating with the EQRO to ensure compliance with CMS protocols
- Producing annual statewide performance summaries

OMPP requires each MCO to submit **Performance Measure Reports**, **Encounter Data**, **PIP documentation**, and **data validation files** in alignment with the Medicaid Managed Care Technical Reporting Guide.

SECTION II.C – Accountability Through Contract Requirements

OMPP enforces specific quality-related obligations within MCO contracts, including:

- Compliance with the Quality Strategy Plan
- Timely submission of required quality reports
- Participation in OMPP quality committees and collaboratives
- Meeting PIP, P4O, and benchmark targets
- Corrective action for poor performance
- Incentive payments tied to improvement and attainment thresholds

Performance is monitored using measures aligned with national standards (HEDIS®, CAHPS®, Core Sets). Payments and penalties may be applied based on performance outcomes.

This SECTION II.D – External Quality Review (EQR)

Indiana's EQR contractor evaluates the quality, timeliness, and access to care provided by MCOs. Activities completed annually include:

- Validation of performance measures
- Review of PIPs
- Analysis of compliance with federal managed care regulations
- Review of network adequacy and availability
- Validation of encounter data

The EQRO produces an annual statewide technical report summarizing findings and improvement opportunities.

Table 2. External Quality Review Recommendations

Topic	EQRO Recommendation	OMPP Response
Performance Improvement Project (PIP) Validation	Improvements are needed in the submission of PIP data and progress measurement. EQRO recommends continued monitoring to ensure quality, timeliness, and access to care.	OMPP has improved oversight by implementing Corrective Action Plans for any AONs.
Performance Measure Validation	The MCOs' information systems capabilities were determined to have no issues. There were problems with the performance measure validation and in the data assessments.	OMPP will continue validating performance measure submissions and address issues if discovered.
Annual Network Adequacy Review	All MCOs struggled to maintain provider accessibility standards and wait time compliance.	OMPP will continue monitoring network adequacy through required routine reporting outlined in the MCO Reporting Manual.
Focus Studies	Encourage MCOs to enhance efforts to align care management enrollment, particularly for members with poorly controlled diabetes; Encourage MCOs to invest in strategies that enable increased care management participation such as SDOH-focused initiatives, member incentives, and provider engagement; Encourage MCOs to introduce targeted interventions in high prevalence counties such as Marion, Lake, and St. Joseph; Consider policies/practices to encourage regular review of diabetes outcomes data, outlining minimum standards for frequency and timeliness of data sharing;	OMPP will continue to monitor these areas and consider these recommendations for improvement in high prevalence counties.

Topic	EQRO Recommendation	OMPP Response
	Encourage MCOs to increase the frequency of provider engagement for high-risk diabetic members, with greater emphasis on data sharing and increased interoperability to support collaboration; Promote opportunities for member engagement strategies, including remote monitoring and diabetes self-management education and support programs; Support the expansion of provider incentives focused on diabetes outcomes and coordination.	

SECTION II.E – Care Management & LTSS Quality Oversight

OMPP directly monitors:

- Care management timeliness
- Person-centered service planning
- Comprehensive assessments
- Critical incident management systems
- HCBS and institutional quality requirements
- PathWays LTSS quality measures
- D-SNP alignment activities beginning CY 2026

OMPP collaborates closely with the Division of Aging (DA), Division of Mental Health and Addiction (DMHA), and external stakeholders to support LTSS quality oversight.

Table X. Interventions, Processes, and Stakeholders

Intervention	Process	Stakeholders
Outcome-Based Contracting	• Pay for outcomes • Maintain and improve current metrics • Reporting that matches the state's goals • Monitor enrollment in the Right Choices Program • Assure member access to care	• OMPP • Contracted MCOs
Prenatal/Postpartum Care Initiatives	• Notification of pregnancy monitoring • Smoking cessation initiatives for	• OMPP • Contracted

	pregnant members • Monitoring member's access to care • Partnership with IDOH • My Healthy Baby project • Indiana Pregnancy Promise Program	MCOs • IDOH • Providers
Improve Health Care for Indiana's Children / EPSDT	• Increase the percentage of children and adolescents receiving well-care • Provider adherence protocol for in-depth physical and mental health screenings • Ongoing provider education, monitoring, and outreach • Collaboration with IDOH to increase blood lead testing • Monitor collaboration between mental health services, PRTF, and Money Follows the Person	• OMPP • Contracted MCOs • Gainwell • DMHA • EPSDT • IDOH
Behavioral Health	• Follow-up after mental health hospitalization (collaborative project) • Increase member access to SUD services and providers • Increase number of IHCP-enrolled SUD providers • Approval & implementation of the SMI Waiver • Use of standard IHCP SUD prior authorization request form	• OMPP • DMHA • Contracted MCOs
Improving Access to Prenatal Care / High-Risk Pregnancy Case Management	• Monitor improvements in the notification of pregnancy process	• OMPP • Contracted MCOs • IDOH • Providers

SECTION III. Development and Review of the Quality Strategy Plan

Development and Review of the Quality Strategy Plan

The Quality Strategy Plan (QSP) is developed and maintained by the Office of Medicaid Policy and Planning (OMPP) in collaboration with program divisions, managed care entities (MCOs), the External Quality Review Organization (EQRO), other state agencies, and stakeholder groups. OMPP uses a structured, data-driven process to establish statewide quality goals, objectives, and performance expectations.

The QSP reflects federal requirements under 42 CFR 438.340 and 42 CFR 457.1240(e). It outlines the strategic direction for improving the quality, timeliness, and accessibility of care across the Indiana Health Coverage Programs (IHCP), including Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP), Hoosier Care Connect (HCC), and Indiana PathWays for Aging (PathWays), inclusive of the aligned D-SNP population.

OMPP reviews and updates the QSP at least once every three years, or more frequently when certain conditions require modification (such as adding new populations, major program changes, federal regulatory updates, or new quality initiatives). When updates are required, OMPP coordinates the update process to ensure alignment with statewide strategic objectives, CMS guidance, and stakeholder feedback.

III.A – Components Used to Develop the Quality Strategy

OMPP uses multiple data sources, quality frameworks, and evaluation processes to inform the QSP. These foundational components include:

- **External Quality Review (EQR) findings**
- **Quality measures**, including Core Sets, P4O measures, and supplemental state measures
- **Performance Improvement Projects (PIPs)**
- **Population health and demographic data**
- **Access, network adequacy, and utilization trends**
- **Member experience data**, including CAHPS® and appeals and grievances
- **MCO contract requirements and readiness assessments**
- **State and federal regulatory updates**
- **Operational and clinical performance data** (encounter, claims, authorizations)
- **Care management and Long-Term Services and Supports (LTSS) data**
- **Stakeholder input**, including members, advocates, providers, and MCOs

OMPP uses these components to evaluate current performance and identify opportunities for improvement, ensuring that the QSP remains relevant and responsive to member needs.

III.B – Stakeholder Collaboration in Developing the Quality Strategy

The QSP development process incorporates broad input from stakeholders and partners. Routine stakeholder collaboration includes:

- Leadership input and direction from OMPP executives
- Clinical and operational feedback from OMPP divisions
- Contributions from MCOs through quality committees and workgroups
- Recommendations from the EQRO based on annual reviews
- Input from sister agencies, including the Division of Aging (DA) and Division of Mental Health and Addiction (DMHA)
- Feedback from members, families, and community advocates
- Provider perspectives gathered through meetings, associations, councils, and public comment

Stakeholder feedback is used to refine goals, objectives, measures, and improvement strategies across IHCP programs.

III.C – Review Cycle and Evaluation of the Quality Strategy

OMPP maintains an annual review cycle for evaluating the effectiveness of the QSP. This evaluation includes:

- Examination of statewide performance trends across all programs
- Assessment of progress toward goals and objectives
- Review of P4O performance
- Evaluation of PIP outcomes
- Monitoring of health disparities and population-specific outcomes
- Review of MCO quality management programs, policies, and performance
- Review of EQRO annual technical reports and recommendations
- Identification of areas requiring corrective action or policy enhancement

If the evaluation identifies substantial changes in populations, programs, or measurement expectations, OMPP initiates a formal QSP update process.

III.D – Coordination with CMS Requirements

OMPP ensures the QSP meets all federal requirements, including:

- Alignment with CMS managed care rules

- Use of national standard measures (Core Sets, HEDIS®, CAHPS®, etc.)
- Incorporation of health equity principles
- Requirements for PIPs, SDPs, and performance measurement reporting
- Requirements for EQR and encounter data validation
- Public posting of required documents
- Annual updates to the CMS-mandated Quality Strategy progress report

OMPP submits QSP updates to CMS for review, providing all requested documentation and ensuring continued compliance with federal standards.

III.E – Continuous Improvement Approach

OMPP leads a continuous improvement process across Medicaid managed care programs using:

- **Plan-Do-Study-Act (PDSA)** cycles
- Regular data review and trending
- Quarterly quality committee meetings
- Ongoing stakeholder engagement
- Identification of emerging clinical, operational, and member-experience issues
- Data validation and performance auditing
- Corrective action planning when needed

This structured process ensures that Indiana's quality strategy remains a living document—updated in response to performance trends, regulatory changes, and stakeholder needs.

III.F – Summary of Quality Strategy Goals

The QSP aims to:

1. Improve access to needed services
2. Strengthen quality and coordination of care
3. Improve population health outcomes
4. Advance health equity and reduce disparities
5. Enhance the member experience
6. Support cost-effective, value-based care
7. Ensure MCO accountability through measurement and oversight

8. Promote innovation in care delivery and community partnerships

These goals guide all quality activities across Indiana Medicaid managed care programs.

SECTION IV. Public Comment Process

Overview of the Public Comment Process

The Office of Medicaid Policy and Planning (OMPP) follows a transparent and structured public comment process for updates to the Quality Strategy Plan (QSP). This ensures that members, families, advocates, providers, managed care entities (MCOs), and community stakeholders have the opportunity to review and provide meaningful input on proposed changes. The process supports accountability and allows OMPP to incorporate stakeholder insights before finalizing the plan.

OMPP provides opportunities for public comment whenever a substantial update to the QSP is proposed, including updates required under federal regulations, program expansions, or material changes to the scope, goals, or quality requirements outlined in the strategy.

IV.A – Posting and Notification

OMPP uses multiple communication channels to notify the public when a draft Quality Strategy Plan is available for feedback. These channels may include:

- Posting the draft QSP on the Indiana Medicaid website
- Distribution of notifications to MCOs, provider associations, advocacy groups, and partner agencies
- Email communication through subscriber lists
- Announcements during regularly scheduled stakeholder meetings or advisory councils

Each public notice includes instructions on how to access the draft QSP and how to submit comments.

IV.B – Public Review Period

The draft QSP is made available for review for a defined comment period, typically between **30 and 45 days**. During this time, stakeholders are encouraged to submit feedback. Comments may be submitted through:

- Email
- Online public comment forms
- Written letters
- Stakeholder listening sessions or public meetings (when applicable)

OMPP reviews all comments received during this period and evaluates suggestions to determine whether revisions are warranted before finalizing the QSP.

IV.C – Consideration and Incorporation of Comments

After the comment period closes, OMPP conducts a review of all feedback received. This includes:

- Categorizing comments by theme or topic
- Reviewing suggestions for clarity, feasibility, and regulatory alignment
- Identifying areas where language, processes, or requirements could be improved
- Noting any concerns or barriers identified by advocates, providers, or members

OMPP incorporates revisions that enhance clarity, accuracy, or alignment with federal requirements or statewide quality improvement priorities. Substantive changes to quality goals, performance measures, or program policies are thoroughly evaluated before being included in the final version of the QSP.

IV.D – Transparency and Availability of Final Documents

Once revisions are complete, OMPP publishes the final Quality Strategy Plan on the Indiana Medicaid website. OMPP may also:

- Provide a summary of changes resulting from public comment
- Notify stakeholders of the final publication
- Review updates at quality committee meetings
- Include the final QSP as part of training for MCOs or policy implementation

The finalized plan becomes the guiding document for statewide quality improvement efforts across Medicaid managed care and aligned D-SNP programs.

IV.E – Ongoing Engagement Beyond the Formal Comment Period

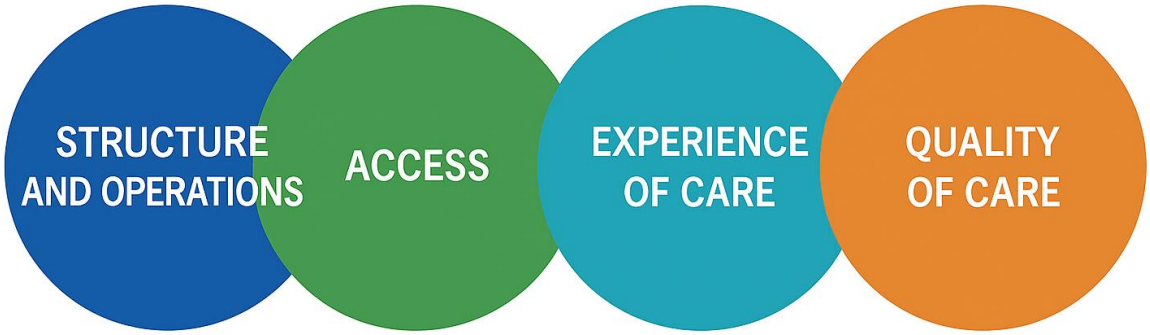
OMPP maintains ongoing communication with stakeholders throughout the year, not only during periods of formal public comment. Continuous engagement includes:

- Quarterly quality committee meetings
- Regular provider engagement sessions
- Feedback from member advisory councils
- Collaboration with partner agencies
- EQRO-related feedback loops

OMPP uses input from these ongoing forums to inform future updates, strengthen quality oversight, and ensure the QSP reflects emerging needs and best practices.

SECTION VI. Quality Metrics and Performance Targets

Figure 4.1 Quality Measure Categories



Overview

The Quality Strategy Plan (QSP) outlines the statewide system of measurement used by the Office of Medicaid Policy and Planning (OMPP) to assess and improve the quality, timeliness, and access to care delivered by managed care entities (MCOs). Quality metrics serve as the foundation for evaluating program performance, identifying opportunities for improvement, and promoting accountability across Indiana Medicaid's managed care programs.

OMPP uses quality metrics to benchmark performance, monitor trends over time, and evaluate the effectiveness of interventions such as Performance Improvement Projects (PIPs), State Directed Payments (SDPs), and Pay-for-Outcomes (P4O) programs. Performance targets are established to promote consistency across MCOs and drive statewide improvement.

VI.A – Structure of the Statewide Quality Measurement System

OMPP's measurement system includes several categories of quality metrics:

- **Nationally standardized performance measures** (e.g., Core Set, HEDIS®, CAHPS®)
- **State-defined performance measures** designed for Indiana-specific priorities
- **Pay-for-Outcomes (P4O) measures** with financial incentives and penalties
- **Performance Improvement Project (PIP) measures** tracked through multi-year improvement cycles
- **Program integrity, access, and operational metrics**
- **LTSS and PathWays-specific measures** related to person-centered planning, assessments, service delivery, and health outcomes

OMPP routinely evaluates and updates its measurement system to remain aligned with federal guidance, national reporting standards, and state priorities.

VI.B – Data Sources and Reporting

OMPP uses multiple data sources to calculate and validate performance metrics, including:

- Encounter and claims data
- Care management system data
- Member experience surveys
- Provider network and access data
- Prior authorization and utilization management reports
- LTSS assessments and case management documentation
- Medical record review (hybrid measure) data
- Member grievance and appeals data
- EQRO data validation and technical reports

MCOs are required to submit data according to standardized templates and technical specifications defined by OMPP. Data must be complete, accurate, and submitted within defined timelines.

VI.C – Performance Targets and Benchmarks

OMPP establishes annual performance targets for statewide quality measures. Performance targets may be based on:

- National benchmarks (e.g., NCQA percentiles)
- Historical statewide performance
- Improvement thresholds (e.g., percentage-point improvement)
- Attainment thresholds (e.g., top decile or performance above the mean)
- Health equity targets addressing disparities by demographics or geography

Targets are set to balance rigor with feasibility and to encourage continuous improvement across all programs. OMPP periodically reviews targets to ensure they remain relevant and achievable.

VI.D – Pay-for-Outcomes (P4O) Measures

The P4O program aligns financial incentives and penalties with quality performance. MCOs may earn incentive payments or incur penalties based on their performance relative to predetermined thresholds.

P4O design elements include:

- Defined measure sets by program (HHW, HIP, HCC, PathWays)
- Attainment and/or improvement scoring
- Health equity bonus or adjustment factors
- Weighting based on strategic priorities
- Withholds that may be earned back through performance
- Validation of data submissions

Measures commonly included in P4O programs include preventive care, chronic disease management, maternal and child health, behavioral health, and LTSS quality measures.

VI.E – Performance Improvement Projects (PIPs)

PIPs are multi-year, structured quality improvement initiatives conducted by each MCO and reviewed by OMPP and the EQRO. PIPs must follow CMS protocol requirements and use valid, reliable measures to evaluate improvement.

PIP elements include:

- Problem identification
- Baseline measurement
- Intervention design and implementation
- Ongoing tracking
- Remeasurement
- Analysis and reporting
- Sustainability planning

Indiana may require statewide PIPs or allow MCO-specific PIPs depending on program needs and emerging priorities.

VI.F – Core Set and Other National Measures

OMPP prioritizes alignment with CMS **Child** and **Adult Core Sets**, which support nationwide consistency and comparability. The state also supports federal reporting requirements across:

- Behavioral health integration measures
- Maternal and perinatal health measures
- Primary care access measures
- LTSS and person-centered planning measures

- HCBS quality and functional assessment measures

National measures allow Indiana to compare performance to other states and identify relative strengths and opportunities.

Table XI. Adult Core Measures Reported

Abbreviation	Measure	Performance
AAB-AD	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older	45.2
AIS-AD	Adult Immunization Status	11.7
AMM-AD	Antidepressant Medication Management	63.0
AMR-AD	Asthma Medication Ratio: Ages 19 to 64	59.3
BCS-AD	Breast Cancer Screening	32.2
CBP-AD	Controlling High Blood Pressure	17.5
CCP-AD	Contraceptive Care – Postpartum Women Ages 21 to 44	28.8
CCS-AD	Cervical Cancer Screening	12.8
CCW-AD	Contraceptive Care – All Women Ages 21 to 44	16.3
CDF-AD	Screening for Depression and Follow-Up Plan: Age 18 and Older	NR
CHL-AD	Chlamydia Screening in Women Ages 21 to 24	55.8
COB-AD	Concurrent Use of Opioids and Benzodiazepines	7.5
COL-AD	Colorectal Cancer Screening	42.7
FUA-AD	Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older	39.9
FUH-AD	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older	45.1
FUM-AD	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older	48.6

GSD-AD	Glycemic Status Assessment for Patients with Diabetes	57.6
HPCMI-AD	Diabetes Care for People with Serious Mental Illness: Glycemic Status > 9.0%	7.0
IET-AD	Initiation and Engagement of Substance Use Disorder Treatment	Initiation – 45.1
		Engagement – 24.8
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder	74.5
PCR-AD	Plan All-Cause Readmissions	6.2
PPC2-AD	Prenatal and Postpartum Care: Age 21 and Over	Pre – 80.1
		Post – 77.6
PQI01-AD	PQI 01: Diabetes Short-Term Complications Admission Rate	4.8
PQI05-AD	PQI 05: COPD or Asthma in Older Adults Admission Rate	5.2
PQI08-AD	PQI 08: Heart Failure Admission Rate	10.8
PQI15-AD	PQI 15: Asthma in Younger Adults Admission Rate	0.6
SAA-AD	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	58.3
SSD-AD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	82.5

Table XII. Child Core Measures Reported

Abbreviation	Measure	Rate
AAB-CH	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years	76.9
ADD-CH	Follow-Up Care for Children Prescribed ADHD Medication	Initiation – 44.3
		Continuation & Maintenance – 54.9

AMR-CH	Asthma Medication Ratio: Ages 5 to 18	68.4
APM-CH	Metabolic Monitoring for Children and Adolescents on Antipsychotics	31.2
APP-CH	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	59.3
CCP-CH	Contraceptive Care – Postpartum Women Ages 15 to 20	51.7
CCW-CH	Contraceptive Care – All Women Ages 15 to 20	9.6
CDF-CH	Screening for Depression and Follow-Up Plan: Ages 12 to 17	0.3
CHL-CH	Chlamydia Screening in Women Ages 16 to 20	41.3
CIS-CH	Childhood Immunization Status	23.0
DEV-CH	Developmental Screening in the First Three Years of Life	31.2
FUA-CH	Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17	31.8
FUH-CH	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17	71.9
FUM-CH	Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17	72.0
IMA-CH	Immunizations for Adolescents	31.3
LSC-CH	Lead Screening in Children	68.5
OEV-CH	Oral Evaluation, Dental Services	53.8
PPC2-CH	Prenatal and Postpartum Care: Under Age 21	Pre – 78.4 Post – 74.4
SFM-CH	Sealant Receipt on Permanent First Molars	18.3
TFL-CH	Prevention: Topical Fluoride for Children	24.4
W30-CH	Well-Child Visits in the First 30 Months of Life	71.2

WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI – 46.9
		Nutrition – 18.0
		Physical Activity – 16.7
WCV-CH	Child and Adolescent Well-Care Visits	54.0

VI.G – Health Equity and Disparities Monitoring

OMPP integrates health equity monitoring across all measurement activities. Quality measures are stratified by factors such as:

- Race
- Ethnicity
- Age
- Geography
- Disability
- Eligibility group
- Medicare-Medicaid dual-status (where applicable)

When stratification reveals disparities, OMPP may require targeted improvement plans, adjustment of priorities, or specific interventions in collaboration with MCOs.

VI.H – Public Reporting

OMPP publishes select performance results to increase transparency and help stakeholders understand statewide trends. Public reporting may include:

- Quality dashboards
- Annual quality and performance summaries
- EQR technical report findings
- Summaries of improvement strategies and outcomes
- Program-specific performance overviews (HIP, HHW, HCC, PathWays)

Public reporting supports accountability and empowers members, families, and advocates to engage with quality initiatives.

SECTION VII. Goals and Objectives

Overview

The Quality Strategy Plan establishes statewide **goals and objectives** that guide the Indiana Health Coverage Programs (IHCP) in improving the quality, accessibility, and outcomes of care delivered through managed care. These goals reflect Indiana's commitment to member-centered care, health equity, accountability, and continuous quality improvement. Each goal is supported by measurable objectives and aligned with performance measures, PIPs, and Pay-for-Outcomes programs.

OMPP's goals are designed to be achievable, data-driven, and responsive to the needs of diverse populations, including children, adults, older adults, persons with disabilities, individuals receiving long-term services and supports (LTSS), and dually eligible Medicare-Medicaid members.

For a list of all required performance measures and additional guidance utilize the resources below. It is the responsibility of every Managed Care Organization/Entity (MCO/E) to remain continuously informed and compliant with all applicable Federal, State, and Local requirements, as well as any directives issued by regulatory or governing bodies. This includes staying current with any additions, revisions, or removals related to legislation, codes, rules, guidance, or other official instructions at any time.

1. Indiana Medicaid Regulatory Reporting Manual
2. Pay for Outcomes Technical Specifications Documentation
3. CAHPS Technical Specifications
4. Guidance Sent Out in Weekly Updates
5. Compliance and Quality Calls, Meetings, Workgroups, Committees
6. Quality and Outcomes
7. IHCP Bulletins
8. Federal Policy Guidance
9. 42 CFR
10. Centers for Medicare & Medicaid Services
11. CMCS
12. Indiana General Assembly
13. Indiana Administrative Rules and Policies
14. Agency for Healthcare Research and Quality
15. NCQA Products
16. Clinical Quality Measures
17. HEDIS and Performance Measurement
18. Health Plan Current Report Cards
19. Child and Adult Health Care Quality Measures
20. Indiana Health Plan Contracts
21. Medicare 2026 Part C & D Star Rating Measures
22. Indiana State Medicaid Agency Contract

Table 3. Quality Strategy Goals and Objectives
X = measure applies to the program

Objective	Objective Description	Process & Outcome Quality Measures	Measure Source	HHW	HIP	HCC	PathWays
Goal 1: Improve health outcomes through preventive care and behavioral health condition management							
1.1	Improve care coordination and follow-up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for Substance Use (FUA) – 7 & 30 Days	HEDIS®	X	X	X	X
		Follow-Up After Hospitalization for Mental Illness (FUH) – 7 & 30 Days	HEDIS®	X	X	X	X
		Follow-Up After ED Visit for Mental Illness (FUM) – 7 & 30 Days	HEDIS®	X	X	X	X
		Initiation & Engagement of Alcohol and Other Drug Treatment (IET)	HEDIS®	X	X	X	X
		Adherence to Antipsychotic	HEDIS®	X	X	X	X

		Medication for Individuals with Schizophrenia (SAA)					
1.2	**Improve use of preventive behavioral health screenings and follow-up**	**Metabolic Monitoring for Children & Adolescents on Antipsychotics (APM-E)**	**HEDIS®**	**X**		**X**	
		Diabetes Screening for Individuals on Antipsychotics (SSD)	**HEDIS®**	**X**	**X**	**X**	**X**
		Cardiovascular Monitoring for Individuals with Cardiovascular Disease & Schizophrenia (SMC)	**HEDIS®**	**X**	**X**	**X**	**X**
		Diabetes Monitoring for Patients with Diabetes & Schizophrenia (SMD)	**HEDIS®**	**X**	**X**	**X**	**X**
Goal 2: Improve the health and wellness of pregnant persons, new mothers, infants, and children							
2.1	**Ensure early detection and follow-up for prenatal**	**Timeliness of Prenatal Care (PPC-1)**	**HEDIS®**	**X**	**X**		

	and postpartum depression						
		Postpartum Care (PPC-2)	HEDIS®	X	X		
2.2	Improve access to preventive and developmental screenings and well-child visits	Well-Child Visits in the First 30 Months of Life (W30)	HEDIS®	X			
		Child & Adolescent Well-Care Visits (WCV)	HEDIS®	X			
		Childhood Immunization Status – Combo 10 (CIS-E)	HEDIS®	X			
		Immunizations for Adolescents (IMA-E)	HEDIS®	X			
Goal 3: Improve oral health and prevent oral disease							
3.1	Prevent oral disease	Oral Evaluation, Dental Services (OED)	HEDIS®	X	X	X	
3.2	Improve access to dental services	Dentists & Oral Surgeons Network Adequacy	OMPP	X	X	X	X
Goal 4: Improve the health of members with chronic conditions							

4.1	Improve health and reduce complications for members with diabetes and other chronic conditions	Glycemic Status Assessment for Patients with Diabetes (GSD)	HEDIS®	X	X	X	X
		Blood Pressure Control for Patients with Diabetes (BPD)	HEDIS®	X	X	X	X
		Eye Exam for Patients with Diabetes (EED)	HEDIS®	X	X	X	X
		Kidney Health Evaluation for Patients with Diabetes (KED)	HEDIS®	X	X	X	X
		Controlling High Blood Pressure (CBP)	HEDIS®	X	X	X	X
4.2	Reduce emergency room use and inpatient readmissions	Adults' Access to Preventive/Ambulatory Health Services (AAP)	HEDIS®	X	X	X	X
		Acute Hospital Utilization (AHU)	HEDIS®	X	X	X	X

		Emergency Department Utilization (EDU)	HEDIS®	X	X	X	X
Goal 5: Improve care coordination across the service continuum							
5.1	Reduce inpatient readmissions	Plan All-Cause Readmissions (PCR)	HEDIS®	X	X	X	X
		MLTSS-4: LTSS Reassessment/Care Plan Update after Inpatient Discharge	CMS				X
		MLTSS-5: Screening, Risk Assessment & Care Plan to Prevent Future Falls	CMS				X
5.2	Ensure smooth transitions between care settings	Initial Health Needs Screening completion within required timeframe	OMPP	X	X	X	X
		Participants Reporting They Know Their Care Manager	CAHPS®				X
		MLTSS-3: Shared Care Plan with Primary Care Provider	CMS				X
		MLTSS-8: Successful Transition after LTSS Facility Stay	CMS				X

5.3	**Deliver person-centered services and supports**	**Service Coordinators Completing Person-Centered Planning Training**	**OMPP**				**X**
		Participants Reporting Their Service Plan Matches What Is Important to Them	**CAHPS®**				**X**
5.4	**Ensure timely access to services enabling members to remain in their preferred setting**	**Care Plan Implemented within 90 Days (Care Management level)**	**OMPP**				**X**
		Care Plan Implemented within 60 Days (Complex Care Management)	**OMPP**				**X**
		MLTSS-1: Comprehensive Assessment & Update	**CMS**				**X**
		MLTSS-2: Comprehensive Care Plan & Update	**CMS**				**X**
		MLTSS-6: Admission to	**CMS**				**X**

		Facility from Community					
		MLTSS-7: Minimizing Facility Length of Stay	**CMS**				**X**

VII.A – Goal 1: Improve Access to Timely, Appropriate, and High-Quality Care

OMPP works to ensure all members have timely access to medically necessary and evidence-based services across physical health, behavioral health, LTSS, and pharmacy.

Objectives

- Ensure adequate provider networks that meet time-and-distance standards
- Improve access to primary, specialty, and behavioral health services
- Increase timely access to HCBS and LTSS assessments and service planning
- Reduce avoidable delays in authorizations and care transitions
- Improve access to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children
- Improve access to prenatal and postpartum care

VII.B – Goal 2: Strengthen Quality and Coordination of Care

Quality and care coordination ensure that members receive the right care at the right time, supported by communication across providers, MCOs, and community partners.

Objectives

- Improve care coordination for complex and high-risk members
- Enhance transitions of care between hospital, home, and community settings
- Increase care management engagement and contact standards
- Improve medication management and adherence
- Integrate physical and behavioral health care coordination
- Strengthen care continuity during MCO changes or benefit transitions

VII.C – Goal 3: Improve Population Health and Reduce Chronic Disease Burden

Indiana focuses on health outcomes across priority conditions such as diabetes, hypertension, asthma, behavioral health disorders, maternal health, and conditions affecting aging adults.

Objectives

- Improve management of chronic conditions using evidence-based standards
- Increase appropriate preventive screenings (cancer, diabetes, cardiovascular)
- Improve maternal and child health outcomes
- Increase immunization rates across the lifespan
- Reduce hospital readmissions and potentially avoidable emergency department use
- Support early intervention for behavioral health conditions

VII.D – Goal 4: Advance Health Equity and Reduce Disparities

OMPP embeds health equity into all quality oversight activities to identify and reduce disparities in access, experience, and outcomes.

Objectives

- Stratify performance measures by race, ethnicity, age, geography, disability status, and other demographic factors
- Identify disparities and require targeted interventions from MCOs
- Promote culturally and linguistically appropriate services
- Support community-based partnerships that address social drivers of health
- Improve access and outcomes for populations with historically lower performance
- Strengthen accessibility for people with disabilities and those receiving LTSS

VII.E – Goal 5: Enhance Member Experience

Positive member experience is central to improving engagement, health outcomes, and member retention.

Objectives

- Improve CAHPS® scores across all domains
- Strengthen communication standards and responsiveness
- Reduce member complaints and grievances through better service
- Simplify navigation of benefits and care management services
- Improve person-centered planning and shared decision-making
- Increase satisfaction with care coordination and transitions of care

VII.F – Goal 6: Support Value-Based Care and Cost-Effective Service Delivery

OMPP encourages MCOs and providers to improve quality while managing costs through outcome-driven approaches.

Objectives

- Expand use of value-based purchasing arrangements
- Align P4O measures with statewide priorities
- Monitor and incentivize performance improvements
- Reduce unnecessary utilization while supporting appropriate access
- Improve service efficiency through evidence-based practices
- Promote accountable care models and community integration strategies

VII.G – Goal 7: Strengthen Accountability and Oversight

OMPP ensures managed care entities meet contractual and regulatory requirements while demonstrating continuous improvement.

Objectives

- Maintain robust contract monitoring processes
- Implement corrective action plans when performance does not meet expectations
- Use EQR findings to guide improvements
- Increase transparency through public reporting of performance data
- Strengthen encounter data quality and validation
- Promote consistent statewide performance expectations across all programs

VII.H – Goal 8: Foster Innovation and Collaboration

OMPP encourages innovation in care delivery, data use, and quality improvement through partnership with MCOs, providers, and community agencies.

Objectives

- Support pilot programs and evidence-informed interventions
- Promote integration of technology to improve care coordination
- Strengthen partnerships with community-based organizations
- Encourage cross-agency collaboration to address shared goals
- Incorporate emerging best practices into statewide initiatives

SECTION VIII. Measurement and Improvement Standards

Overview

Measurement and improvement standards define how the Office of Medicaid Policy and Planning (OMPP) evaluate managed care entity (MCO) performance and ensures that statewide quality goals are met. These standards establish expectations for data submission, reporting, validation, corrective action, and continuous quality improvement. They also ensure consistency in how performance is measured across all Indiana Health Coverage Programs (IHCP).

VIII.A – Performance Measurement Standards

OMPP requires that MCOs follow standardized technical specifications for all quality measures. These standards ensure that data is calculated consistently across MCOs, programs, and populations.

Performance measurement standards include:

- Use of nationally recognized specifications (e.g., Core Sets, HEDIS®, CAHPS®)
- Adherence to state-specified technical guidance
- Application of correct denominators and numerators
- Use of complete and accurate encounter data
- Standardized definitions for populations and eligibility
- Timely submission of performance data in required formats
- Use of approved medical record review processes for hybrid measures

MCOs must also maintain internal quality assurance controls when calculating performance measures.

VIII.B – Encounter Data Submission and Validation Standards

Encounter data serves as the backbone of quality measurement. To ensure accuracy:

- MCOs must submit encounter data according to OMPP's technical specifications and file layouts.
- Data must be complete, accurate, and submitted within prescribed deadlines.
- OMPP conducts encounter data audits and validation activities to ensure compliance.
- MCOs must correct any identified issues and resubmit data as required.
- Encounter data must support all relevant quality, cost, utilization, and network reporting.

High-quality encounter data are essential for accurate statewide measurement and evaluation.

VIII.C – Member Experience and Satisfaction Measurement Standards

OMPP uses member experience data to monitor satisfaction with care, communication, access, and overall quality.

Standards include:

- Administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey
- Reporting of all required CAHPS® measures
- Ensuring members have access to language and disability accommodations
- Monitoring trends in complaints and grievances
- Using member feedback to inform corrective actions and improvement initiatives

Member experience measures are integrated into P4O scoring and quality oversight.

VIII.D – Standards for Performance Improvement Projects (PIPs)

PIPs must follow CMS protocols and OMPP's expectations for design, execution, and evaluation.

Required elements include:

- Clear identification of a clinical or operational problem
- Use of a valid and reliable performance measure
- Baseline measurement
- Implementation of targeted interventions
- Remeasurement at defined intervals
- Documentation of results and analysis
- Sustainability planning after completion

OMPP reviews PIP results annually and may require modifications, additional interventions, or technical assistance.

VIII.E – Corrective Action and Performance Monitoring

When performance does not meet expectations, OMPP implements corrective action processes to support improvement and accountability.

Corrective action may include:

- Formal Corrective Action Plans (CAPs)
- Timelines for remediation
- Required staff training or process redesign
- Resubmission of corrected data
- Increased oversight or reporting
- Financial penalties if quality requirements are not met
- In severe cases, contract action

OMPP uses performance dashboards, audit results, grievance data, and EQR findings to identify when corrective action is needed.

VIII.F – Timeliness Standards

Timeliness standards ensure members receive care, services, and information promptly.

OMPP monitors:

- Timeliness of initial assessments and reassessments
- Adherence to service authorization timelines
- Timely initiation of care management or care coordination services
- Time-and-distance requirements for provider access
- Timeliness in critical incident reporting and follow-up

Failure to meet timeliness standards may result in corrective action or penalties.

VIII.G – Standards for Network Adequacy and Availability of Services

MCO networks must meet state requirements for the type, number, and geographic distribution of providers.

Network adequacy standards include:

- Minimum time-and-distance standards for key provider types
- Availability of specialty care, behavioral health, LTSS, and pharmacy services
- Access to 24/7 urgent care and emergency services
- Access to culturally and linguistically appropriate services
- Adequate capacity for high-risk and special-needs populations

OMPP evaluates network adequacy through MCO reports, audits, and member access complaints.

VIII.H – Standards for Care Coordination and Case Management

MCOs must provide care coordination and case management services that support members with complex needs.

Standards include:

- Comprehensive initial assessments and reassessments
- Person-centered service planning
- Coordination among physical health, behavioral health, LTSS, and pharmacy providers
- Communication across care teams, caregivers, and community partners
- Monitoring of service delivery and follow-up on care gaps
- Use of evidence-based care management models

Care coordination standards are closely linked to LTSS quality oversight and D-SNP alignment.

VIII.I – Data Quality and Validation Standards

Quality results depend on high-quality data. OMPP maintains strong data validation standards, including:

- System-level data integrity checks
- Annual external validation by the EQRO
- File-level audits for completeness and accuracy
- Verification of medical record review processes
- Validation of measure calculations
- Documentation and submission of corrective action when errors are discovered

Data validation findings directly influence performance evaluation and reporting.

VIII.J – Continuous Quality Improvement Expectations

All MCOs must maintain a robust Quality Assessment and Performance Improvement (QAPI) program that aligns with OMPP's standards.

Expectations include:

- Use of data to identify improvement opportunities
- Implementation of quality interventions
- Monitoring and evaluation of outcomes
- Engagement with care teams, providers, and members

- Active participation in OMPP quality committees and stakeholder groups
- Reporting progress on quality initiatives
- Integration of health equity strategies into improvement plans

Continuous improvement is a core requirement of managed care contracts and statewide quality oversight.

SECTION IX. Performance Improvement Projects (PIPs)

Overview

Performance Improvement Projects (PIPs) are structured, data-driven quality improvement initiatives required of all managed care entities (MCOs). PIPs are designed to achieve significant and sustained improvement in clinical care, care coordination, member experience, and health outcomes. Each PIP must follow CMS protocol requirements and be validated annually by the External Quality Review Organization (EQRO).

OMPP uses PIPs to drive statewide improvement in priority areas such as maternal and child health, behavioral health, chronic disease management, preventive care, and Long-Term Services and Supports (LTSS). PIPs complement other quality tools such as Pay-for-Outcomes (P4O), State Directed Payments (SDPs), and MCO quality oversight.

IX.A - Purpose of PIPs

PIPs are designed to:

- Improve the **quality, accessibility, and timeliness** of care
- Address identified gaps in performance
- Achieve **measurable and sustained** improvement
- Promote the use of **evidence-based interventions**
- Support statewide priorities and populations
- Strengthen accountability across MCOs

PIPs ensure that MCOs take an active role in improving care and addressing barriers affecting member outcomes.

IX.B - Required PIP Domains

OMPP requires MCOs to conduct PIPs in domains that align with federal expectations and state priorities. Required domains include:

- **Clinical Care** (e.g., diabetes management, maternal health, behavioral health treatment)
- **Non-Clinical/Operational** (e.g., call center performance, care coordination engagement)
- **LTSS Quality** (e.g., person-centered planning, critical incident follow-up, assessments and reassessments)
- **Health Equity** (e.g., reducing disparities in access or outcomes)

OMPP may mandate statewide PIPs to ensure alignment or may allow MCO-specific PIPs based on performance concerns or population needs.

IX.C - Required PIP Components

Each PIP must include the following required components:

1. **Project Aim and Problem Statement**
    - Clear description of the issue based on data analysis
2. **Baseline Measurement**
    - Initial performance measurement using a validated metric
3. **Population and Methodology**
    - Definition of the eligible population and data collection methods
4. **Intervention Design**
    - Development of targeted strategies based on best practices and root-cause analysis
5. **Implementation**
    - Execution of interventions with timelines and responsible parties
6. **Re-Measurement**
    - Ongoing measurement to evaluate improvement over time
7. **Evaluation of Effectiveness**
    - Analysis demonstrating statistically meaningful improvement
8. **Sustainability Planning**
    - Plan for maintaining improvements after project conclusion

All PIPs must adhere to CMS protocol, including validity, reliability, documentation, and transparent reporting.

IX.D - Role of the External Quality Review Organization (EQRO)

The EQRO validates each PIP annually to ensure:

- The PIP follows CMS protocol
- Measures are correctly defined and used
- Data collection is accurate and complete
- Interventions are appropriate and targeted

- Improvement is statistically valid and meaningful
- Documentation meets federal requirements

EQRO validation ensures that PIP results are credible and comparable across MCOs.

IX.E – OMPP Oversight and Monitoring

OMPP reviews PIP documentation regularly and provides feedback to ensure compliance with standards. Oversight activities include:

- Review and approval of initial PIP proposals
- Quarterly or semi-annual monitoring
- Review of progress reports and intervention effectiveness
- Performance trend analysis
- Identification of barriers and required adjustments
- Requesting Corrective Action Plans (CAPs) if needed

OMPP ensures that PIPs align with the QSP goals and statewide quality priorities.

IX.F – Use of PIP Results to Support Statewide Quality Improvement

OMPP uses information from PIPs to:

- Identify effective interventions that can be scaled statewide
- Identify gaps or weaknesses that require additional oversight
- Inform Pay-for-Outcomes (P4O) initiatives
- Inform updates to quality measures, goals, or policies
- Guide stakeholder and provider education
- Strengthen health equity strategies
- Support continuous improvement across all managed care programs

Lessons learned through PIPs help inform future quality initiatives and system-level improvements.

IX.G – Examples of Statewide Priority PIP Areas

Common PIP focus areas include:

- **Maternal and infant health** (prenatal care, postpartum care, birth outcomes)
- **Behavioral health integration** (follow-up after hospitalization, depression screening, SUD treatment)
- **Chronic disease management** (diabetes A1c control, hypertension management)
- **Preventive care** (childhood immunizations, well-child visits, cancer screenings)

- **Care coordination and LTSS quality** (assessments, person-centered planning, reducing critical incidents)
- **Pharmacy management** (opioid stewardship, medication adherence)
- **Reducing disparities** in access and outcomes across demographic groups

These areas reflect Indiana's statewide health priorities.

Table 4a. MDwise 2025 Performance Improvement Projects

PIP Topic	PIP Aim	PIP Interventions
Diabetes	Increase enrollment of members with diabetes into Disease Management, Care Management, and Case Management to ensure proper glycemic monitoring.	• Refer members identified through the Health Needs Screen directly to care management for disease/care/complex case management services. • Generate automatic referrals for members with diabetes after an inpatient stay or during prior authorization review. • Conduct outreach to members identified as having ER visits with a diabetes-related diagnosis (two calls + one letter minimum). • Connect eligible members with Community Health Workers for in-person or phone support in Allen, Marion, Monroe, and Lake counties.
Infant and Maternal Health	Improve access to obstetric/gynecological care for pregnant members during pregnancy and within 84 days postpartum.	• Warm-transfer members identified through the HNS to care management for case management engagement. • Conduct outreach to members identified through NOP daily reporting to engage them in case management. • Conduct outreach to members identified through My Healthy Baby weekly reporting for case management engagement.
Member Satisfaction	Increase member satisfaction based on complaints, grievances, and survey responses (e.g., CAHPS).	• Use Quality Outreach Representatives to contact members by phone. • Send engagement mailers and postcards. • Deploy text message engagement campaigns.

Table 4b. Anthem 2025 Performance Improvement Projects

PIP Topic	PIP Aim	PIP Interventions
Improving Member Outcomes	• Improve quality of SDOH and member whole-health data through Azara and rural FQHC partnerships in MY 2024. • Improve outcomes for rural members with asthma, diabetes, or cardiovascular disease through ongoing provider engagement.	• Contract with Azara to share and analyze SDOH and clinical data for FQHCs. • Match rural provider groups with a consultant specializing in targeted clinical quality areas. • Provide best-practice strategies to providers to increase compliance with targeted metrics.
Improving Diabetes Control	• Increase HbA1c control in previously non-compliant members using home A1c kits and telephonic support. • Increase HbA1c control with CHW-supported diabetes management. • Improve HbA1c control using member incentives and access to fresh fruits/vegetables. • Reduce diabetes-related ED and inpatient visits for participating members.	• Secure a home-based A1c test kit vendor. • Implement CHW diabetes education protocol. • Use Anthem's disease management program. • Expand fruit and vegetable enhanced benefit offerings.

Table 4c. MHS 2025 Performance Improvement Projects

508 Summary: PIP Topic	PIP Aim	PIP Interventions
Diabetes	• Increase the proportion of adults with diabetes who receive an annual eye exam. • Increase the proportion of adults with successful blood pressure management.	• Implement targeted outreach to members due for diabetic eye exams. • Provide hypertension-related education and follow-up management support. • Partner with providers to identify and close diabetes-related care gaps.
Reduction in Maternal and Infant Mortality	• Increase the proportion of pregnant women enrolled in Start Smart for Baby (SSFB). • Reduce hospital admissions for high-risk OB members.	• Proactive outreach to pregnant members for SSFB enrollment. • Case management support for high-risk OB members to reduce admissions. • Coordination with prenatal care providers to address clinical risks early.

Improving Member Satisfaction	• Increase positive response rates from members contacting MHS. • Improve overall MHS health plan rating.	• Strengthen customer service and issue resolution processes. • Implement ongoing member feedback monitoring and follow-up. • Enhance communication channels for members seeking assistance.

Table 4d. CareSource 2025 Performance Improvement Projects

PIP Topic	PIP Aim	PIP Interventions
Member Satisfaction	Improve member-reported satisfaction through increased engagement and enhanced benefit utilization.	• Implement a new Member Services matrix to proactively offer benefits. • Improve processes for informing and linking members to enhanced benefits during inbound/outbound calls. • Strengthen member education on available resources and supports.
Kidney Health Evaluation Access	Improve compliance with annual kidney health evaluations for members with diabetes.	• Deliver targeted provider education on recommended annual kidney evaluation guidelines. • Provide decision-support tools to increase evaluation rates. • Support provider adoption of evidence-based testing protocols.
Preeclampsia Risk Management	Reduce preterm birth among pregnant members at risk for preeclampsia through systematic prenatal case review.	• Establish a Prenatal Interdisciplinary Review Team (PIRT). • Conduct systematic case reviews for members at risk. • Coordinate prenatal care adjustments based on risk identification.

TABLE 5a — MDwise (Healthy Indiana Plan) 2025 Performance Improvement Projects

PIP Topic	PIP Aim	PIP Interventions
Diabetes	Increase enrollment of members with diabetes in Disease Management, Care Management, and Case Management to ensure proper glycemic monitoring.	• Identify new members reporting diabetes on the HNS and directly refer them to care management. • Conduct Care/Case Management outreach when diabetes-related services appear in IP/OP prior authorization requests. • Generate automatic referrals for diabetes after inpatient stays.

		• Conduct outreach (2 calls + 1 letter) to members with ER visits related to diabetes. • Connect eligible members in select counties to a Community Health Worker for in-person or phone visits.
Infant and Maternal Health	Improve access to obstetric and gynecological care for pregnant members during pregnancy and within 84 days post-delivery.	• (Interventions not provided in the source text.) • Please confirm if HIP should duplicate HHW MDwise interventions for maternal health.
Member Satisfaction	Increase member satisfaction as measured by complaints, grievances, and self-reported survey data (e.g., CAHPS).	• Use MDwise Quality Outreach Representatives for telephone engagement. • Use mailers and postcards to contact members. • Deploy text message campaigns to improve engagement.

TABLE 5b — Anthem (Healthy Indiana Plan) 2025 Performance Improvement Projects

PIP Topic	PIP Aim	PIP Interventions
Improving Member Outcomes	• Improve SDOH and member whole-health data quality in MY 2024 through Azara and rural FQHC partnerships. • Improve outcomes for rural-provider-panel members with asthma, diabetes, or cardiovascular disease.	• Contract with Azara to implement data aggregation and analytic processes. • Match provider groups with specialized quality consultants. • Provide best-practice strategies to providers to increase compliance with targeted metrics.
Improving Diabetes Control	• Increase HbA1c control using home A1c kits and telephonic support. • Increase HbA1c control using CHW diabetes management support. • Increase HbA1c control using member incentives and increased access to fruits/vegetables. • Reduce diabetes-related ER and inpatient visits for participating members.	• Secure home-based A1c test kit vendor. • Finalize CHW diabetes education protocol. • Utilize the disease management program. • Implement the fruit and vegetable enhanced benefit.

TABLE 5c — MHS (Healthy Indiana Plan) 2025 Performance Improvement Projects

PIP Topic	PIP Aim	PIP Interventions

Diabetes	• Increase the proportion of adults with diabetes who receive an annual eye exam. • Increase the proportion of adults with successfully managed hypertension.	• Interventions not yet established (first year of the PIP).
Reduction in Maternal and Infant Mortality	• Increase pregnant member enrollment in Start Smart for Baby (SSFB). • Reduce hospital admissions among high-risk obstetric members.	• Interventions not yet established (first year of the PIP).
Improving Member Satisfaction	• Increase proportion of positive responses from members contacting MHS. • Improve overall health plan rating.	• Interventions not yet established (first year of the PIP).

TABLE 5d — CareSource (Healthy Indiana Plan) 2025 Performance Improvement Projects

PIP Topic	PIP Aim	PIP Interventions
Member Satisfaction	Improve member satisfaction by increasing engagement and utilization of enhanced benefits.	• Implement a new Member Services matrix to proactively offer benefits. • Improve processes for linking members to enhanced benefits during inbound and outbound calls.
Kidney Health Evaluation Access	Improve annual kidney evaluation compliance for members ages 18–85 with diabetes.	• Deliver targeted provider education on recommended kidney evaluations. • Provide decision-support tools to increase evaluation rates. • Support provider adoption of evidence-based testing protocols.
Preeclampsia Risk Management	Reduce pre-term births among pregnant members at risk for pre-eclampsia through systematic case review.	• Establish a Prenatal Interdisciplinary Review Team (PIRT). • Conduct systematic reviews for members at risk. • Coordinate prenatal care modifications based on risk assessment.

TABLE 6a. Anthem (HCC) 2025 Performance Improvement Projects

PIP Topic	PIP Aim	PIP Interventions

Improving Member Outcomes	• Improve quality of SDOH and member whole-health data in MY 2024 through Azara with rural FQHCs. • Improve outcomes for rural-provider-panel members with asthma, diabetes, or cardiovascular disease.	• Contract with Azara to implement analytic and data-sharing processes. • Match provider groups with a provider quality consultant specializing in identified needs. • Provide best-practice strategies to providers to improve member compliance with targeted metrics.
Improving Diabetes Control	• Increase HbA1c control in previously non-compliant members using home test kits + telephonic support. • Increase HbA1c control using CHW support. • Increase HbA1c control through incentives and improved access to fresh fruits/vegetables. • Reduce diabetes-related ED and inpatient utilization among participating members.	• Secure home-based A1c test kit vendor. • Finalize CHW diabetes education protocol. • Utilize Anthem's disease management program. • Implement fruit and vegetable enhanced benefit.

TABLE 6b. MHS (HCC) 2025 Performance Improvement Projects

PIP Topic	PIP Aim	PIP Interventions
Diabetes	• Increase the proportion of adults with diabetes who receive an annual eye exam. • Increase the proportion of adults with successful blood pressure/hypertension management.	• Interventions not yet established (first year of the PIP).
Reduction in Maternal and Infant Mortality	• Increase enrollment of pregnant members in Start Smart for Baby (SSFB). • Reduce hospital admissions for high-risk OB members.	• Interventions not yet established (first year of the PIP).
Improving Member Satisfaction	• Increase proportion of positive responses from members contacting MHS. • Improve MHS overall health plan rating.	• Interventions not yet established (first year of the PIP).

TABLE 6c. UnitedHealthcare (HCC) 2025 Performance Improvement Projects

PIP Topic	PIP Aim	PIP Interventions
Member Satisfaction	Determine member satisfaction with customer service and identify improvement opportunities using Adults CAHPS Q24 and Q25.	• Analyze grievances and complaints to determine improvement opportunities. • Retrospectively review monthly grievance data to identify trends and process improvements. • Track grievance types and implement tailored interventions to reduce recurring categories.
Diabetes	Improve HbA1c control among diabetic members.	• Leverage diabetic outcomes data (e.g., ED utilization, eye exam rates) to identify improvement opportunities. • Utilize Livongo pilot to increase adherence to diabetes management. • Conduct targeted provider and member outreach via mailings and telephonic outreach. • Address minority-health disparities and medication adherence barriers. • Provide care management services and distribute diabetes-specific educational materials.

TABLE 7 — Indiana PathWays for Aging 2025 Performance Improvement Projects

PIP Topic	PIP Aim	PIP Interventions
HCBS Service Planning	• Improve member involvement in HCBS service planning by increasing the percentage reporting their service plan includes what is important to them. • Improve timeliness of HCBS service plans by increasing the percentage completed within required timeframes.	• Service Coordinator training on person-centered service planning and practices. • Coordinator training on service-planning documentation requirements. • Plan audits and technical assistance based on audit findings. • Tracking service plan content and timeliness, with follow-up including

	• Improve completion rates of comprehensive assessments and care plans within 90 days of enrollment (new members) or within the measurement year (current members).	technical assistance, heightened scrutiny, and corrective action plans.
HCBS Service Delivery	• Improve timeliness of first HCBS service delivery by increasing the percentage delivered within 21 days of service plan completion. • Improve state capacity to collect HCBS service delivery data by increasing EVV-compliant providers and the percentage exceeding 90% reporting rates.	• Mandatory MCO reporting of service delivery timeliness. • Tracking HCBS provider EVV connectivity and reporting levels. • Technical assistance for providers lacking EVV connectivity or not meeting reporting targets.
Care Coordination	• Increase percentage of care plans shared with PCPs and documented medical practitioners within 30 days of development. • Increase number of days at-risk individuals continue to live in the community by establishing supports to prevent unnecessary nursing facility admissions.	• Care Manager training and supports to facilitate care-plan sharing. • Outreach and education for PCPs regarding the purpose and use of care plans. • Mandatory MCO reporting of care-plan sharing. • Tracking timeliness and service-plan content; technical assistance and corrective action when needed. • MCO policies/procedures for timely processing of at-risk referrals. • Member support interventions (e.g., home-safety toolkits, dementia screening education, telephonic post-discharge assessments).

IX.H - Collaboration and Support for MCOs

OMPP collaborates with MCOs throughout the PIP lifecycle by:

- Providing technical guidance and templates
- Sharing best practices across plans
- Facilitating cross-MCO collaborative meetings

- Coordinating external training opportunities
- Offering feedback and direction during project review
- Supporting the identification of data and analytic needs

This collaboration ensures that PIPs contribute meaningfully to improving care for IHCP members.

IX.I – Sustainability and Continuous Improvement

Once a PIP is completed and validated, MCOs must demonstrate:

- How improvements will be maintained
- How successful interventions will be integrated into ongoing operations
- Monitoring plans to ensure long-term impact
- Strategies to mitigate regression into previous performance levels

Sustained improvement is a key requirement of Indiana's PIP process.

SECTION X. Pay-for-Outcomes (P4O) Performance Measures

Overview

The Pay-for-Outcomes (P4O) program is a key accountability mechanism used by the Office of Medicaid Policy and Planning (OMPP) to financially incentivize high performance and quality improvement among managed care entities (MCOs). The P4O program aligns financial payments with quality performance by rewarding strong outcomes, measurable improvement, and reductions in disparities.

P4O measures are selected based on statewide priorities, historical performance trends, opportunities for improvement, and alignment with federal quality initiatives. P4O supports Indiana's goals of improving access, quality, health outcomes, and health equity across all Medicaid managed care programs, including PathWays for Aging and aligned D-SNP populations.

TABLE 8a. 2025 P4O Measures by Program

Program	Abbreviation	Description
Hoosier Healthwise	HNS	Health Needs Screening
Hoosier Healthwise	W30	Well-Child Visits in the First 30 Months of Life
Hoosier Healthwise	W30	Well-Child Visits (First 15 Months)
Hoosier Healthwise	WCV	Child and Adolescent Well-Care Visits
Hoosier Healthwise	CIS	Childhood Immunization Status – Combo 10

Hoosier Healthwise	LSC	Lead Screening in Children
Hoosier Healthwise	IMA-E	Immunizations for Adolescents – Combo 1
Hoosier Healthwise	State Directed	Pregnant Members Receiving Care Coordination (30+ days)
Hoosier Healthwise	OED	Oral Evaluation, Dental Services
Hoosier Healthwise	PND-E	Prenatal Depression Screening and Follow-Up
Healthy Indiana Plan	AAP	Adults' Access to Preventive/Ambulatory Health Services
Healthy Indiana Plan	HNS	Health Needs Screening
Healthy Indiana Plan	PPC	Prenatal & Postpartum Care – Timeliness of Prenatal Care
Healthy Indiana Plan	PPC	Prenatal & Postpartum Care – Postpartum Care
Healthy Indiana Plan	PND-E	Prenatal Depression Screening & Follow-Up
Healthy Indiana Plan	FUH	Follow-Up After Hospitalization for Mental Illness (7 days)
Healthy Indiana Plan	FUH	Follow-Up After Hospitalization for Mental Illness (30 days)
Healthy Indiana Plan	State Defined	Pregnant Members Receiving Care Coordination
Healthy Indiana Plan	GSD	Glycemic Status Assessment for Patients with Diabetes
Hoosier Care Connect	HNS	Health Needs Screening
Hoosier Care Connect	CHAT	Completion of Comprehensive Health Assessment
Hoosier Care Connect	OED	Oral Evaluation, Dental Services

Hoosier Care Connect	AAP	Adults' Access to Preventive/Ambulatory Health Services
Hoosier Care Connect	IMA-E	Immunizations for Adolescents – Combo 1
Hoosier Care Connect	WCV	Child and Adolescent Well-Care Visits
Hoosier Care Connect	GSD	Glycemic Status Assessment for Patients with Diabetes
Hoosier Care Connect	FUH	Follow-Up After Hospitalization for Mental Illness (7 days)
Hoosier Care Connect	FUH	Follow-Up After Hospitalization for Mental Illness (30 days)
Indiana PathWays for Aging	State Directed	Service Coordinator Person-Centered Planning Competency
Indiana PathWays for Aging	HNS	Health Needs Screening
Indiana PathWays for Aging	State Directed	Participant Experience Accessing Care (grievances related to access)

TABLE 8b. 2026 P4O Measures by Program

Program	Measure
Hoosier Healthwise	Health Plan Star Rating
Hoosier Healthwise	Depression Screening & Follow-Up for Adolescents (DSF-E)
Hoosier Healthwise	Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)
Hoosier Healthwise	Postpartum Depression Screening and Follow-Up (PDS-E)
Hoosier Healthwise	Childhood Immunization Status (CIS)

Hoosier Healthwise	Adolescent Immunization Status (IMA – Combo 1)
Hoosier Healthwise	Completion of Health Needs Screenings for New Members
Healthy Indiana Plan	Health Plan Star Rating
Healthy Indiana Plan	Initiation and Engagement of Substance Use Disorder Treatment (IET)
Healthy Indiana Plan	Adult Preventive Care (AAP)
Healthy Indiana Plan	Controlling High Blood Pressure (CBP)
Healthy Indiana Plan	Use of Opioids from Multiple Providers (UOP)
Healthy Indiana Plan	Completion of Health Needs Screening for New Members
Healthy Indiana Plan	Oral Evaluation, Dental Services (OED)
Hoosier Care Connect	Health Plan Star Rating
Hoosier Care Connect	Initiation and Engagement of Substance Use Disorder Treatment (IET)
Hoosier Care Connect	Plan All-Cause Readmissions (PCR)
Hoosier Care Connect	Childhood Immunization Status (CIS – Combo 10)
Hoosier Care Connect	Adult Preventive Care (AAP)
Hoosier Care Connect	Completed Health Needs Screening (HNS)
Hoosier Care Connect	Completion of Comprehensive Health Assessment
Hoosier Care Connect	Glycemic Status Assessment for Patients with Diabetes (GSD)
Indiana PathWays for Aging	Care Coordination Program Case Load Excellence

Indiana PathWays for Aging	Service Coordination & Service Plan Timeliness – Sub-Measure A
Indiana PathWays for Aging	Service Coordination & Service Plan Timeliness – Sub-Measure B
Indiana PathWays for Aging	Participant Experience
Indiana PathWays for Aging	LTSS Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)

X.A – Structure of the P4O Program

OMPP's P4O program consists of two major components:

- **Attainment:** Meeting or exceeding a defined performance threshold
- **Improvement:** Demonstrating measurable improvement from the prior year

MCOs may earn incentive payments or incur penalties based on their combined attainment and improvement scores across the required measure set.

Each program—HHW, HIP, HCC, and PathWays—uses a tailored set of measures that reflect the needs of their respective populations.

X.B – Selection of P4O Measures

OMPP selects P4O measures through an annual review process that considers:

- Statewide health priorities
- National clinical guidelines and best practices
- Feasibility and accuracy of data collection
- Historical performance and opportunity for improvement
- Alignment with Core Set measures and CMS expectations
- Health equity goals
- Consistency with PIPs, SDPs, and other quality strategies

Measures may be added, removed, or modified annually based on these factors.

X.C – Types of P4O Measures

P4O measures fall within several domains, including:

1. Preventive Care

- Child and adolescent well-care visits
- Childhood immunizations
- Lead screening
- Adult preventive visits

2. Maternal and Child Health

- Prenatal and postpartum care
- Timeliness of prenatal care
- Low birthweight or early elective deliveries
- Follow-up after maternity care transitions

3. Behavioral Health

- Follow-up after hospitalization for mental illness or substance use disorder
- Depression screening and follow-up
- Medication adherence for behavioral health conditions

4. Chronic Disease Management

- Diabetes (A1c control)
- Hypertension control
- Asthma medication management
- Cholesterol management

5. LTSS and PathWays Measures

- Timeliness of assessments and reassessments
- Person-centered service planning
- Critical incident follow-up timeliness
- Care management engagement

6. Member Experience

- CAHPS® measures related to access, communication, and overall ratings

X.D – Health Equity and Disparities Adjustments

OMPP incorporates health equity into the P4O program by:

- Stratifying measures by race, ethnicity, age, geography, and disability status
- Applying health equity weighting or bonus scoring
- Requiring targeted interventions for populations experiencing disparities
- Encouraging MCOs to partner with community organizations to address root-cause inequities

X.E – Scoring Methodology

P4O scoring considers both **attainment** and **improvement**:

Attainment

The MCO meets or exceeds a performance threshold, such as:

- National percentile benchmark
- Statewide mean or top-performer level
- Pre-defined target

Improvement

The MCO demonstrates measurable year-to-year progress from its own baseline.

Combined Scoring

OMPP assigns weights to each measure based on priority areas.
Examples of weighted measures include:

- Maternal health
- Behavioral health follow-up
- Chronic disease control
- Preventive care
- LTSS quality indicators

The overall score determines the portion of the P4O withhold that is earned back or forfeited.

X.F – Financial Incentives and Penalties

P4O is tied to financial performance:

- A portion of MCO capitation rates are **withheld** each year.
- MCOs earn back all, some, or none of the withheld amount based on P4O performance.
- Exceptional performance may result in **additional incentive payments** in some years.
- Poor performance or lack of improvement may result in **forfeiture of the withhold**.

This design ensures accountability and encourages meaningful investment in quality improvement.

X.G – Data Validation and Oversight

To ensure accuracy and integrity:

- All P4O measures undergo data validation by the actuary vendor.
- MCOMCOs must document data sources, methods, and calculations.
- Incorrect or incomplete data submissions must be corrected and resubmitted.
- OMPP may adjust scores or take corrective action for non-compliance.

Validated, accurate data are required before final P4O payments are determined.

X.H – Integration With Other Quality Initiatives

The P4O program aligns with and reinforces other key quality strategies, including:

- Performance Improvement Projects (PIPs)
- External Quality Review (EQR) recommendations
- State Directed Payments (SDPs)
- MCO quality management plans
- Health equity initiatives
- Care coordination and access improvement efforts

Together, these programs form a unified, statewide approach to improving quality across IHCP.

X.I – Annual Review and Refinement of P4O Measures

OMPP reviews P4O measures annually to ensure ongoing relevance. The annual review considers:

- Updated national benchmarks
- Emerging public health issues
- Changes in population needs
- Shifts in program focus (e.g., PathWays LTSS priorities)
- Lessons learned from prior P4O cycles

OMPP may revise measures, add new measures, change weights, or update targets as needed.

SECTION XI. Transition of Care Policy

Overview

Transition of care refers to the movement of a member between health care settings, providers, or levels of care. Effective transition of care processes are essential to reduce avoidable complications, prevent readmissions, ensure continuity of services, and support member safety. The Office of Medicaid Policy and Planning (OMPP) requires managed care entities (MCOs) to follow standardized transition of care policies designed to support timely communication, coordination, and follow-up across all Indiana Health Coverage Programs (IHCP), including PathWays for Aging and aligned DSNP programs.

The Transition of Care Policy applies when members move between:

- Hospitals and home settings
- Hospitals and nursing facilities
- Nursing facilities and home- and community-based services (HCBS)
- Behavioral health facilities
- Acute care to LTSS settings
- One MCO to another (inter-plan transfers)
- Fee-for-service and managed care programs

The goal is to ensure smooth, safe, and member-centered transitions.

XI.A – Core Requirements for Transition of Care

All MCOMCOs must implement processes that ensure:

1. Continuity of existing services

Members must not experience gaps in medically necessary services during transitions, including LTSS, behavioral health, or pharmacy services.

2. Timely transition planning

Transition planning must begin as soon as the MCO becomes aware of an upcoming transition, such as hospital admission, discharge planning, or change in level of care.

3. Comprehensive communication

MCOMCOs must ensure effective communication between sending and receiving providers, including transfer of:

- Discharge summaries
- Medication lists
- Assessments
- Person-centered service plans
- Care management notes
- Critical incident information when applicable

4. Active involvement of the member and caregivers
Members, families, and authorized representatives must be engaged in decisions, discharge planning, and post-transition care coordination.

XI.B – Hospital Transitions

For inpatient hospital admissions, the MCOMCO must:

- Monitor admissions through real-time notifications
- Assign or notify a care manager as required
- Coordinate discharge planning with hospital staff
- Ensure timely follow-up visits after discharge
- Address medication reconciliation and any post-discharge authorizations

MCOMCOs must ensure **post-discharge follow-up within required timeframes**, such as:

- Behavioral health hospitalization follow-up
- Medical hospitalization follow-up
- Postpartum follow-up

Transitions of care following hospitalization are integrated into the P4O program to reduce readmissions and improve outcomes.

XI.C – Transitions Between LTSS and Acute Care Settings

Members receiving LTSS may experience transitions between acute care hospitals, nursing facilities, and community-based settings. Requirements include:

- Notification to the member's care manager upon any hospitalization
- Reassessment of LTSS needs following discharge
- Updates to the person-centered service plan
- Coordination with HCBS providers or nursing facilities
- Ensuring no gaps in critical in-home or facility-based services

For PathWays members, the MCOMCO must also coordinate with:

- LTSS care managers
- Nursing facility transition staff
- The Division of Aging, when required
- DSNP care coordinators (for aligned members)

XI.D – Inter-Plan and Program Transitions

Transitions may occur when a member:

- Switches from one MCOMCO to another
- Moves between HHW, HIP, HCC, and PathWays
- Gains or loses Medicare eligibility (entering or exiting DSNP alignment)
- Moves between managed care and fee-for-service Medicaid

Requirements include:

1. **90-day continuity of care** for existing authorizations.
2. Transfer of all care management, service plans, assessments, and case notes.
3. Coordination of ongoing services such as:
    - Behavioral health supports
    - Home health
    - LTSS services
    - Prescriptions
4. Ensuring new authorizations are issued timely to prevent service disruption.

This ensures members do not lose critical services when their eligibility or enrollment changes.

XI.E – Medication Continuity and Pharmacy Transitions

MCOMCOs must ensure:

- Ongoing coverage for active prescriptions
- Transitional fills when formulary or prior authorization rules differ
- Urgent review of pharmacy-related disputes
- Alignment of medications following hospital discharge

Special attention is required for:

- Behavioral health medications
- Chronic disease medications
- Controlled substances
- LTSS-related prescriptions (e.g., wound care supplies)

XI.F – Communication Standards

All transitions of care must include timely communication between:

- Providers
- MCOs
- Hospitals
- Nursing facilities
- HCBS agencies
- Members and caregivers

Communication must be:

- Documented
- Accurate
- Culturally and linguistically appropriate
- Compliant with confidentiality requirements

MCOs must maintain 24/7 lines of communication for hospitals and facilities reporting admissions and discharges.

XI.G – Requirements for Care Management During Transitions

Care managers must:

- Initiate contact within required timeframes
- Assess the members' post-transition needs
- Facilitate home- and community-based supports
- Review medications and discharge instructions
- Coordinate follow-up appointments
- Address social drivers of health that may impact recovery
- Monitor for re-hospitalization risks

For PathWays and DSNP-aligned members, care managers must coordinate across Medicare and Medicaid benefits.

XI.H – Documentation and Monitoring

MCOs must document:

- All transition activities
- Timeliness of notifications

- Completion of assessments
- Communication with providers and caregivers
- Outcomes following transitions

OMPP monitors transition performance through:

- Encounter data
- Hospital readmission rates
- LTSS transition measures
- P4O indicators
- EQRO reviews
- Member grievances and appeals

Failure to meet transition standards may result in corrective action or financial penalties.

XI.I – Member Rights During Transitions

Members have the right to:

- Receive medically necessary services without interruption
- Be included in all transition-related decisions
- Have information provided in an accessible, understandable format
- File grievances or appeals if transition issues occur

SECTION XII. Identification of Persons Who Need Long-Term Services and Supports or Persons with Special Health Care Needs

XII.A – Overview

The Office of Medicaid Policy and Planning (OMPP) requires all Managed Care Entities (MCOs) to have standardized processes to **identify members with potential long-term services and supports (LTSS) needs** or **special health care needs (SHCN)**. These processes ensure timely assessment, stratification, and coordination of services to maintain the member's health, safety, independence, and access to necessary supports.

Identification occurs through a combination of:

- Initial Health Needs Screening (HNS)
- Comprehensive Health Assessment Tool (CHAT) for applicable PathWays populations
- Review of claims and utilization data
- Pregnancy notifications and self-reported conditions
- Provider or caregiver referrals

XII.B – Health Needs Screening (HNS)

1. Purpose

The HNS identifies member needs in the following domains:

- Physical health
- Behavioral health
- LTSS needs
- Social drivers of health (SDoH) such as housing, food access, employment
- Potential eligibility for care management or complex case management

2. Timeframes

MCOs must complete the HNS within:

- **90 days** of enrollment for HHW, HIP, and HCC members
- **30 days** of enrollment for Indiana PathWays for Aging members

The HNS may be administered:

- In person
- Telephonically
- Online
- By mail

Non-clinical staff may conduct the screen when using the OMPP-approved standardized tool.

3. Tool Requirements

- All MCOs must use the **OMPP-approved HNS**.
- MCOs may request additional questions but must seek OMPP approval prior to implementation.
- For members receiving NFLOC HCBS in the community:
  The CHAT replaces the HNS and must be completed within 30 days of enrollment.

XII.C – Comprehensive Health Assessment (CHAT)

The CHAT is used for members whose needs exceed basic screening and is required for:

- PathWays members receiving Nursing Facility Level of Care (NFLOC) services in the community
- Members identified via HNS as having SHCN or requiring LTSS
- Members transferring into an MCO from another MCO with existing care plans

The CHAT may include:

- Direct discussion with the member and/or caregiver
- Review of medical history, medications, and claims
- Consultation with providers
- Review of functional needs, risks, and supports

All interactions must be **documented in case notes and the member record** and made available to OMPP upon request.

XII.D – Stratification Into Levels of Care Coordination

MCOs must use HNS, CHAT, and other available information to stratify members into an appropriate level of service, which may include:

- **Care Management (CM)**
- **Complex Case Management (CCM)**
- **Service Coordination (Indiana PathWays for Aging)**
- **Other plan-specific support programs**

Stratification methodologies may vary by MCO but must:

- Be evidence-based
- Consider functional needs, medical/behavioral acuity, and SDoH
- Be reviewed and approved by OMPP when required
- Be consistently applied and documented

XII.E – Supporting Members with Special Health Care Needs (SHCN)

MCOs must ensure processes and supports for SHCN populations, including:

- Timely completion of HNS and CHAT
- Development of person-centered care plans
- Coordination across physical, behavioral, and LTSS providers
- Sharing assessment findings with the member's PMP, OMPP, and other parties per confidentiality rules
- Tracking and analyzing issues related to children with special health care needs
- Participation in state-required studies and quality initiatives

All documentation related to SHCN identification and follow-up must be retained in the member record.

XII.F – Transition of Members with Special Health Care Needs

When a member with SHCN transitions:

- Between MCOs
- Between Medicaid programs
- Between community and institutional settings
- Into or out of LTSS services

The receiving MCO must:

- Continue existing services for **90 days**
- Obtain all care plans, assessments, and clinical information
- Prevent service gaps
- Coordinate with prior care managers when applicable
- Ensure continuity of ongoing case management or service coordination functions

XII.G – Data, Reporting, and Oversight Requirements

MCOs must maintain systems and processes that allow OMPP to monitor:

- Completion rates of HNS and CHAT
- Timeframes and compliance with assessment requirements
- Stratification results and movement between levels of care
- Service plan timeliness and adherence

- Utilization trends and SDoH impacts
- Care coordination outcomes for SHCN and LTSS populations

OMPP may require corrective action, impose remedies, or request modifications to assessment tools or processes when deficiencies are identified.

XII.H – Member Rights

Members with LTSS or special health care needs have the right to:

- Receive timely assessments
- Participate in person-centered care planning
- Have their preferences and supports documented and honored
- Request reassessments as needed
- Receive services without discrimination
- File grievances or appeals related to access, timeliness, or quality of services

SECTION XIII. Assessment and Oversight

XIII.A – Overview

The Office of Medicaid Policy and Planning (OMPP) conducts comprehensive oversight of all Managed Care Entities (MCOs) to ensure compliance with federal requirements, contractual obligations, and the goals outlined in the Quality Strategy Plan. Assessment and oversight activities allow the state to monitor quality, detect gaps, enforce accountability, and support continuous improvement across the Indiana Health Coverage Programs (IHCP).

Oversight is conducted through structured monitoring, data validation, on-site reviews, trend analysis, and the application of remedies when deficiencies are identified. These activities safeguard member health, ensure program integrity, and promote high-quality, person-centered care.

XIII.B – Monitoring and Compliance Structure

OMPP uses a standardized oversight framework that includes:

- Continuous review of MCO reporting (monthly, quarterly, and annual reports)
- Verification of data accuracy, completeness, and timeliness
- Monitoring of operational performance and member outcomes
- On-site audits and focused reviews
- Evaluation of contractual compliance
- Collaboration with internal divisions (e.g., Program Integrity, Policy, LTSS, Behavioral Health)
- Review of external inputs, including grievances, appeals, and stakeholder feedback

This oversight structure ensures consistency across programs while allowing OMPP to identify program-specific needs and challenges.

XIII.C – Required Reports and Data Validation

Each MCO must submit reports covering:

- HEDIS performance
- Care and case management
- Utilization management
- Network adequacy
- Member Services
- Provider Services
- Member grievances and appeals
- Claims payment, timeliness, and denial trends
- LTSS assessments, care plans, and service authorization timeliness
- Pharmacy utilization and adherence to the statewide uniform preferred drug list
- CAHPS survey results
- Encounter data submission and accuracy
- Quality improvement initiatives

OMPP validates submitted data through:

- Automated checks for accuracy and completeness
- Cross-platform consistency reviews
- Trend analysis to identify variations or anomalies
- Follow-up inquiries to resolve discrepancies
- Requiring MCOs to provide source documentation when needed

Data validation ensures the reports used for oversight and performance evaluation reflect true operational performance.

XIII.D – Performance Monitoring

OMPP evaluates performance using:

- Pay for Outcomes (P4O) measures
- HEDIS and Core Set quality measures
- LTSS-specific measures for the PathWays program

- Behavioral health and substance use disorder metrics
- Access standards across provider types
- Member experience indicators
- Oversight of PIPs and quality improvement activities

Performance is evaluated for both improvement and compliance with minimum standards. Results inform quality priorities, required interventions, and corrective actions.

XIII.E – On-Site Reviews and Audits

On-site monitoring may include:

- Review of care management records and documentation
- Interviews with MCO staff
- Evaluation of subcontractor oversight
- Assessment of compliance with LTSS requirements
- Validation of service authorization practices
- Examination of member-facing materials
- Evaluation of MCO internal audits and quality assurance activities

These reviews provide a detailed look at MCO operations beyond routine reporting.

XIII.F – Identification and Correction of Deficiencies

When oversight activities identify issues, OMPP may require:

- Written warnings
- Corrective Action Plans (CAPs)
- Documentation of root cause analysis
- Periodic progress updates
- Additional reporting or data validation
- Revisions to policies, workflows, or staffing
- Oversight meetings to monitor progress

The severity, duration, and impact of the issue determine the level of response required. CAPs are monitored until OMPP determines deficiencies have been resolved and performance is stable.

XIII.G – Enforcement Actions and Remedies

If an MCO does not correct deficiencies or violates contractual or regulatory requirements, OMPP may apply remedies such as:

- Liquidated damages
- Withhold of payments
- Suspension of enrollment
- Temporary management requirements
- Directed interventions
- Sanctions
- Contract termination

These remedies reinforce accountability and ensure member protections.

Table 9: Sanctions Applied by Year

Type of Sanction Applied	2022	2023	2024
Liquidated Damages	24	27	15
Corrective Action Plan	29	5	5
Warning Letter	0	3	1

XIII.H – Transparency and Public Reporting

OMPP publishes publicly available reports on:

- Quality measures
- MCO performance outcomes
- Member experience results
- Network adequacy
- Annual External Quality Review (EQR) results
- Program dashboards and summaries

This transparency supports stakeholder engagement and promotes trust in the Medicaid managed care system.

XIII.I – Continuous Improvement

Assessment and oversight activities inform ongoing enhancements to program design and quality strategy. OMPP uses findings to:

- Refine reporting requirements
- Strengthen performance expectations

- Update targets and benchmarks
- Improve policy alignment
- Adjust contracts and operational standards
- Support MCO education and technical assistance

This continuous improvement cycle ensures that oversight is not only corrective but also developmental, helping improve member outcomes and system performance.

SECTION XIV. Quality and Appropriateness of Care

XIV.A – Overview

OMPP is committed to ensuring that all Managed Care Entities (MCOs) provide high-quality, evidence-based, and medically appropriate care to members across all Indiana Health Coverage Programs (IHCP). Quality and appropriateness of care standards ensure that members receive services in the right setting, at the right time, and in the right amount to achieve optimal health outcomes. These standards apply across physical health, behavioral health, LTSS, pharmacy services, and any care delivered through subcontracted entities.

OMPP monitors care quality through defined performance measures, external quality review, utilization management oversight, network adequacy assessments, care coordination reviews, and member experience evaluations.

XIV.B – Requirements for Appropriateness of Care

All MCOs must ensure:

- **Medically necessary services** are delivered in accordance with state and federal definitions of medical necessity.
- **Care aligns with nationally recognized clinical guidelines**, including those required or approved by OMPP.
- **Members receive services in the least restrictive, most appropriate setting**, considering individual needs and functional abilities.
- **Preventive care and early intervention** are emphasized to avoid adverse health events or unnecessary inpatient utilization.
- **Care management and service coordination** are used to address complex needs, transitions, and risk factors.
- **Services are culturally and linguistically appropriate**, accessible, and free from discriminatory practices.
- **Continuity and coordination of care** occur across providers, settings, and programs—including Medicare for members who are dually eligible.

XIV.C – Clinical Standards and Practice Guidelines

MCOs must adopt and implement evidence-based practice guidelines that:

- Are based on valid clinical evidence or consensus among health professionals
- Address physical health, behavioral health, LTSS, and pharmacy care
- Are reviewed and updated periodically
- Are distributed to network providers and available to members upon request

- Support decision making in utilization management, care management, and quality improvement initiatives

MCOs must ensure providers use these guidelines consistently, and OMPP may require submission, review, or revision of guidelines at any time.

XIV.D – Monitoring of Care Delivery and Outcomes

OMPP evaluates the quality and appropriateness of care using:

- Quality performance indicators (HEDIS, Core Set, LTSS metrics)
- Pay for Outcomes (P4O) evaluation
- Performance Improvement Projects (PIPs)
- Member grievance and appeal patterns
- Utilization patterns and outliers
- Access-to-care measures and network adequacy reports
- Case file reviews for care management and service coordination
- CAHPS member experience data

Performance trends are reviewed across programs to identify disparities, operational issues, or opportunities for improvement.

XIV.E – Continuity and Coordination of Care

MCOs must ensure continuity of care through:

- Timely sharing of assessments, care plans, and clinical information
- Coordination across physical and behavioral health providers
- Integration of LTSS needs, including personal care, waiver services, and nursing facility level supports
- Clear and timely communication with members and caregivers
- Coordination during transitions between hospitals, nursing facilities, community settings, and MCOs
- Collaboration with Medicare for dual-eligible members, including aligned D-SNP operations

The goal is to support seamless transitions, reduce avoidable hospitalizations, and maintain member stability.

XIV.F – Ensuring Adequate Access to Services

MCOs must maintain:

- Sufficient provider networks to offer all covered services

- Geographic and timely access to PMPs, specialists, behavioral health providers, LTSS providers, and ancillary services
- Access for members with disabilities, including physical accessibility, communication supports, and accommodations
- Emergency and urgent care availability 24/7
- Nondiscriminatory access regardless of health status, complexity, or prior utilization

OMPP reviews network adequacy through reporting, geographic mapping, and member/provider feedback.

XIV.G – Utilization Oversight and Appropriateness Reviews

OMPP monitors MCO utilization management to ensure:

- Authorization decisions follow medical necessity criteria
- Denials are clinically justified and documented
- Members are not discouraged from receiving appropriate services
- MCOs do not impose inappropriate barriers or delays
- Service limits and review processes are consistent with state policy
- Overutilization and underutilization are identified and addressed
- Pharmacy utilization aligns with the statewide uniform preferred drug list

OMPP may require MCOs to revise criteria, retrain staff, or submit corrective actions when deficiencies are identified.

XIV.H – Subcontractor Oversight

MCOs must ensure that any subcontractor providing direct care or administrative services:

- Meets all quality and appropriateness requirements
- Follows OMPP-approved practice guidelines
- Submits accurate performance and utilization data
- Participates in quality improvement activities as required
- Maintains compliance with state and federal regulations
- Is monitored regularly by the MCO through audits and performance reviews

Subcontractor performance deficiencies are treated as MCO deficiencies.

XIV.I – Member Experience and Rights

Quality and appropriateness are also evaluated through:

- Member grievances and appeals

- Complaints related to access, quality, safety, or provider behavior
- Satisfaction survey results
- Reports of discrimination or culturally inappropriate services
- Member rights compliance, including the right to be involved in care decisions
- Member education on benefits, services, and care coordination

The member experience is a core indicator of the appropriateness of care delivered.

XIV.J – Continuous Quality Improvement

OMPP expects MCOs to actively pursue improvements in care quality through:

- Analysis of performance barriers
- Collaboration with providers on targeted strategies
- Engagement with community partners
- Innovations in preventive care, chronic disease management, and LTSS
- Implementation of lessons learned from PIPs, EQR findings, and state reviews
- Development of interventions addressing identified disparities

Continuous improvement is essential to advancing health outcomes across the IHCP membership.

SECTION XV. Network Adequacy and Availability of Services

XV.A – Overview

OMPP requires all Managed Care Entities (MCOs) to maintain provider networks that ensure timely, geographically appropriate, and equitable access to all covered services across the Indiana Health Coverage Programs. Network adequacy standards safeguard members' ability to access preventive care, primary care, behavioral health services, long-term services and supports (LTSS), specialty care, and ancillary services without unnecessary delays or burdens.

MCOs must design networks that accommodate varying health needs, levels of complexity, demographic differences, and member preferences, including considerations for individuals with disabilities, individuals residing in rural communities, and members with special health care needs.

XV.B – Core Network Adequacy Standards

MCOs must meet the following requirements:

- Maintain a sufficient number and distribution of primary medical providers (PMPs), specialists, hospitals, behavioral health providers, pharmacies, dental providers, LTSS providers, and ancillary services.
- Ensure provider availability across all counties in which the MCO operates.
- Provide access to routine care, urgent care, and emergency services within state-established time and distance standards.
- Ensure that network providers are accepting new patients in numbers adequate to support MCO enrollment.
- Maintain directory accuracy and update provider information regularly.
- Ensure physical accessibility, communication supports, and reasonable accommodations for members with disabilities.
- Offer culturally and linguistically appropriate services.

XV.C – Time and Distance Requirements

To ensure timely access, MCOs must meet OMPP-established travel standards (mileage and minutes), which vary by program type and provider type. These standards ensure:

- Access to PMPs close to the member's residence
- Availability of specialists within reasonable travel distances
- Proportional standards for rural, suburban, and urban counties
- Adjustments for LTSS and home-based services, where travel standards may differ due to in-home or community-based service delivery

MCOs must monitor compliance with these standards through geospatial mapping, provider counts, and member enrollment reports.

XV.D – Provider Enrollment and Network Maintenance

Each MCO must:

- Execute written provider agreements that comply with OMPP standards.
- Validate and ensure all network providers are enrolled with the Indiana Health Coverage Programs (IHCP).
- Implement credentialing and re-credentialing processes consistent with federal and state requirements.
- Monitor provider capacity and panel sizes to avoid over-assignment or barriers to care.
- Maintain a continuous recruitment strategy to fill gaps in high-need areas or specialties.
- Notify OMPP at least 90 days in advance if they are unable to maintain adequate network coverage in any county.

Network sufficiency must be maintained throughout the contract period, regardless of changes in provider availability, enrollment patterns, or service demands.

XV.E – Network Monitoring and Reporting

MCOs must submit network access reports, including:

- Number of contracted providers by specialty and county
- Counts of in-network providers accepting new patients
- Member-to-provider ratios
- Time and distance analysis for each provider category
- Accessibility designations (ADA-compliant sites, accommodations offered)
- LTSS provider availability, including home health, durable medical equipment providers, personal care, and waiver service providers

OMPP reviews and validates these reports to ensure accuracy, identify gaps, and monitor trends. Additional reporting may be required if issues are identified.

XV.F – Specialty and Behavioral Health Access Requirements

MCOs must demonstrate robust access to:

- High-volume and high-impact specialties (e.g., cardiology, endocrinology, neurology, oncology)
- Non-psychiatrist behavioral health providers including psychologists, counselors, social workers, and advanced practice nurses
- Community mental health centers and substance use disorder treatment providers
- Providers serving children with special health care needs

- LTSS providers supporting individuals receiving home- and community-based services
- Providers meeting cultural, linguistic, or disability-specific needs

If access gaps exist, MCOs must take immediate action to mitigate shortages, including contracting with additional providers, expanding telehealth access, or arranging out-of-network services when appropriate.

XV.G – Out-of-Network Access

If an MCO cannot provide medically necessary services within its network:

- The MCO must authorize out-of-network services at no additional cost to the member.
- Members must not be required to travel unreasonable distances to receive services.
- The MCO must coordinate and reimburse out-of-network providers at rates no less favorable than in-network rates for covered services when access gaps exist.
- Out-of-network care must comply with all prior authorization and medical necessity requirements unless an emergency exists.

The MCO remains responsible for ensuring continuity of care and avoiding unnecessary delays regardless of network limitations.

XV.H – Network Adequacy Remediation

If an MCO fails to meet network adequacy standards, OMPP may require:

- Submission of a corrective action plan
- Enhanced network reporting
- Immediate contracting with providers in deficient areas
- Temporary or permanent restrictions on enrollment
- Financial remedies, including liquidated damages
- Additional oversight reviews or audits

Persistent noncompliance may escalate to sanctions up to and including contract termination.

XV.I – Member Communication and Transparency

MCOs must ensure members receive accurate and accessible information regarding provider networks, including:

- Up-to-date and easy-to-navigate provider directories
- Information in English, Spanish, and other prevalent languages
- Alternate format materials for individuals with disabilities
- Clear instructions for obtaining referrals, authorizations, or specialty care
- Notification when a provider leaves the network and assistance selecting a new provider

The MCO must assist members in selecting providers and ensure that transitions do not result in gaps in care.

XV.J – Continuous Improvement in Network Adequacy

OMPP expects MCOs to proactively evaluate:

- Provider shortages
- Member demographic shifts
- Utilization patterns
- Changes in community health needs
- Feedback from providers, members, and advocacy groups

Strategies may include telehealth expansion, targeted recruitment, incentives for providers in underserved areas, and partnerships with community-based organizations.

Continuous improvement ensures that networks evolve to meet the health needs of Indiana's Medicaid population effectively and equitably.

SECTION XVI. Coverage and Authorization of Services

XVI.A – Overview

OMPP requires all Managed Care Entities (MCOs) to maintain a utilization management (UM) program that ensures members receive medically necessary services in an efficient, timely, and person-centered manner. Coverage and authorization standards are designed to promote access to appropriate care, prevent unnecessary delays or denials, and support consistent application of clinical criteria across all programs and provider types.

This section outlines requirements for prior authorization, medical necessity determinations, UM staffing and training, appeal rights, service limitations, and coordination across clinical areas including physical health, behavioral health, pharmacy services, LTSS, and home- and community-based services.

XVI.B – Medical Necessity Standards

MCOs must determine coverage using:

- State-defined criteria for medical necessity
- Federally mandated requirements
- OMPP-approved clinical practice guidelines
- Behavioral health and LTSS-specific criteria when applicable

Decisions must be based solely on clinical appropriateness, not cost, risk selection, or anticipated utilization patterns.

XVI.C – Prior Authorization Requirements

MCOs may require prior authorization (PA) for certain services, but:

- PA criteria must be clearly defined, evidence-based, and consistently applied.
- PA rules must be communicated to members and providers in an accessible and transparent format.
- Emergency services must never require prior authorization.
- PA processes must not create inappropriate barriers or delays in medically necessary care.
- Service-specific timelines must comply with state and federal requirements, including expedited review options when delays could adversely impact health.

Each MCO must maintain appropriate staffing, including clinicians qualified to review requests relevant to their scope of practice.

XVI.D – Utilization Management Processes

UM programs must include:

- Clear procedures for receiving, reviewing, and deciding authorization requests
- Mechanisms to ensure consistent application of clinical criteria

- Retrospective and concurrent utilization review
- Monitoring for overutilization and underutilization
- Regular evaluation of UM policies to ensure fairness, accuracy, and compliance
- Systems to track timeliness of requests and decisions
- Documentation of all UM activities in member records

UM processes must integrate with quality improvement, care management, and service coordination functions.

XVI.E – Member and Provider Communication

MCOs must:

- Provide written notice of all authorization decisions, including approvals, modifications, denials, and terminations
- Clearly explain reasons for adverse decisions using plain, accessible language
- Include information about appeal rights and how to request an expedited review
- Notify providers promptly to minimize delays in care
- Maintain channels for members with disabilities or language needs to receive assistance and accessible communication

Member experience considerations must be embedded throughout the authorization process.

XVI.F – Appeals and Expedited Reviews

All members have the right to appeal adverse authorization decisions. MCOs must:

- Allow oral initiation of appeals when followed by written confirmation (unless expedited)
- Provide an expedited review when delays could jeopardize life, health, or functioning
- Comply with required state and federal timeframes for standard and expedited decisions
- Maintain documentation of all appeals, outcomes, and communication
- Ensure appeals are reviewed by a clinician not involved in the original decision

MCOs must also maintain external review processes and inform members of their right to request a state fair hearing.

XVI.G – Authorization and LTSS Requirements

For members receiving long-term services and supports, the MCO must:

- Use OMPP-approved tools such as the Health Needs Screening (HNS) and Comprehensive Health Assessment Tool (CHAT)
- Conduct reassessments within specified timelines

- Authorize services consistent with person-centered care planning principles
- Ensure service plans reflect assessed needs, risks, preferences, and goals
- Coordinate authorizations across physical health, behavioral health, and LTSS services
- Prevent gaps in service delivery during transitions, including between MCOs or care settings

LTSS authorization decisions must specifically consider functional status, caregiver supports, risks to health and safety, and member choice.

XVI.H – Pharmacy Services and Preferred Drug List

MCOs must:

- Follow the statewide uniform preferred drug list (SUPDL)
- Apply uniform clinical criteria and prior authorization processes for medications included in the SUPDL
- Conduct pharmacy reviews to ensure medications align with diagnoses and treatment plans
- Monitor the use of controlled substances and medications posing risk for misuse or inappropriate polypharmacy
- Provide exceptions processes consistent with state and federal requirements

Pharmacy UM must support safety, evidence-based care, and access to appropriate treatments.

XVI.I – Behavioral Health and Substance Use Disorder Services

MCOs must ensure:

- Authorization processes align with parity requirements between behavioral health and physical health benefits
- Criteria for inpatient, residential, outpatient, and SUD services reflect nationally recognized standards
- Timely access to follow-up care following emergency department visits or hospitalizations
- No inappropriate denials due to lack of behavioral health provider availability
- Coordination of care for members with chronic conditions, co-occurring disorders, or high-risk profiles

Utilization review processes must be staffed by qualified behavioral health professionals.

XVI.J – Ensuring Equitable and Appropriate Authorization Decisions

MCOs must:

- Evaluate authorization trends for potential disparities related to age, sex, race, ethnicity, language, disability, or geographic region
- Address any identified inequities through corrective actions

- Maintain procedures to identify members at risk for adverse outcomes due to service delays or denials
- Ensure members with special health care needs receive appropriate accommodations

Equity considerations must be embedded across authorization and coverage systems.

XVI.K – OMPP Oversight of Authorization Practices

OMPP monitors authorization activities through:

- Regular reporting on approval, denial, and modification rates
- Review of timeliness and compliance with required standards
- Evaluation of appeal overturn rates
- Examination of member and provider grievances related to UM
- Audits of authorization records
- Trend analyses to identify systemic risks or barriers to care

When deficiencies are identified, OMPP may require corrective actions, impose remedies, or adjust contract requirements.

SECTION XVII. External Quality Review Arrangements

XVII.A – Overview

The External Quality Review (EQR) is a federally required, independent evaluation of the quality, timeliness, and access to care provided by Indiana's Managed Care Entities (MCOs). The Office of Medicaid Policy and Planning (OMPP) contracts with an External Quality Review Organization (EQRO) to conduct these reviews for all applicable Indiana Health Coverage Programs, including Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging.

The EQR process ensures that the State maintains an objective and comprehensive assessment of MCO performance, identifies opportunities for improvement, and confirms that contractual and regulatory requirements are met.

XVII.B – Scope of External Quality Review

The EQRO must conduct annual reviews that evaluate:

- **Quality, access, and timeliness of care** delivered by each MCO
- **Adherence to state and federal requirements** under 42 CFR 438 Subpart E
- **Accuracy and reliability** of performance measures
- **Effectiveness and integrity** of Performance Improvement Projects (PIPs)
- **Compliance with standards for managed care operations**, including delegation oversight, utilization management, and care coordination
- **Network adequacy and availability of services**
- **Specific focus areas identified by OMPP**, including LTSS performance for PathWays

The EQRO uses standardized protocols and CMS-approved methodologies to ensure consistency and reliability.

XVII.C – Annual EQR Activities

The EQRO completes the following annual activities:

1. Validation of Performance Measures

The EQRO evaluates whether MCO-reported performance data (such as HEDIS and Core Set measures) are complete, accurate, and collected according to required specifications.

2. Validation of Performance Improvement Projects (PIPs)

The EQRO reviews each MCO's PIPs to verify that:

- Topics are relevant and evidence-based
- Methodology is sound
- Interventions are appropriate
- Results reflect real improvement in member outcomes

- Projects meet CMS validation criteria

3. Review of Compliance With Standards

The EQRO assesses MCO compliance with federal managed care regulations, contract requirements, and operational standards. This may include:

- Utilization management
- Member rights
- Grievances and appeals
- Care coordination
- LTSS standards for PathWays
- Subcontractor oversight
- Provider network management

4. Validation of Encounter Data

The EQRO reviews encounter data to confirm it is complete, timely, and sufficiently accurate for use in rate-setting, quality measurement, and program oversight.

5. Specialized Analyses

OMPP may request additional reviews in priority areas such as:

- Behavioral health follow-up performance
- Transitions of care
- Member experience trends
- LTSS health and welfare indicators
- Network adequacy mapping and access evaluation

XVII.D – Reporting and Recommendations

The EQRO produces detailed reports for each MCO, including:

- Findings related to quality, access, and timeliness of care
- Identification of compliance deficiencies or operational risks
- Recommendations for corrective actions
- Observations on best practices and system-level opportunities
- Validation determinations for performance measures and PIPs

A statewide **Annual Technical Report** is prepared and published summarizing results across all MCOs and highlighting statewide trends and improvement areas.

XVII.E – MCO Responsibilities

All MCOs must:

- Participate fully in all EQRO activities
- Submit required documentation, data files, and supporting evidence
- Respond to EQRO inquiries promptly and accurately
- Implement recommended corrective actions when deficiencies are identified
- Incorporate EQRO findings into Quality Assessment and Performance Improvement (QAPI) work plans
- Maintain internal processes capable of supporting annual validation and review requirements

Noncompliance with EQRO requirements may result in corrective action plans, remedies, or sanctions.

XVII.F – OMPP Oversight and Use of EQR Findings

OMPP uses EQR findings to:

- Strengthen contract oversight and accountability
- Identify statewide quality improvement priorities
- Refine Pay for Outcomes measures, goals, or benchmarks
- Inform updates to the Quality Strategy Plan
- Evaluate MCO performance for corrective actions, sanctions, or procurement considerations
- Ensure alignment with CMS guidance and national quality initiatives

EQR results contribute directly to OMPP's continuous quality improvement framework.

XVII.G – Transparency and Public Posting

OMPP publicly posts EQR reports and related documents to promote transparency, member awareness, and community engagement. Public posting includes:

- The statewide Annual Technical Report
- Individual MCO EQR findings
- Validated performance measure results
- Summaries of PIP performance

This ensures stakeholders—including members, advocates, and providers—can clearly see how each MCO performs and where improvements are needed.

XVII.H – Continuous Evolution of EQR Activities

As program needs evolve, OMPP may expand EQR focus areas to include:

- New LTSS quality measures

- Member experience in integrated care programs
- Equity-focused assessments
- Deeper analysis of SDoH impacts
- Care coordination and transition outcomes
- Evaluation of new or revised contractual standards

The EQR process is designed to remain flexible and responsive to Indiana's Medicaid priorities.

APPENDIX I: History and Overview of Managed Care Programs

A. Introduction

Indiana's Medicaid managed care programs have evolved significantly over the past three decades. Across Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging, the State has implemented models designed to improve access, coordination, quality, and cost-effectiveness for diverse populations. This appendix provides an overview of each program's purpose, target populations, and historical development as part of Indiana's broader vision for integrated, member-centered Medicaid services.

B. Hoosier Healthwise (HHW)

Program Overview

Hoosier Healthwise is Indiana's Medicaid managed care program serving low-income children, pregnant individuals, and families. The program emphasizes early intervention, preventive health services, continuity of care, and coordination between primary and specialty providers.

Covered services include physical health, behavioral health, pharmacy, dental, vision, transportation, and family planning.

Historical Development

- Established in 1994 as a primary care case management model (PrimeStep).
- Transitioned to managed care in 1996 with the introduction of contracted MCOs.
- Expanded through collaboration with the Children's Health Insurance Program (CHIP), allowing enrollment for children up to age 19 in families with moderate incomes.
- Policies have been continuously updated to promote healthy pregnancies, childhood wellness, and adherence to pediatric care guidelines.

C. Healthy Indiana Plan (HIP)

Program Overview

The Healthy Indiana Plan provides coverage for adults ages 19–64 with incomes up to 138% of the federal poverty level. HIP emphasizes consumer engagement, personal responsibility, preventive care, and appropriate use of services.

HIP includes benefits such as primary care, behavioral health, specialist care, pharmacy, inpatient and outpatient hospital services, and diagnostic testing.

Historical Development

- Launched in 2008 as a nationally recognized, market-based Medicaid expansion alternative.
- Expanded in 2015 with HIP 2.0 to include broader adult populations and promote preventive health activities.
- Integrated with HHW for families to improve consistency of care delivery.
- Continues to incorporate innovations including enhanced benefits, tailored care management, and preventive health incentives.

D. Hoosier Care Connect (HCC)

Program Overview

Hoosier Care Connect serves individuals under age 60 who are aged, blind, or disabled, including those receiving Supplemental Security Income and other qualifying disability-related categories. The program focuses on coordinated care for individuals with complex medical, behavioral, and social needs.

Covered benefits include comprehensive medical services, behavioral health, pharmacy, dental, transportation, and other medically necessary supports.

Historical Development

- Developed following legislative direction in 2013 to transition aged, blind, and disabled members into managed care.
- Launched in 2015 to improve health outcomes, care coordination, and member experience for high-need individuals.
- Updated and reprocured in 2021 to strengthen care coordination and expand access to specialized services.
- Continues to align with Indiana's broader quality goals and the future direction of LTSS integration.

E. Indiana PathWays for Aging

Program Overview

Indiana PathWays for Aging is the State's managed long-term services and supports (MLTSS) program for individuals age 60 and older who require comprehensive, coordinated health and supportive services. PathWays integrates physical health, behavioral health, pharmacy, and LTSS under a single managed care model.

Members may receive services in the community through home- and community-based supports or in institutional settings, depending on level of need.

Historical Development

- Designed to modernize Indiana's LTSS system by expanding access to community-based care and simplifying navigation.
- Established through a statewide procurement to select MCOs with experience serving Medicare–Medicaid populations.
- Implemented July 2024 as part of Indiana's LTSS reform efforts.
- Integrates Medicaid benefits with aligned Dual Special Needs Plans (D-SNPs), beginning January 2026, to strengthen care management for dual-eligible members.
- Includes new standards for person-centered practices, service coordination, health and welfare monitoring, and quality measurement.

F. Traditional Medicaid Populations

Program Overview

Some Medicaid populations are served through Indiana's fee-for-service system rather than managed care. These include:

- Individuals receiving long-term services and supports through HCBS waivers (unless enrolled in PathWays)
- Individuals in nursing facilities or state-operated facilities
- Dual-eligible members not enrolled in PathWays or a D-SNP
- Certain specialty eligibility categories such as Refugee Medical Assistance and Breast and Cervical Cancer program participants
- Other populations not currently assigned to a managed care delivery system

Role in the Medicaid Delivery System

The traditional Medicaid model provides direct reimbursement to participating providers. It remains an important component of Indiana's Medicaid landscape, ensuring access for individuals whose needs or circumstances warrant fee-for-service coverage.

G. Summary

Across each program, Indiana's adoption and expansion of managed care reflects a shared commitment to:

- Improving access to high-quality care
- Enhancing coordination across services and providers
- Supporting preventive health and early intervention
- Promoting cost-effective delivery models
- Prioritizing member experience, equity, and person-centered planning

Appendix I provides the foundation for understanding the diverse programs that collectively contribute to Indiana's Medicaid managed care system and inform the broader Quality Strategy Plan.

APPENDIX II: Historical Timelines

A. Introduction

Indiana's Medicaid managed care system has evolved through a series of strategic policy decisions, legislative actions, and programmatic reforms. These historical milestones reflect the State's commitment to improving health outcomes, strengthening care coordination, and expanding access to high-quality, cost-effective services.

The following timelines summarize major developments across Indiana's managed care programs, including risk-based managed care, Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging. These timelines provide context for the current Quality Strategy Plan and illustrate the progression of Indiana's Medicaid modernization efforts.

B. Risk-Based Managed Care Timeline

1994 – Indiana launches its first managed care initiative through PrimeStep, a primary care case management model.
1996 – Risk-based managed care is introduced, contracting with health maintenance organizations to operate under capitated arrangements.
2000s – Continued refinements are made to expand provider participation, strengthen network standards, and improve the member experience.
2011 – HHW and HIP operations are aligned under a family-focused structure to streamline coverage and improve care continuity.
2013–2014 – Legislative direction is provided to expand managed care to aged, blind, and disabled populations, prompting development of Hoosier Care Connect.
2015 – Expanded use of managed care for complex populations and ongoing improvement of performance measures and oversight mechanisms.
2020s – Continued integration of quality initiatives, reporting standardization, data optimization, and alignment of long-term services and supports under managed care.
2024 – Launch of Indiana PathWays for Aging marks a major shift toward coordinated, whole-person care for older adults.

C. Hoosier Healthwise Timeline

1994 – Hoosier Healthwise is established to serve low-income children and families.
1996 – Transitions from PrimeStep into a risk-based managed care model.
2007–2010 – Program enhancements expand access to preventive and pediatric services, emphasizing childhood wellness.
2011 – Alignment with HIP begins to promote whole-family care and consistent provider relationships.
2018 – Policy changes consolidate pregnant members under HIP for income levels at or below 138% FPL.
2020–Present – Ongoing emphasis on improving birth outcomes, strengthening children's preventive services, and addressing social drivers of health.

D. Healthy Indiana Plan (HIP) Timeline

2008 – HIP is launched as a groundbreaking Medicaid reform model focusing on consumer responsibility and preventive care.
2015 – HIP 2.0 expands eligibility, modernizes benefits, and incorporates care coordination and incentive structures.
2015–2018 – Integration of pregnant members, refinements to POWER Account policies, and alignment

with HHW.
2019–2023 – Continued improvements in behavioral health access, chronic disease management, and community health partnerships.
2024–Present – HIP maintains a central role within Indiana's adult Medicaid delivery system, contributing significantly to preventive health outcomes and managed care performance.

E. Hoosier Care Connect Timeline

2013 – Indiana General Assembly directs FSSA to evaluate moving aged, blind, and disabled members into managed care.
2014 – Design and stakeholder engagement processes shape the HCC model, focusing on coordinated care for high-need individuals.
2015 – Hoosier Care Connect launches statewide.
2020 – Competitive procurement results in updated contracts with enhanced requirements for care coordination, quality improvement, and provider accountability.
2021–Present – HCC continues to evolve, integrating additional quality initiatives, aligning with LTSS reform efforts, and supporting transitions toward the PathWays model for older adults.

F. Indiana PathWays for Aging Timeline

2019–2021 – Indiana begins planning for a modernized, statewide managed LTSS program to better support older adults.
2022–2023 – Development of program requirements, stakeholder engagement, and procurement of participating MCOs.
2023 – Selection of three MCOs positioned to deliver integrated Medicare-Medicaid services through aligned D-SNPs beginning in 2026.
2024 – Program goes live July 1, transitioning older adults and LTSS members into a coordinated, person-centered managed care model.
2025–2026 – Continued refinement of quality measures, LTSS oversight, and full D-SNP alignment requirements.
2026 and Beyond – PathWays becomes Indiana's central delivery system for aging and LTSS populations, with expanded focus on community living, health and welfare protections, and care integration.

G. Summary

Indiana's move toward fully integrated managed care reflects a long-term vision of improving health outcomes, increasing accountability, and modernizing the Medicaid delivery system. Over three decades, the State has:

- Expanded managed care to nearly all Medicaid populations
- Strengthened quality oversight and performance expectations
- Invested in coordinated care models for vulnerable populations
- Enhanced access to preventive, primary, behavioral health, and LTSS services
- Aligned Medicaid operations with national standards and CMS innovation priorities

These historical developments provide the foundation for Indiana's current and future quality strategy.

APPENDIX III: Indiana Health Coverage Program-Specific Goals and Objectives

A. Introduction

This appendix outlines the program-specific goals and objectives for each Indiana Health Coverage Program (IHCP) operating under managed care. While Indiana maintains unified statewide quality priorities, each program also has tailored objectives aligned to the unique needs of its enrolled populations.

These goals strengthen the Quality Strategy Plan (QSP) by ensuring that performance expectations reflect population-specific clinical, behavioral, social, and long-term support needs. The following sections summarize the major goals and strategic focus areas for Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging.

B. Hoosier Healthwise (HHW)

Program Goals

1. Improve Maternal and Child Health Outcomes

- Increase access to comprehensive prenatal and postpartum care
- Improve early identification of maternal health risks
- Promote full childhood immunization through age-appropriate schedules
- Expand developmental and behavioral screening rates for children and adolescents
- Strengthen early intervention for chronic pediatric conditions

2. Increase Preventive and Primary Care Utilization

- Improve well-child visits, including EPSDT compliance
- Enhance adolescent preventive visit completion
- Increase receipt of preventive dental services
- Reduce avoidable emergency department utilization for children

3. Strengthen Care Integration and Coordination

- Support coordination across pediatric, behavioral health, and specialty providers
- Improve transitions between emergency, inpatient, and outpatient care settings
- Promote continuity of care within families by maintaining consistent PMPs

4. Advance Health Equity for Children and Families

- Reduce disparities in birth outcomes
- Improve access to services for children with special health care needs
- Support culturally and linguistically appropriate pediatric care

C. Healthy Indiana Plan (HIP)

Program Goals

1. Promote Preventive Health and Chronic Disease Management

- Increase preventive care visits among adults ages 19–64
- Improve chronic disease management, including diabetes, hypertension, and cardiovascular conditions
- Reduce avoidable hospital admissions through early intervention and medication adherence programs

2. Strengthen Member Engagement and Personal Responsibility

- Support member understanding of benefits and participation requirements
- Encourage use of preventive services to maximize benefit coverage
- Promote health literacy, particularly within populations facing social needs

3. Improve Behavioral Health Access and Outcomes

- Increase access to mental health and substance use disorder services
- Improve follow-up after ED visits and inpatient behavioral health stays
- Expand coordination for members receiving integrated physical and behavioral health services

4. Reduce Avoidable Emergency Department Utilization

- Promote PMPs as the primary point of care
- Enhance member outreach and education around appropriate service use
- Support alternative care options including telehealth and community behavioral health

D. Hoosier Care Connect (HCC)

Program Goals

1. Enhance Care for Individuals with Complex, Chronic, or Disability-Related Needs

- Improve coordination across providers, specialists, and behavioral health teams
- Increase completion of comprehensive health assessments and risk stratification
- Strengthen care management engagement for high-risk members

2. Promote Independent Living and Community Integration

- Reduce avoidable inpatient admissions and readmissions
- Support timely transitions between levels of care
- Enhance access to home-based and community support services

3. Improve Access to Specialty and Behavioral Health Services

- Expand network adequacy for specialists treating chronic or complex conditions
- Improve engagement with behavioral health services for co-occurring disorders
- Support medication adherence and evidence-based disease management

4. Address Social Drivers of Health

- Identify members with unmet housing, food, transportation, or caregiver support needs
- Connect members with community-based organizations and state resources
- Foster culturally competent service coordination

E. Indiana PathWays for Aging

Program Goals

1. Deliver Person-Centered LTSS and Medical Care

- Ensure assessments and care plans reflect member goals, preferences, strengths, and risks
- Increase timely service plan development and reassessments
- Strengthen shared care planning with PMPs and medical specialists

2. Promote Community Living and Avoid Unnecessary Institutionalization

- Increase access to home- and community-based services (HCBS)
- Reduce preventable nursing facility admissions
- Support safe, successful transitions back to the community

3. Protect Health and Safety

- Strengthen monitoring for abuse, neglect, exploitation, and critical incidents
- Improve timely delivery of authorized LTSS services
- Increase provider accountability through quality and performance metrics

4. Improve Integration of Medicare and Medicaid Services

- Align care coordination for dual-eligible members through companion D-SNPs
- Ensure smooth navigation between Medicare and Medicaid benefits
- Provide comprehensive, coordinated support for chronic and behavioral health needs

5. Advance Health Equity and Reduce Disparities

- Identify disparities across race, ethnicity, disability status, language, geography, and income
- Implement targeted interventions to improve equitable access to LTSS and health services

- Promote inclusive communication, accessibility, and culturally appropriate care

F. Summary

Indiana's programs specific goals reflect the diverse health needs of children, adults, individuals with disabilities, and older adults. While each program maintains tailored objectives, they all contribute to a unified quality framework centered on:

- Improving health outcomes
- Enhancing access and equity
- Strengthening care coordination
- Promoting person-centered practices
- Ensuring accountability and continuous improvement

These program-level goals support the broader Quality Strategy Plan and guide ongoing monitoring, performance evaluation, and quality improvement efforts across the Indiana Medicaid managed care system.

APPENDIX IV: OMPP Quality Committee Descriptions

A. Introduction

The Office of Medicaid Policy and Planning (OMPP) oversees multiple quality committees responsible for guiding, monitoring, and evaluating the quality strategy for Indiana Medicaid managed care programs. These committees serve as collaborative forums where state leadership, subject matter experts, contracted Managed Care Entities (MCOs), providers, and community stakeholders review performance data, identify system gaps, and recommend improvements.

The committees described below form the governance framework that supports the development, implementation, and continuous refinement of Indiana's Quality Strategy Plan (QSP).

B. OMPP Quality Strategy Committee

Purpose

The Quality Strategy Committee provides high-level oversight of the statewide quality strategy, ensuring alignment with federal requirements, state priorities, and performance improvement goals.

Key Responsibilities

- Oversee implementation of the Quality Strategy Plan
- Review quality performance trends across programs
- Identify cross-program opportunities for improvement
- Recommend updates to the QSP and related performance measures
- Support alignment between quality initiatives and payment models

Membership

OMPP leadership, program directors, quality experts, clinical advisors, and representation from other FSSA divisions as appropriate.

C. Quality and Outcomes Committee

Purpose

The Quality and Outcomes Committee monitors MCO performance across all required quality, operational, and contractual reporting domains.

Key Responsibilities

- Conduct in-depth review of MCO-reported data
- Validate performance results and identify discrepancies
- Provide feedback to MCOs regarding reporting quality and compliance
- Monitor progress toward Pay for Outcomes (P4O) measures
- Support development of corrective action plans when deficiencies are identified

Membership

OMPP Quality and Outcomes staff, program management teams, and staff from other sections as needed.

D. External Quality Review Coordination Group

Purpose

This group supports planning, coordination, and oversight of all External Quality Review (EQR) activities conducted annually by the State's External Quality Review Organization (EQRO).

Key Responsibilities

- Prepare data and materials needed for EQR activities
- Coordinate EQR-related communication with MCOs
- Review draft and final EQR findings
- Identify system-level improvement needs based on EQR results
- Support integration of EQR recommendations into program oversight and QSP updates

Membership

OMPP staff working in quality, compliance, policy, data analytics, and program operations.

E. LTSS Quality and Oversight Committees

These committees focus on quality and performance monitoring for long-term services and supports (LTSS), including Indiana PathWays for Aging.

1. LTSS Quality Improvement Committee

Purpose

To monitor LTSS quality metrics, service delivery performance, and member health and welfare outcomes.

Key Responsibilities

- Review LTSS assessments, care plans, and timeliness metrics
- Monitor critical incidents and trends
- Review of LTSS provider performance
- Recommend LTSS-specific quality improvement initiatives

2. LTSS Financial and Program Steering Committee

Purpose

To oversee fiscal integrity and financial performance of LTSS programs, including monitoring of spending patterns and payment structures.

Key Responsibilities

- Review LTSS rate and payment policies
- Monitor use of state-directed payments

- Evaluate emerging financial risks
- Ensure alignment between financial oversight and quality goals

F. Behavioral Health Quality Workgroup

Purpose

To address behavioral health performance across managed care, including mental health, substance use disorder treatment, crisis response, and integration with physical health.

Key Responsibilities

- Review behavioral health performance measures
- Monitor access to mental health and SUD services
- Identify gaps in the provider network
- Support alignment with statewide behavioral health initiatives
- Recommend quality strategies specific to behavioral health populations

Membership

OMPP clinical staff, behavioral health experts, DMHA representatives, and MCO behavioral health leads.

G. Member and Caregiver Advisory Committees

OMPP utilizes structured advisory groups to ensure the member voice is reflected in program decisions.

1. MCO Member and Informal Caregiver Advisory Committee

Purpose

To gather direct feedback from Medicaid members and caregivers regarding access, quality of care, and service experiences.

Key Responsibilities

- Review member feedback and identify system barriers
- Provide recommendations for improving access and communication
- Support member engagement efforts

2. Beneficiary Advisory Committee (BAC)

Purpose

To advise OMPP and the Medical Care Advisory Committee on policy and program issues directly affecting Medicaid beneficiaries.

Key Responsibilities

- Provide insights into member needs and experiences
- Inform OMPP of barriers to care and system navigation challenges
- Recommend approaches that promote person-centered service delivery

H. Medical Care Advisory Committee (MCAC)

Purpose

The MCAC provides formal stakeholder input into Medicaid policy development and is federally required under 42 CFR 431.

Key Responsibilities

- Review policy proposals affecting managed care
- Provide clinical and consumer perspectives on program changes
- Promote transparency and accountability in Medicaid operations

Membership

Providers, advocates, health systems, consumers, and state agency representatives.

I. Interagency and Cross-Division Workgroups

OMPP participates in multiple cross-agency workgroups to ensure coordinated oversight and policy alignment, including:

- Interagency Workgroup on Public Health and Medicaid Integration
- HCBS Critical Incident Workgroup
- HCBS Value-Based Purchasing Steering Committee
- Mortality Review Committee
- Nursing Facility Quality Improvement Workgroup

Each workgroup contributes expertise to strengthen integrated oversight of managed care, LTSS delivery, and member protections.

J. Summary

Indiana's quality governance structure is supported by a robust network of committees and workgroups that:

- Review and monitor performance
- Foster collaboration among stakeholders
- Provide input into policy and program design
- Support continuous improvement in care delivery

This governance infrastructure ensures that managed care operations align with federal requirements, state priorities, and the objectives of the Quality Strategy Plan.

APPENDIX V: Program-Level Performance Results

Table V-A.1. Hoosier Healthwise – Goal 1 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for Substance Use – 7-Day	HEDIS	17.78	29.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for Substance Use – 30-Day	HEDIS	27.77	40.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After Hospitalization for Mental Illness (FUH) – 7-Day	HEDIS	43.44	38.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After Hospitalization for Mental Illness (FUH) – 30-Day	HEDIS	67.47	56.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for Mental Illness (FUM) – 7-Day	HEDIS	47.14	40.0
1.1	Improve care coordination and follow up for members with	Follow-Up After ED Visit for Mental Illness (FUM) – 30-Day	HEDIS	61.58	54.0

	behavioral health and substance use disorders				
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Initiation: Alcohol Abuse or Dependence	HEDIS	31.18	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Engagement: Alcohol Abuse or Dependence	HEDIS	9.63	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Initiation: Opioid Abuse or Dependence	HEDIS	55.66	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Engagement: Opioid Abuse or Dependence	HEDIS	34.60	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Initiation: Other Drug Abuse or Dependence	HEDIS	43.70	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Engagement: Other Drug Abuse or Dependence	HEDIS	14.21	43.0
1.1	Improve care coordination and follow	IET – Initiation: Total	HEDIS	41.44	43.0

	up for members with behavioral health and substance use disorders				
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Engagement: Total	HEDIS	14.78	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	HEDIS	52.90	58.82
1.2	Improve the use of preventive behavioral health screenings and follow up to screenings	Metabolic Monitoring (APM) – Blood Glucose Testing	HEDIS	20.17	51.17
1.2	Improve the use of preventive behavioral health screenings and follow up to screenings	Metabolic Monitoring (APM) – Cholesterol Testing	HEDIS	26.81	33.09
1.2	Improve the use of preventive behavioral health screenings and follow up to screenings	Metabolic Monitoring (APM) – Blood Glucose & Cholesterol	HEDIS	24.39	32.11
1.2	Improve the use of preventive behavioral health screenings and follow up to screenings	Diabetes Screening (SSD)	HEDIS	78.80	82.55
1.2	Improve the use of preventive behavioral health screenings and follow up to screenings	Cardiovascular Monitoring (SMC)	HEDIS	Not Reported	73.17

1.2	Improve the use of preventive behavioral health screenings and follow up to screenings	Diabetes Monitoring (SMD)	HEDIS	62.50	70.05

Table V-A.2. Hoosier Healthwise – Goal 2 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)
2.1	Ensure early detection and follow up regarding prenatal and postpartum depression	PPC: Timeliness of Prenatal Care	HEDIS	83.26	85.0
2.1	Ensure early detection and follow up regarding prenatal and postpartum depression	PPC: Postpartum Care	HEDIS	82.15	83.0
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Well-Child Visits in the First 30 Months of Life (W30) – 0-15 Months	HEDIS	61.95	61.0
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Well-Child Visits in the First 30 Months of Life (W30) – 15-30 Months	HEDIS	61.95	69.0
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings,	Child and Adolescent Well-Care Visits (WCV)	HEDIS	48.40	51.65

	developmental screenings, and well child visits				
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Childhood Immunization Status (CIS-E) – Combo 10	HEDIS	27.27 (MY2023)	34.0
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Immunizations for Adolescents (IMA-E) – Combo 2	HEDIS	34.73 (MY2023)	35.0

Table V-A.3. Hoosier Healthwise – Goal 3 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)
3.1	Preventing oral disease	Oral Evaluation, Dental Services (OED)	HEDIS	New Measure (MY2023)	40.0
3.2	Improve access to dental services	Dentists and Oral Surgeons Network Adequacy	OMPP	—	2 within 60 miles per county

Table V-A.4. Hoosier Healthwise – Goal 4 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)

4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Glycemic Status Assessment for Patients with Diabetes (GSD)	HEDIS	New Measure (MY 2024)	TBD
4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Blood Pressure Control for Patients with Diabetes (BPD)	HEDIS	59.06	72.99
4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Eye Exam for Patients with Diabetes (EED)	HEDIS	33.46	52.0
4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Kidney Health Evaluation for Patients with Diabetes (KED)	HEDIS	35.49 (MY 2023)	36.0
4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Controlling High Blood Pressure (CBP)	HEDIS	62.61 (MY 2023)	63.38

Table V-A.5. Hoosier Healthwise – Goal 5 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)
5.1	Reduce the number of inpatient readmissions	Plan All-Cause Readmissions (PCR) – Ages 18–64	HEDIS	0.9393	0.9124

	for physical and behavioral health				
5.2	Ensure smooth transitions between level of care settings	Completion of Initial Health Needs Screening within 90 Days of MCO Enrollment	OMPP	52.30	≥ 80%

Table V-B.1. Healthy Indiana Plan – Goal 1 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for Substance Use – 7-Day	HEDIS	17.78	29.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for Substance Use – 30-Day	HEDIS	27.77	40.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up after Hospitalization for Mental Illness (FUH) – 7-Day	HEDIS	43.44	38.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up after Hospitalization for Mental Illness (FUH) – 30-Day	HEDIS	67.47	56.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for Mental Illness (FUM) – 7-Day	HEDIS	47.14	40.0

1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for Mental Illness (FUM) – 30-Day	HEDIS	61.58	54.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Initiation: Alcohol Abuse or Dependence	HEDIS	31.18	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Engagement: Alcohol Abuse or Dependence	HEDIS	9.63	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Initiation: Opioid Abuse or Dependence	HEDIS	55.66	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Engagement: Opioid Abuse or Dependence	HEDIS	34.60	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Initiation: Other Drug Abuse or Dependence	HEDIS	43.70	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Engagement: Other Drug Abuse or Dependence	HEDIS	14.21	43.0
1.1	Improve care coordination and follow up for members with behavioral	IET – Initiation: Total	HEDIS	41.44	43.0

	health and substance use disorders				
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Engagement: Total	HEDIS	14.78	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	HEDIS	52.90	58.82
1.2	Improve the use of preventive behavioral health screenings and follow up	Metabolic Monitoring (APM) – Blood Glucose Testing	HEDIS	20.17	51.17
1.2	Improve the use of preventive behavioral health screenings and follow up	Metabolic Monitoring (APM) – Cholesterol Testing	HEDIS	26.81	33.09
1.2	Improve the use of preventive behavioral health screenings and follow up	Metabolic Monitoring (APM) – Blood Glucose & Cholesterol	HEDIS	24.39	32.11
1.2	Improve the use of preventive behavioral health screenings and follow up	Diabetes Screening (SSD)	HEDIS	78.80	82.55
1.2	Improve the use of preventive behavioral health screenings and follow up	Cardiovascular Monitoring (SMC)	HEDIS	Not Reported	73.42
1.2	Improve the use of preventive behavioral health screenings and follow up	Diabetes Monitoring (SMD)	HEDIS	62.50	64.87

Table V-B.2. Healthy Indiana Plan – Goal 2 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)
2.1	Ensure early detection and follow up regarding prenatal and postpartum depression	PPC: Timeliness of Prenatal Care	HEDIS	83.26	85.0
2.1	Ensure early detection and follow up regarding prenatal and postpartum depression	PPC: Postpartum Care	HEDIS	82.15	83.0
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Well-Child Visits in the First 30 Months of Life (W30) – 0-15 Months	HEDIS	61.95	61.0
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Well-Child Visits in the First 30 Months of Life (W30) – 15-30 Months	HEDIS	61.95	69.0
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Child and Adolescent Well-Care Visits (WCV)	HEDIS	48.40	51.78
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Childhood Immunization Status (CIS-E) – Combo 10	HEDIS	27.27 (MY2023)	34.0
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Immunizations for Adolescents (IMA-E) – Combo 2	HEDIS	34.73 (MY2023)	35.0

Table V-B.3. Healthy Indiana Plan – Goal 3 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2025)
3.1	Improve access to dental services	Dentists and Oral Surgeons Network Adequacy	OMPP	—	2 within 60 miles per county

Table V-B.4. Healthy Indiana Plan – Goal 4 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)
4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Glycemic Status Assessment for Patients with Diabetes (GSD)	HEDIS	New Measure (MY 2024)	55.0
4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Blood Pressure Control for Patients with Diabetes (BPD)	HEDIS	59.06	—
4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Eye Exam for Patients with Diabetes (EED)	HEDIS	33.46	52.0
4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Kidney Health Evaluation for Patients with Diabetes (KED)	HEDIS	35.49 (MY 2023)	36.0

4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Controlling High Blood Pressure (CBP)	HEDIS	62.61 (MY 2023)	63.38

Table V-B.5. Healthy Indiana Plan – Goal 5 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)
5.1	Reduce the number of inpatient readmissions for physical and behavioral health	Plan All-Cause Readmissions (PCR)	HEDIS	0.9393	0.9124
5.2	Ensure smooth transitions between level of care settings	Completion of Initial Health Needs Screening within 30 or 90 Days of MCO Enrollment	OMPP	52.30	≥ 80%

Table V-C.1. Hoosier Care Connect – Goal 1 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for Substance Use – 7-Day	HEDIS	17.78	29.0
1.1	Improve care coordination and follow up for members with	Follow-Up After ED Visit for Substance Use – 30-Day	HEDIS	27.77	40.0

	behavioral health and substance use disorders				
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up after Hospitalization for Mental Illness (FUH) – 7-Day	HEDIS	43.44	38.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up after Hospitalization for Mental Illness (FUH) – 30-Day	HEDIS	67.47	56.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for Mental Illness (FUM) – 7-Day	HEDIS	47.14	40.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for Mental Illness (FUM) – 30-Day	HEDIS	61.58	54.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Initiation: Alcohol Abuse or Dependence	HEDIS	31.18	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Engagement: Alcohol Abuse or Dependence	HEDIS	9.63	43.0

1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Initiation: Opioid Abuse or Dependence	HEDIS	55.66	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Engagement: Opioid Abuse or Dependence	HEDIS	34.60	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Initiation: Other Drug Abuse or Dependence	HEDIS	43.70	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Engagement: Other Drug Abuse or Dependence	HEDIS	14.21	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Initiation: Total	HEDIS	41.44	43.0
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	IET – Engagement: Total	HEDIS	14.78	43.0
1.1	Improve care coordination and follow up for members with	Adherence to Antipsychotic Medications for	HEDIS	52.90	58.82

	behavioral health and substance use disorders	Individuals with Schizophrenia (SAA)			
1.2	Improve the use of preventive behavioral health screenings and follow up	Metabolic Monitoring (APM) – Blood Glucose Testing	HEDIS	20.17	51.17
1.2	Improve the use of preventive behavioral health screenings and follow up	Metabolic Monitoring (APM) – Cholesterol Testing	HEDIS	26.81	33.09
1.2	Improve the use of preventive behavioral health screenings and follow up	Metabolic Monitoring (APM) – Blood Glucose & Cholesterol	HEDIS	24.39	32.11
1.2	Improve the use of preventive behavioral health screenings and follow up	Diabetes Screening (SSD)	HEDIS	78.80	82.55
1.2	Improve the use of preventive behavioral health screenings and follow up	Cardiovascular Monitoring (SMC)	HEDIS	Not Reported	73.17
1.2	Improve the use of preventive behavioral health screenings and follow up	Diabetes Monitoring (SMD)	HEDIS	62.50	70.05

Table V-C.2. Hoosier Care Connect – Goal 2 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)

2.1	Ensure early detection and follow up regarding prenatal and postpartum depression	PPC: Timeliness of Prenatal Care	HEDIS	83.26	85.0
2.1	Ensure early detection and follow up regarding prenatal and postpartum depression	PPC: Postpartum Care	HEDIS	82.15	83.0
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Well-Child Visits in the First 30 Months of Life (W30) – 0-15 Months	HEDIS	61.95	61.0
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Well-Child Visits in the First 30 Months of Life (W30) – 15-30 Months	HEDIS	61.95	69.0
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Child and Adolescent Well-Care Visits (WCV)	HEDIS	48.40	51.65
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings, developmental screenings, and well child visits	Childhood Immunization Status (CIS-E) – Combo 10	HEDIS	27.27 (MY2023)	34.0
2.2	Improve the health of infants, children, and adolescents focusing on preventive screenings,	Immunizations for Adolescents (IMA-E) – Combo 2	HEDIS	34.73 (MY2023)	35.0

	developmental screenings, and well child visits				

Table V-C.3. Hoosier Care Connect – Goal 3 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)
3.1	Preventing oral disease	Oral Evaluation, Dental Services (OED)	HEDIS	New Measure (MY2023)	40.0
3.2	Improve access to dental services	Dentists and Oral Surgeons Network Adequacy	OMPP	—	2 within 60 miles per county

Table V-C.4. Hoosier Care Connect – Goal 4 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)
4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Glycemic Status Assessment for Patients with Diabetes (GSD)	HEDIS	New Measure (MY 2024)	55.0
4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Blood Pressure Control for Patients with Diabetes (BPD)	HEDIS	59.06	72.99

4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Eye Exam for Patients with Diabetes (EED)	HEDIS	33.46	52.0
4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Kidney Health Evaluation for Patients with Diabetes (KED)	HEDIS	35.49 (MY 2023)	36.0
4.1	Improve the health and reduce complications for members diagnosed with diabetes and other chronic conditions	Controlling High Blood Pressure (CBP)	HEDIS	62.61 (MY 2023)	63.38

Table V-C.5. Hoosier Care Connect – Goal 5 Statewide Baseline and Performance

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2022)	Statewide Target (2026)
5.1	Reduce the number of inpatient readmissions for physical and behavioral health	Plan All-Cause Readmissions (PCR)	HEDIS	0.9393	0.9124
5.2	Ensure smooth transitions between level of care settings	Completion of Initial Health Needs Screening within 30 or 90 Days of MCO Enrollment (based on care program)	OMPP	52.30	≥ 80%

Table V-D. Indiana PathWays for Aging – Baseline Year 2025 Program-Level Performance Results

Objective	Objective Description	Quality Measure	Measure Source	Statewide Baseline (2025)	Statewide Target (2026)
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)	HEDIS	TBD	TBD
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up after Hospitalization for Mental Illness (FUH)	HEDIS	TBD	TBD
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After ED Visit for Mental Illness (FUM)	HEDIS	TBD	TBD
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Initiation and Engagement of Alcohol and Other Drug Use Treatment (IET)	HEDIS	TBD	TBD
1.1	Improve care coordination and follow up for members with behavioral health and substance use disorders	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	HEDIS	TBD	TBD

1.2	Improve the use of preventive behavioral health screenings and follow up	Diabetes Screening for People with Schizophrenia/Bipolar Disorder Using Antipsychotics (SSD)	HEDIS	TBD	TBD
1.2	Improve the use of preventive behavioral health screenings and follow up	Cardiovascular Monitoring for People with CVD and Schizophrenia (SMC)	HEDIS	TBD	TBD
1.2	Improve the use of preventive behavioral health screenings and follow up	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	HEDIS	TBD	TBD
2.0	Improve the health and wellness of pregnant persons, new mothers, infants, and children	Not applicable to Indiana PathWays for Aging	—	—	—
3.2	Improve access to dental services	Dentists and Oral Surgeons Network Adequacy	OMPP	—	—
4.1	Improve the health and reduce complications for members diagnosed with diabetes	HBD: Hemoglobin A1c Control for Patients with Diabetes – Poor Control	HEDIS	TBD	TBD
4.1	Improve the health and reduce complications for members diagnosed with diabetes	HBD: Hemoglobin A1c Control for Patients with Diabetes	HEDIS	TBD	TBD
4.1	Improve the health and reduce complications for members	HBD: HbA1c Control – Poor Control (alternate denominator specification)	HEDIS	TBD	TBD

	diagnosed with diabetes				
5.1	Reduce the number of inpatient readmissions for physical and behavioral health	MLTSS-4: LTSS Reassessment/Care Plan Update after Inpatient Discharge	CMS	TBD	TBD
5.1	Reduce the number of inpatient readmissions for physical and behavioral health	MLTSS-5: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls	CMS	TBD	TBD
5.1	Reduce the number of inpatient readmissions for physical and behavioral health	Completion of Initial Health Needs Screening within 90 Days of MCO Enrollment	OMPP	TBD	TBD
5.2	Ensure smooth transitions between level of care settings	Participants Who Report Knowing Their MCO Care Manager	CAHPS	TBD	TBD
5.2	Ensure smooth transitions between level of care settings	MLTSS-3: Shared Care Plan with Primary Care Provider	CMS	TBD	TBD
5.2	Ensure smooth transitions between level of care settings	MLTSS-8: Successful Transition after Long-Term Facility Stay	CMS	TBD	TBD
5.2	Ensure smooth transitions between level of care settings	Service Coordinators Completing Person-Centered Planning Training within 90 Days of Hire	OMPP	TBD	TBD
5.3	Deliver person-centered services and supports	Members Reporting Service Plan Reflects What Is Important to Them	CAHPS	TBD	TBD

5.3	Deliver person-centered services and supports	Care Plan Implemented within 90 Days of MCO Effective Date (CM Level)	OMPP	TBD	TBD
5.4	Assure timely access to services supporting members' preferred living setting	Care Plan Implemented within 60 Days of MCO Effective Date (Complex CM Level)	OMPP	TBD	TBD
5.4	Assure timely access to services supporting members' preferred living setting	MLTSS-1: Comprehensive Assessment and Update	CMS	TBD	TBD
5.4	Assure timely access to services supporting members' preferred living setting	MLTSS-2: Comprehensive Care Plan and Update	CMS	TBD	TBD
5.4	Assure timely access to services supporting members' preferred living setting	MLTSS-6: Admission to a Facility from the Community	CMS	TBD	TBD
5.4	Assure timely access to services supporting members' preferred living setting	MLTSS-7: Minimizing Facility Length of Stay	CMS	TBD	TBD

APPENDIX VI: Acronyms and Definitions

Acronyms

Acronym – Term
AAB – Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
AAP – Adults' Access to Preventive/Ambulatory Health Services
A1c / HBD – Hemoglobin A1c Diabetes Measures
AIM / IMAE – Immunizations for Adolescents
APM – Metabolic Monitoring for Children/Adolescents on Antipsychotics
BAC – Beneficiary Advisory Committee
BPD – Blood Pressure Control for Patients with Diabetes
CAHPS – Consumer Assessment of Healthcare Providers and Systems
CBP – Controlling High Blood Pressure
CCM – Complex Case Management
CHAT – Comprehensive Health Assessment Tool
CHIP – Children's Health Insurance Program
CISE / CIS – Childhood Immunization Status
CM – Care Management
CVD – Cardiovascular Disease
DA – Division of Aging
DMHA – Division of Mental Health and Addiction
DSNP – Dual Eligible Special Needs Plan
EED – Eye Exam for Patients with Diabetes
EQR – External Quality Review
EQRO – External Quality Review Organization
EPSDT – Early and Periodic Screening, Diagnostic, and Treatment
FSSA – Family and Social Services Administration
FUA – Follow-up After ED Visit for Substance Use
FUM – Follow-up After ED Visit for Mental Illness
FUH – Follow-up After Hospitalization for Mental Illness
GSD – Glycemic Status Assessment
HCC – Hoosier Care Connect
HEDIS – Healthcare Effectiveness Data and Information Set
HHW – Hoosier Healthwise
HIP – Healthy Indiana Plan
HNS – Health Needs Screening
IHCP – Indiana Health Coverage Programs
IET – Initiation & Engagement of Substance Use Disorder Treatment
IMAE – Immunizations for Adolescents
KED – Kidney Health Evaluation for Patients with Diabetes
LTSS – Long-Term Services and Supports
MCAC – Medical Care Advisory Committee
MCO – Managed Care Entity
MCCAG – Managed Care Clinical Advisory Group
MLTSS – Managed Long-Term Services and Supports (CMS LTSS quality measures)
NOP – Notification of Pregnancy
OED – Oral Evaluation, Dental Services

OMPP – Office of Medicaid Policy and Planning
P4O – Pay for Outcomes
PA – Prior Authorization
PathWays – Indiana PathWays for Aging (MLTSS program)
PCP – Primary Care Provider
PCR – Plan All-Cause Readmissions
PCSP – Person-Centered Service Plan
PIP – Performance Improvement Project
PMP – Primary Medical Provider
QAPI – Quality Assessment and Performance Improvement
QSP – Quality Strategy Plan
SAA – Antipsychotic Medication Adherence
SDoH – Social Drivers of Health
SDP – State Directed Payment
SHCN – Special Health Care Needs
SMC – Cardiovascular Monitoring
SMD – Diabetes Monitoring
SSD – Diabetes Screening for Individuals on Antipsychotics
SUPDL – Statewide Uniform Preferred Drug List
W30 – Well-Child Visits in the First 30 Months of Life
WCV – Child & Adolescent Well-Care Visits

Definitions

Care Management (CM)
A coordinated set of activities that ensure members receive medically necessary services, support chronic condition management, and promote care continuity across providers.

Case Management / Complex Case Management (CCM)
Intensive, structured support for members with high medical, behavioral, functional, or social needs requiring comprehensive coordination.

Comprehensive Health Assessment Tool (CHAT)
A required tool for PathWays members and others with LTSS/SHCN needs; used to assess functional, medical, behavioral, and social needs to support care planning.

Encounter Data
Records of all services delivered to members, submitted by MCOs for reporting, performance measurement, rate setting, and federal compliance.

External Quality Review (EQR)
The federally required annual evaluation of MCO quality, access, and timeliness conducted by an independent EQRO.

Health Needs Screening (HNS)
A standardized initial screening conducted within required timeframes to identify physical, behavioral, LTSS, and SDoH needs.

Long-Term Services and Supports (LTSS)
Services helping members with chronic illness, disability, or functional limitations, delivered in community-based or institutional settings.

Managed Care Entity (MCO)
A contracted health organization responsible for delivering Medicaid managed care benefits, meeting quality standards, and complying with state and federal requirements.

Managed Long-Term Services and Supports (MLTSS)
A model in which an MCO delivers and coordinates all LTSS services, including assessments, service plan development, and ongoing monitoring.

Network Adequacy
Standards requiring MCOs to maintain sufficient provider types and numbers within time and distance requirements to ensure timely access to care.

Pay for Outcomes (P4O)
A performance-based payment model that withholds a portion of capitation and allows MCOs to earn it back based on attainment and improvement on quality measures.

Performance Improvement Project (PIP)
A multiyear, structured intervention required of each MCO to achieve significant, sustained improvement in targeted clinical or operational areas.

Person-Centered Service Plan (PCSP)
A plan created with the member that documents goals, needs, risks, services, and preferences; required for LTSS and PathWays populations.

Social Drivers of Health (SDoH)
Non-medical factors such as housing, food access, transportation, and social support that influence health outcomes.

Timeliness Standards
Requirements ensuring screenings, assessments, authorizations, care management engagement, and care coordination activities occur within defined timeframes.

Utilization Management (UM)
Processes used by MCOs to determine medical necessity, review service requests, issue prior authorizations, and monitor service use.

APPENDIX VII: Summary of Public Comments

A. Introduction

As part of the Quality Strategy Plan (QSP) update process, OMPP solicits input from Medicaid members, advocacy organizations, providers, tribal partners, and community stakeholders. Public comment ensures transparency, strengthens collaboration, and supports the development of a QSP that reflects the needs and experiences of Indiana Medicaid populations.

This appendix summarizes key themes from the public comments received during the comment period and highlights how OMPP addressed or incorporated the feedback.

B. Public Comment Process

OMPP made the Quality Strategy Plan available for public review during the designated comment period. Communication regarding the opportunity for input was shared through:

- Posting the draft QSP on the Medicaid Policy webpage
- Notification through advisory committees
- Outreach to partner agencies and advocacy groups
- Distribution to the federally recognized tribe in Indiana as part of required tribal consultation

Stakeholders were invited to submit feedback via email, written submission, or through public meetings.

C. Summary of Public Comment Themes

Feedback received during the public comment period generally aligned with the following major categories:

1. Access to Care and Provider Networks

Stakeholders emphasized:

- The importance of strengthening networks, particularly for behavioral health, SUD services, dental care, and specialists
- Concerns about provider availability in rural areas
- The need for transparency around network changes
- Ensuring culturally competent and disability-inclusive provider access

2. Long-Term Services and Supports (LTSS) and PathWays for Aging

Commenters highlighted:

- The need for clear communication to members and caregivers about program transitions
- The importance of member choice and person-centered planning
- Ensuring timely completion of assessments and delivery of services
- Strengthening protections around health and welfare

- Supporting the direct care workforce and service provider stability

3. Quality Measures and Performance Expectations

Stakeholders requested:

- Continued alignment of quality measures with national standards
- Consideration of social drivers of health in quality measurement
- Refinement of measures related to maternal and child health outcomes
- Greater transparency around MCO performance results

4. Behavioral Health and Substance Use Disorder Services

Feedback included:

- The need for improved access and timeliness of behavioral health services
- Strengthening follow-up requirements after hospitalizations and emergency visits
- Improving integration of physical and behavioral health care
- Enhancing the network of SUD providers and treatment programs

5. Care Coordination and Care Management

Commenters emphasized:

- The importance of meaningful, high-quality care management
- Ensuring care plans are person-centered, accessible, and updated often
- Reducing administrative barriers that delay needed services
- Supporting smooth transitions between care settings and between MCOs

6. Member Experience, Communication, and Equity

Themes included:

- Expanding availability of translated documents and alternate formats
- Simplifying member materials and notices
- Ensuring that member needs related to disability, culture, and language are addressed
- Strengthening outreach to vulnerable populations
- Reducing disparities in outcomes across demographic groups

7. Administrative and Reporting Feedback

MCOs, providers, and partners offered input on:

- Reporting burden and opportunities for streamlining

- Clarifying expectations around PIPs, data submission, and auditing
- Alignment of reporting requirements across programs

D. OMPP Responses and Actions

OMPP reviewed all submitted comments and incorporated feedback where appropriate. Key responses included:

1. Strengthening Access Initiatives

- Enhanced language in the QSP regarding network monitoring and adequacy oversight
- Reinforced expectations for behavioral health and dental access
- Added emphasis on culturally competent and disability-inclusive care

2. Refining Quality Measures and Oversight

- Updated measure descriptions and P4O context to better reflect statewide priorities
- Increased clarity around LTSS quality metrics for PathWays
- Improved integration of equity considerations across quality strategies

3. Enhancing LTSS and PathWays Requirements

- Strengthened expectations for person-centered planning and timely assessments
- Reinforced monitoring processes for critical incidents and provider performance

4. Supporting Member Experience and Equity

- Expanded focus on communication accessibility and health literacy
- Increased emphasis on identifying and addressing disparities in outcomes and access

5. Streamlining and Clarifying Administrative Requirements

- Clarified language around reporting standards, EQR expectations, and oversight processes
- Incorporated feedback to align reporting with program needs and reduce duplication

E. Tribal Consultation Feedback

OMPP engaged with Indiana's federally recognized tribe during the comment period. Feedback centered on:

- Ensuring access to culturally informed care
- Supporting tribal health providers' ability to serve members
- Coordination between State Medicaid programs and tribal health services

OMPP reviewed and addressed these considerations within the final QSP where applicable.

F. Closing Summary

The public comment process plays a vital role in shaping a Quality Strategy that is reflective of the needs of members, providers, stakeholders, and community partners. OMPP values the input received and remains committed to:

- Ongoing stakeholder engagement
- Transparent review of program performance
- Continuous improvement of quality and access for all Medicaid members

The feedback summarized in this appendix contributed directly to revisions incorporated in the final version of the Quality Strategy Plan.