



The Indiana Family and Social Services Administration

Hoosier

CARE

CONNECT

December 10, 2014





Agenda

- Hoosier Care Connect Overview
- Implementation & Member Transition
- Next Steps

Hoosier Care Connect Program Overview





Program Goals and Values

In designing Hoosier Care Connect, FSSA sought to achieve the goals and values informed by stakeholder feedback to the ABD Task Force convened for House Enrolled Act 1328.

Improve quality outcomes and consistency of care across the delivery system

- Develop financial incentives aligned with quality outcomes
- Establish quality measures

Ensure enrollee choice, protections and access

- Provide and promote consumer choice and autonomy
- Provide person-centered and local in-person care



Program Goals and Values - Continued

Coordinate Care Across the Delivery System and Care Continuum

- Acknowledge the whole person and span the healthcare delivery system
- Reduce duplication and uncoordinated care

Provide Flexible Person Centered Care

- Promote flexible care plans which address the whole person
- Address unique client needs and develop individualized service plans

Transition Planning, Contract Oversight and Implementation Issues

- Ensure state oversight and contractor accountability
- Minimize client impact during transition



Managed Care Entity Selection Process



- 3 MCEs selected through procurement process
- Assessed on factors such as:
 - Experience serving complex populations
 - Approaches to care management



Overview: Contract with Managed Care Entities (MCEs)

- Receive per member per month payments and are at financial risk for all services included in contract
- Deliver care coordination services
- Develop network of providers and reimburse claims
- MCEs are accountable for achieving metrics related to outcomes, process, quality and satisfaction
- Contract incorporates financial incentives tied to achievement of performance metrics



Overview: Examples of MCE Functions

Function	MCE Requirement Examples
Quality Improvement	<ul style="list-style-type: none"> • MCE to meet State-defined quality and process measures • Development of quality improvement program
Member Services	<ul style="list-style-type: none"> • Provision of care coordination programs • Operation of customer service number and 24 hour nurse hotline • Processing grievances and appeals
Utilization Management	<ul style="list-style-type: none"> • Prior authorization and concurrent review
Provider Network	<ul style="list-style-type: none"> • Contracting and credentialing provider network
Information Systems	<ul style="list-style-type: none"> • Processing provider claims • Developing health information technology programs • Submitting data to the State
Administrative Requirements	<ul style="list-style-type: none"> • Development of infrastructure and staffing • Meeting requirements for solvency and financial stability • Meeting medical loss ratio requirements



Included Populations

Included Populations

- Aged (65+)
- Blind
- Disabled
- Individuals receiving Supplemental Security Income (SSI)
- M.E.D. Works enrollees

Excluded Aged, Blind & Disabled Populations

- Medicare enrollees
- Institutionalized enrollees
- Home and Community-Based Services Waiver enrollees
- Money Follows the Person Grant enrollees

Approximately 84,000 enrollees are anticipated in the first year of Hoosier Care Connect



Other Excluded Populations

- Undocumented persons eligible for emergency services only
- Individuals enrolled in Hoosier Healthwise or Healthy Indiana Plan
- Individuals enrolled in the Family Planning Eligibility Program
- Breast and Cervical Cancer Program enrollees
- Medicare Savings Program enrollees



Overview of the Eligible Population

This list represents the top diagnoses/conditions of the eligible population.

Adults

- Cardiovascular
- Psychiatric
- Skeletal and Connective
- Gastrointestinal
- Pulmonary
- Diabetes

Children

- Psychiatric
- Hearing
- Pulmonary
- Nervous System
- Skeletal and Connective
- Metabolic



Covered Benefits

While MCEs are not financially responsible for carved-out services, they must ensure coordination of all Medicaid covered services and implement strategies to prevent duplication and fragmentation of care across the healthcare delivery system.

Included Benefits

- Primary care
- Acute care
- Prescription drugs
- Behavioral health
- Emergency services
- Transportation
- Dental

Carve-Outs

- Medicaid Rehabilitation Option Services (MRO)
- 1915(i) State Plan Home and Community Based Services
- FirstSteps
- Individualized education plans



Excluded Services

Individuals enrolled with an MCE who become eligible for an excluded service will be transitioned to fee-for-service

- Long-term nursing home care
- Hospice in an institutional setting*
- State psychiatric hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- HCBS waivers
- Psychiatric residential treatment facilities (PRTF)

*Enrollees receiving in-home hospice will remain enrolled with MCE



Care Coordination Responsibilities

MCEs are responsible for assessing members to identify their need for care coordination services

Health Needs Screening

- Completed within 90 days of enrollment

Comprehensive Health Assessment

- Completed in 150 days of enrollment for members identified during Health Needs Screening
- Identifies the psychosocial, functional and financial needs of the member
- Incorporates family and caregiver and provider input to identify the member's strengths, needs and available resources



Care Coordination Responsibilities

Following the Health Needs Screening and Comprehensive Health Assessment, members requiring additional supports are stratified into a care coordination level

Disease Management

Care Management

Complex Case Management

Right Choices Program (RCP)



Disease Management

Help guide the care for members with chronic health conditions and prevention

- ❖ Asthma
- ❖ ADHD
- ❖ Depression
- ❖ Pregnancy
- ❖ Autism/PDD
- ❖ COPD
- ❖ Coronary Artery Disease
- ❖ Chronic Kidney Disease
- ❖ Congestive Heart Failure
- ❖ Hypertension
- ❖ Diabetes
- ❖ Other, MCE-specific programs



Care Management

To help members who need assistance with care coordination, making preventive care appointments or accessing care to address the members' chronic health condition

- ❖ A purposeful plan
- ❖ Includes direct contact with the member; every effort for phone contact
- ❖ If member is receiving Medicaid Rehabilitation Option (MRO) case management from Community Mental Health Center (CMHC), then MCE must coordinate with CMHC



Complex Case Management

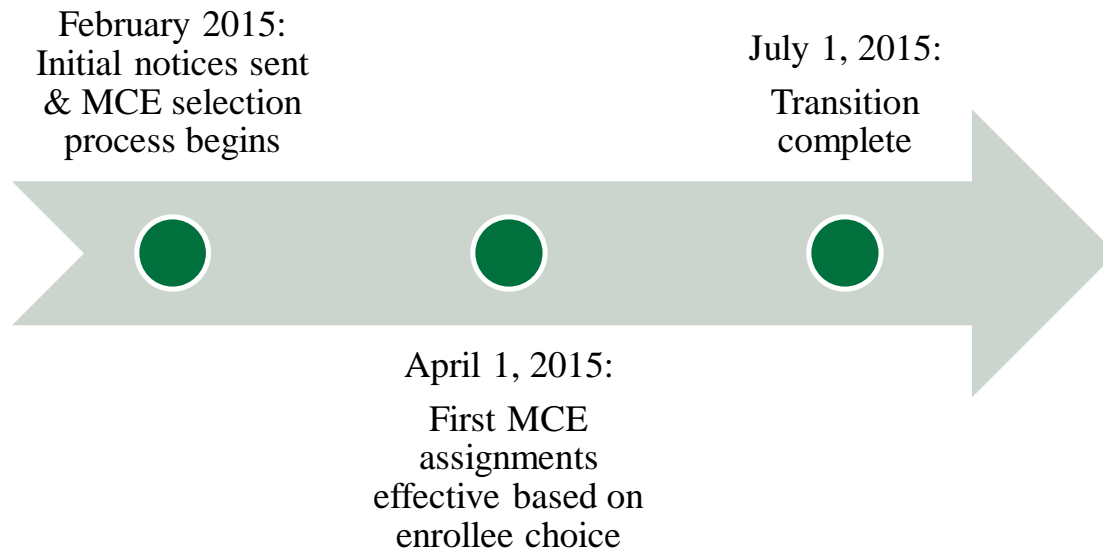
- Member Focus – active coordination of care and services with the member and between providers while navigating the extensive systems and resources required for the member
- Provider Focus – active coordination of care and services with the member who choose not to be involved or unable to participate to help navigate the extensive systems and resources required for the member

Implementation & Member Enrollment Process





Program Implementation - Enrollee Transition Process



- All enrollees will have the option to choose an MCE
- Targeted outreach to include notices and phone calls
- Auto-assignment will only occur when a selection is not made by the enrollee
- For transition, enrollees will have from February through June to self-select

*All dates are estimated and subject to change



Managed Care Entity Selection Process

- The Enrollment Broker serves as a neutral third party to assist enrollees in making an MCE selection
- Factors for enrollees to consider in making an MCE selection:
 - Availability of current healthcare providers in MCE network
 - Location of healthcare providers near the enrollee's home
 - MCE enhanced benefits and programs that are of interest to the enrollee



Care Select Phase-Out

Hoosier Care Connect and Care Select will operate concurrently for a short time period to optimize member choice and ensure continuity of care

- April 1, 2015 through June 30, 2015
- Impacts only individuals who are enrolled in Care Select and have not selected a Hoosier Care Connect MCE
- As of July 1, 2015 Care Select will no longer operate
 - Any remaining Care Select enrollees will be assigned to Hoosier Care Connect

*All dates are estimated and subject to change



Continuity of Care

Multiple strategies have been devised to ensure continuity of care for members as they transition to Hoosier Care Connect

Honoring Existing Prior Authorizations

- Year 1: 90 days
- Ongoing: 30 days

Maintaining Care Coordination

- Maintenance of care coordination stratification and services until new assessment

MCE Operational Requirements

- MCE Transition Coordinator
- Processes to identify outstanding authorizations



State Monitoring of Transition Process

FSSA will implement a variety of strategies to oversee the Hoosier Care Connect implementation and member transition process

Readiness Review Process

- MCEs will not be assigned membership until readiness is demonstrated
- Examples:
 - Adequate network access
 - Sufficient staffing

Ongoing Monitoring

- Regular reporting of operational, fiscal and quality measures
- Monthly onsite visits
- Policy and procedure review
- Unannounced site visits
- Review of all communication materials prior to distribution

Next Steps





Managed Care Entity Provider Network Development

MCE	Contact
Anthem	Esther Cervantes Provider Relations 812-202-3838 estherling.cervantes@anthem.com
MHS	John Yates Vice President, Contracting and Network (317) 684-9478 jyates@mhsindiana.com
MDwise	(317) 822-7300 x 5800

Healthcare providers can obtain information on how to join a Hoosier Care Connect network from the MCEs



Provider Contracting Overview

Overview

- Healthcare providers can contract with one or multiple MCEs

Timing

- Providers are encouraged to initiate the contracting process
 - Members will begin making selections in February 2015

Payment

- Providers are paid according to the rate negotiated with the MCE

In Network Services

- Once network adequacy standards have been met, members may be required to use in-network providers
- Exceptions:
 - Emergency services & self-referral services
 - First 90 days of contract
 - Necessary services unavailable within 60 miles



Ongoing Communications

- January – February 2015: Regional presentations
- Updates will be made available via:
 - <http://www.fssa.in.gov>
 - Under “Resources”
 - Under “Hoosier Care Connect/Aged, Blind and Disabled Task Force”
- Questions and comments can be submitted to HoosierCareConnect@fssa.in.gov

Questions?

