# St. Francis Health Network (SFHN) Key Contacts

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<thead>
<tr>
<th></th>
<th>COMMERCIAL</th>
<th>GOVERNMENT</th>
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</thead>
<tbody>
<tr>
<td>*Authorizations/ Referrals, Prior Authorizations &amp; Utilization Review (Criteria available upon request.)</td>
<td>Call: 585-7777 or (800) 862-3436</td>
<td>Call: 570-6816 or (800) 291-4140</td>
</tr>
<tr>
<td></td>
<td>Fax: 570-6818</td>
<td>Fax: 570-6818</td>
</tr>
<tr>
<td>DME, Supplies, Home Health Care Authorization</td>
<td>When you obtain authorization from SFHN, a contracted provider will be identified.</td>
<td>585-7777 or (800) 747-3693</td>
</tr>
<tr>
<td>Case Management</td>
<td>578-4300 x258</td>
<td></td>
</tr>
<tr>
<td>ED Coordinators</td>
<td>Marilyn Gaddy, RN, 528-7210</td>
<td></td>
</tr>
<tr>
<td>ED Coordinators</td>
<td>Karen Bledsoe, RN, 528-3710</td>
<td></td>
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<tr>
<td>Social Worker</td>
<td>Brenda Melton, 528-8836</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td>Beth Aldridge, 528-2311</td>
<td></td>
</tr>
<tr>
<td>Clinical Care Nurse Coordinator</td>
<td>Shannan Bowman, RN, 783-8744</td>
<td></td>
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<tr>
<td>Claims Filing Address</td>
<td>St. Francis Health Network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 502090</td>
<td></td>
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<tr>
<td></td>
<td>Indianapolis, IN 46250</td>
<td></td>
</tr>
<tr>
<td>*Claims Status</td>
<td>Commercial: 596-5925/Toll Free: (866) 873-4515</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax: 570-6822 or (800) 616-9979</td>
<td></td>
</tr>
<tr>
<td>*Claims Inquiries (Paid or Denied)</td>
<td>782-6931</td>
<td></td>
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<tr>
<td></td>
<td>Terry Monroe</td>
<td></td>
</tr>
<tr>
<td>*Hoosier Healthwise (Medicaid Risk Based)</td>
<td>782-6553    782-7413</td>
<td></td>
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<tr>
<td></td>
<td>Diana Poore Drew Thomas</td>
<td></td>
</tr>
<tr>
<td>Member Eligibility &amp; Benefits Verification, Member Claims Appeals/ Grievances</td>
<td>Call: # on Member ID Card</td>
<td></td>
</tr>
<tr>
<td>*Provider Relations</td>
<td>782-6553</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diana Poore</td>
<td></td>
</tr>
</tbody>
</table>

* These phone numbers are for provider’s use only – members/patients direct their inquiries to the insurance companies.

St. Francis Health Network Web Site:  
http://sites.franciscanalliance.org/sfhn
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Welcome to the St. Francis Health Network! We are very pleased you have chosen to be part of this physician, hospital, and community organization (PHCO).

St. Francis Health Network is truly a PHCO as it is governed by a Board of Directors, a Professional Services Committee, and a Finance Committee that are comprised of physician, hospital and community representatives. (Please see the organization chart provided on the next page.) Board and Committee members have the opportunity to be actively involved in determining present and future programs. They participate in defining and approving policies and procedures, including financial determinations.

In the ever changing managed care environment, SFHN has brought substantial benefit to physicians, the hospital, and the community. The initial goal of providing a unified vehicle for negotiating and contracting with managed care plans has been achieved very successfully.

SFHN has increased providers’ understanding of managed care and has been a conduit for moving the physicians and the hospital toward building the platform of trust required for increased levels of cooperative, integrated healthcare delivery. As the partnership between the physicians, hospital, and community deepens, SFHN’s mission to bring cost effective, high quality healthcare to the community will continue to be a top priority.

Sincerely,

Jennifer Westfall
Executive Director, SFHN
<table>
<thead>
<tr>
<th>Board of Directors</th>
<th>Finance &amp; Operations</th>
<th>Professional Services</th>
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</thead>
<tbody>
<tr>
<td><strong>Bob Brody (Chair)</strong></td>
<td><strong>Glen Brunk, M.D. (Chair)</strong></td>
<td><strong>Michael Shoemaker, M.D. (Chair)</strong></td>
</tr>
<tr>
<td>Jay Brehm</td>
<td>Carrie Anderson, M.D.</td>
<td>Scott Bowers, M.D.</td>
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<tr>
<td>William “Bill” Buffie, M.D.</td>
<td>Jay Brehm</td>
<td>Shanna Bowman, M.D.</td>
</tr>
<tr>
<td>Richard Feldman, M.D.</td>
<td>Ben Copeland, M.D.</td>
<td>Robert Gloyeske, M.D.</td>
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<tr>
<td>Margarita Hart</td>
<td>Patrick Enright, M.D.</td>
<td>*Anne Guy</td>
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<tr>
<td>Keith Jewell</td>
<td>Jason Geddes</td>
<td>Susan Hartman, M.D.</td>
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<tr>
<td>Mark Jones, M.D.</td>
<td>Faisal Khan, M.D.</td>
<td>W. Joe Johnston, M.D.</td>
</tr>
<tr>
<td>Dean Mayfield</td>
<td>Fred Lane, M.D.</td>
<td>Charles Kinsella, M.D.</td>
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<tr>
<td>Isaac Myers II, M.D.</td>
<td>Michael Morrelli, M.D.</td>
<td>*Susan McRoberts</td>
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<tr>
<td>Timothy Nussbaum, M.D.</td>
<td>Richard Rejer, M.D.</td>
<td>Polly Moore, M.D.</td>
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<tr>
<td>Bryan Perkins, M.D.</td>
<td>Greg Smith, M.D.</td>
<td>Eve Olson, M.D.</td>
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<tr>
<td>John Post</td>
<td>Philip Snyder, M.D.</td>
<td>Ana Priscu, M.D.</td>
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<tr>
<td>Sister Marlene Shapley</td>
<td>Roger West, M.D.</td>
<td>Rod Robinson, M.D.</td>
</tr>
<tr>
<td>Stacy Wells</td>
<td>Daniel Williams, M.D.</td>
<td>*Kim Siegfried</td>
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<td></td>
<td>Wendy Winckelbach, D.P.M.</td>
<td>C. Tom Thomas, M.D.</td>
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<tr>
<td>*Glen Brunk, M.D.</td>
<td></td>
<td>Randy Todd, M.D.</td>
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<tr>
<td>*Pam Jones</td>
<td>*Joseph LaRosa, M.D.</td>
<td>Thomas Wisler, M.D.</td>
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<tr>
<td>*Joseph LaRosa, M.D.</td>
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<td>*Michael Shoemaker, M.D.</td>
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<td>*Jay Brehm</td>
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<tr>
<td>*Bob Brody</td>
<td></td>
<td>*Susan Brown</td>
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<tr>
<td>*Joseph LaRosa, M.D.</td>
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<td>*Sister Marlene Shapley</td>
</tr>
<tr>
<td>*Sister Marlene Shapley</td>
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*Non-Voting Attendee
St. Francis Health Network

Commitment to Our Mission

St. Francis Health Network Mission Statement

The St. Francis Health Network, composed of physicians, hospital and community leaders, exists to promote the consistent delivery of quality medical care in the most cost effective setting. We will develop managed care strategies in which the continuum of care provided through the Network will enhance and promote the improvement of the overall health of the community we serve.

SFHN Standards and Responsibilities

1. To address all participants as dignified individuals.
2. To protect the insured person’s right to quality treatment.
3. To negotiate the financing of health care programs to be fair to all parties (payers, providers, and employers).
4. To continue to evaluate present products and help develop new products that meet the community’s needs.
5. To implement fair and reasonable utilization management policies and procedures.
6. To provide prompt and accurate payment of capitation and claims.
7. To have open and timely communication with physicians and other healthcare providers on all matters pertaining to contracts, medical management, quality improvement, ancillary providers, utilization of services, and cost of providing services.
8. To provide forums for physician, hospital, and community participation, e.g., Board of Directors, Professional Services Committee, and Finance Committee.
9. To provide ongoing education for physicians and other healthcare providers and their staff to promote understanding of Network participation and plan implementation.
10. To operate at all levels along the managed care continuum within the philosophy of Franciscan Alliance.
Policies and Procedures

St. Francis Health Network has on file Utilization Management and Quality Management Policies and Procedures that cover in detail many of the topics covered in this manual. The Policies and Procedures are available upon request either as a whole or as an individual policy. Please contact Dr. Joe LaRosa, Medical Director, or Diana Poore, Provider Relations Manager with your request.

Clinical Referral Guidelines

St. Francis Health Network (SFHN) uses the current edition of the Milliman Care Guidelines. PCPs (PCPs) and Specialty Care Physicians (SCPs) can access these guidelines through CROSS (Franciscan St. Francis Health intranet) or by contacting Nancy George at 782-7698 or Nancy.George@franciscanalliance.org. SFHN asks that PCPs utilize the guidelines when referring to capitated and non-capitated specialists. The guidelines are also used by SFHN Managed Care Specialists to determine if a referral to an out-of-network specialist is appropriate. If a referral request does not meet the guidelines, then the request is sent to the SFHN Medical Director for review. If the patient’s diagnosis and treatment plan meet the guidelines, authorization will be approved.
Participating Provider Rights, Standards, and Responsibilities

Physicians and other SFHN healthcare providers are to be responsible to the Network and its members in at least the following ways:

1. **Available by Phone:** Be available by phone within 30 minutes for emergencies, 24 hours a day, 7 days a week (attending physician or his/her designated covering physician.) For routine telephone messages, return the patient’s call within one working day.

2. **Change in Practice Status:** Physicians are to notify SFHN in writing of any change in practice status, e.g., closed or open to current patients only. A minimum of 60 days notice is required.

3. **Confidentiality:** Physicians agree to maintain personal privacy and confidentiality of member’s medical record.

4. **Contractual Requirements Regarding Billing Members:** Physicians agree to bill members only for any copays, deductibles, or coinsurance due and any non-covered services for which the member was notified in writing prior to the provision of such service that the member would be responsible for payment.

5. **Covering or On-Call Physicians:** Any reimbursement for primary care on-call or covering services is to be arranged between the physicians. The member is not to be billed for covered services except for the appropriate copayment, deductible, and coinsurance, if any.

6. **Credentialed and Recredentialing:** As mandated by the State of Indiana, SFHN accepts only the CAQH online Universal Credentialing Datasource. To learn more about the CAQH online universal application, please review the website at www.caqh.org. Please remember to authorize SFHN to have access to your information. All credentialing and recredentialing standards and processes are described in detail in SFHN’s credentialing and recredentialing policy and procedure. Any practitioner can request a copy of the SFHN credentialing criteria. SFHN does not discriminate against any practitioner seeking qualification as a participating provider. A credentialing decision is not based on an applicant’s race, ethnic/national identity background, gender, age, sexual orientation, languages spoken, type of procedure in which the practitioner specializes, or payer source.

According to Indiana State Mandate, IC 27-8-11-7 (d) SFHN will:
- Notify a practitioner concerning a deficiency on a completed credentialing application form submitted by the practitioner not later than thirty (30) business days after SFHN receives the completed credentialing form;
- Notify the practitioner the status of his or her completed credentialing application no later than: (1) sixty (60) days after SFHN receives the completed credentialing
application form; and (2) every thirty (30) days after the notice is provided under subdivision (1), until SFHN makes a final credentialing determination concerning the provider to meet Indiana State Mandate.

The practitioner has the right to:
- Request and receive information regarding the status of his/her application and credentialing process;
- Contact the Managed Care and Credentialing Coordinator or Provider Relations Manager for information regarding the status of his/her SFHN credentialing;
- Directly contact the Franciscan St. Francis Health Medical Staff Department to check on their credentialing status with the hospital.

7. **Ethical and Religious Directives:** Physicians are to conduct their practices in a manner consistent with the Ethical and Religious Directives for Catholic Health Facilities. Members and their families are to be treated with dignity and respect.

8. **Grievance or Expedited Grievance, Right to File:** If a SFHN physician/provider disagrees with a denial decision made by SFHN’s Medical Director, the physician/provider has the right to file a grievance or expedited grievance on the behalf of his/her patient. This right applies to all types of medical and behavioral health services. A grievance or expedited grievance that includes appropriate medical information may be faxed to (317) 782-6143 or mailed to:

   St. Francis Health Network  
   700 E. Southport Road  
   Indianapolis, IN 46227  
   Attention: Utilization Management

Any grievance submitted will be reviewed to determine if the request is an expedited grievance or a standard grievance:

A. **Expedited Grievance** – The decision could potentially cause harm to the patient and must be resolved within 72 hours.

B. **Grievance** – Grievance is determined to not be an expedited grievance and will be resolved within 20 business days.

9. **Inform Members/Patients and Include Them in Health Care Decisions:** Physicians are to provide members with a clear and concise explanation of their health care including information about all tests and treatments proposed, alternative forms of treatment, significant risks and side effects, length of recovery, and probable results of their treatment from the provider. With this information, the member may participate, in a reasonable and informed manner in all treatment decisions affecting their care. Upon being so informed and understanding the alternatives, members may request or refuse treatment. Members may also request a second opinion regarding such
treatment.

10. **Medical Management Policies and Procedures**: Physicians are to be knowledgeable of and comply with SFHN Medical Management Policies and procedures.

11. **Non-Discrimination**: Physicians agree to accept patients for services without regard to race, religion, sex, color, nationality, or health status.

12. **Office Site and Medical Record Audits**: Physicians are to allow SFHN and HMO staff access to office site and medical records as needed to comply with NCQA and Managed Care Entity requirements.

13. **Termination of Non-Compliant Commercial Members**: A physician may wish to term a non-compliant SFHN member who:

   A) Refused to pay past due accounts which may have occurred under a previous insurer or may be due to non-payment of copays or non-covered services,

   B) Is suspected of obtaining narcotic prescriptions from multiple sources,

   C) Has missed three (3) appointments without office notification, or

   D) Does not follow the recommended plan of treatment.

   **When non-compliance is related to refusal to pay, letter “A” above, please do the following:**

   1) Notify the patient in writing that after giving the patient/member every opportunity to pay, payment has still not been made on the past due account. Include in the patient’s notification of term letter that the PCP will continue to provide care until the patient selects a new PCP or up to 30 days whichever comes first.

   2) Fax a copy of the patient term letter to SFHN’s Provider Relations Manager. Also provide SFHN with any information not included in the letter that documents/supports the physician’s decision to term the member.

   3) SFHN will then notify the patient’s HMO plan and request that the HMO contact the patient to ask that a new PCP be selected.

   **When non-compliance is related to the provision of medical care, letters “B”, “C” and/or “D” above, SFHN physicians are asked to adhere to the following policies and procedures:**

   1) PCPs and SCPs are asked to monitor and assess SFHN members for compliance to their prescribed treatment plans. The physician or his/her designee is asked to schedule an appointment with the member to discuss the non-compliance issue.

   2) A “Member Non-Compliance Form” (sample on page I-11) is to be completed at that time and signed by both the physician and the member. The member’s signature does not signify that the member is accepting the fact that he/she has been non-compliant; merely that he/she
has been notified.

3) The physician is asked to alert SFHN to non-compliant behavior by forwarding a confidential copy of the non-compliant behavior to the SFHN Care Coordination Manager.

4) The SFHN Care Coordination Manager will enlist each health plan’s assistance in notifying and educating members on the seriousness of adhering to their physician’s plan of care by contacting the appropriate HMO representative and forwarding the documentation of non-compliant behavior.

5) The SFHN Care Coordination Manager will refer the member to a SFHN Case Manager who will contact the member and assist him/her in complying with the plan of care prescribed by the member’s physician.

6) SFHN’s Utilization Management Nurse and/or Case Manager will coordinate specific and population based care delivery in accordance with NCQA standards, State and Federal regulations, employer standards, and HMO and Hoosier Healthwise Program Policy and Procedures.

7) If the non-compliant behavior continues, the patient will be notified by the physician and the HMO plan via mail of the last day the physician will serve as the member’s healthcare provider.

14. **Urgent Care Services:** The per member per month capitation paid to Primary Care Physicians (PCPs) covers urgent care services for commercial HMO members. From 9:00 a.m. to 5 p.m., PCPs are expected to see SFHN members with urgent care needs within 24 hours.

**PRACTITIONER TERMINATION AND REINSTATEMENT**

St. Francis Health Network will reinstate a practitioner who voluntarily terminated his/her participation in the network within 30 days or less and if the network wishes to reinstate his/her participation. However, the practitioner must still have hospital privileges at one of the Franciscan St. Francis Health facilities.

If the practitioner’s termination or break in service was 30 days or more, then SFHN will require the practitioner to complete the initial credentialing process. The network will re-verify credentialing requirements that are no longer within the credentialing time limits. Professional Services Committee (Credentialing Committee) will review the practitioner’s credentials and make a final determination prior to the practitioner’s re-entry into the network.
Member Non-Compliance Notification Form

Date: ______________________

Please check specific area of concern:

_____ Narcotic prescriptions from multiple sources.

_____ Missed three (3) appointments without office notification.

_____ Non-Compliance with lab work draws.

_____ Other

Comments:

________________________________________________________________________

________________________________________________________________________

Dear Patient,

This is to inform you of the above concerns; this information will be forwarded on to your health plan. A case manager will be notifying you to improve your compliance with the above concern. If the above concern continues, you will be notified via mail of the last day that I will serve as your healthcare provider.

Thank you,

Physician’s Signature: ________________________________

*Patient’s Signature: ________________________________

*The patient signature does not signify that the member is accepting the fact that they have been non-compliant, merely that they were notified.

Please fax to the Care Coordination Manager-
St. Francis Health Network at (317) 782-6143.
SFHN Member Rights and Responsibilities

All health care is based on both scientific principles and human relationships. A partnership based on trust, respect, and cooperation among HMOs, SFHN, health care providers and their staff, and members will result in better health care. In commitment to their partnership with the provider Networks and their members, **the HMOs with whom SFHN contracts intend to:**

1. Inform members about covered services, access to primary and specialty services, and copays for those services.
2. Provide the member with a clear and concise explanation of the requirements for obtaining their health care within a managed care plan.
3. Inform members of their rights including the right to respectful and dignified treatment without regard to race, religion, sex, color, nationality, or health status.
4. Inform members of their right to a clear and concise explanation of their health care including information about all tests and treatments proposed, alternative forms of treatment, significant risks and side effects, length of recovery, and probable results of their treatment from the provider. With this information, the member may participate, in a reasonable informed manner, in all treatment decisions affecting their care. Upon being so informed and understanding the alternatives, the member may request or refuse treatment. The member may also request a second opinion regarding such treatment.
5. Inform members of their right to personal privacy and confidentiality of their medical records.

**The member’s responsibility is to:**

1. Follow managed care policies and regulations.
2. Provide all the information he/she knows about his/her condition and any recent changes that have occurred.
3. Tell the physician if he/she does not understand the treatment course or what is expected of him/her. (If members have any questions about any aspect of their treatment, it is their right and responsibility to consult with their health care provider.)
4. Follow the instructions and guidelines given to him/her by the member’s physician.
5. Keep scheduled appointments, or notify the provider office twenty-four hours in advance if canceling or changing the appointment.
6. Seek preventative tests or screening and treatment as recommended.
7. Treat his/her physician with respect and dignity.
8. Members should understand that they may jeopardize their recovery when they refuse to follow the recommendations of the health care provider or fail to report necessary information about their condition.
SECTION II.

SFHN HMO Plans

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- Member Services Phone Numbers II-7
SFHN Contracted Health Maintenance Organization (HMO) Plans

Commercial Plans
- ADVANTAGE Health Plan
- Franciscan (ADVANTAGE Health Plan)

Government Plan
- Hoosier Healthwise-Anthem St. Francis (Medicaid Risk Program)
St. Francis Health Network Administers the Contracted HMO Plans

- Administration of the contracted HMO plans is provided by St. Francis Health Network (SFHN) with the HMOs retaining responsibility for member services, services that cannot be provided pursuant to Catholic Directives, vision benefits, and dental benefits.

- Responsibility for physician credentialing, utilization management, claims processing, and quality management has been delegated by the HMO’s to SFHN. The policies and procedures for the provision of these services are the same for all the HMO plans.

- Reimbursement for services provided the commercial HMO members is based on capitation and SFHN’s maximum allowable fee schedule with a withhold.

- Behavioral Health Services are administered through Midwest Behavioral Health for all commercial members.

- SFHN HMO members are to obtain all laboratory and radiology services at one of the Franciscan St. Francis Health locations.

- All inpatient and outpatient hospital services including diagnostic procedures, surgeries, physical therapy, speech therapy, occupational therapy, and urgent care services are to be obtained at Franciscan St. Francis Health or at one of the Hospital’s satellite offices.

- DME and supplies must be prior-authorized by SFHN and are to be obtained from a SFHN contracted provider.

- Eligibility, benefit clarification, and all member services are provided by the members’ HMO. The number to call for information is on the members’ ID cards. Member/patients covered benefits, including copayments, may vary.
SFHN COMMERCIAL HMO PLANS

ADVANTAGE HEALTH PLAN
(ADVANTAGE HMO (effective March 1, 1997) with POS Option (effective July 1, 1999)

- Advantage Health Plan is an HMO originally developed by Sagamore for the small employer market. In 1999, Sagamore added a Point-of-Service (POS) option and expanded its market to include large employer groups. In 2000 Sagamore spun off its HMO division and Advantage became a separate organization. Advantage has two plans: Advantage Health Plan (HMO with or without a POS wraparound) and Advantage Franciscan (HMO).

- When sold as an HMO benefit plan, an Advantage member’s care must be provided or coordinated by the member’s PCP and be obtained by a SFHN physician if benefits are to be covered. When sold with the POS rider, the member has the flexibility to self-refer for certain services and still have coverage. However, the member has a lesser benefit and higher out-of-pocket expense when self-referring in or out-of-network.

- Members with the POS benefit are to request prior authorization before obtaining in-network or out-of-network self-referred services. The number the member must call for authorization is on his/her ID card. (Sample Advantage ID cards are located in this Section.) Claims are to be forwarded to SFHN. Second level benefits are subject to a deductible and coinsurance with an annual out-of-pocket maximum.

- Certain services must be obtained within the SFHN if the member is to have POS benefits and may include: Routine physical exam; hearing exam; well-baby care; immunizations/injections; and mental health, substance abuse, chemical dependency inpatient and outpatient services.

- Member services for the HMO and POS plans are provided by Advantage, e.g., eligibility, benefit clarification, and appeals and grievances. The number to call is on the member’s ID card. Family members may select different networks: The wife and children may have a SFHN PCP and the husband may select a Suburban Health Organization (SHO) PCP.

FRANCISCAN HEALTH PLAN
(An ADVANTAGE HMO) effective with SFHN September 1, 1996

- Franciscan Health Plan is an Advantage HMO available only to Franciscan St. Francis Health employees.

- SFHN has a risk agreement with Advantage for Franciscan that carves out pharmacy, services that cannot be provided pursuant to Catholic directives, and vision or dental benefits.

- Franciscan is administered by SFHN. Claims processing and prior authorization policies are the same as for other SFHN commercial HMOs.
SFHN Commercial HMO Members’ Identification Card:

SFHN is identified on a member’s insurance card. A copy of the HMO’s identification card follows:
Advantage HMO/Advantage PPO/POS
(HMO/POS no longer appears on the cards)

<table>
<thead>
<tr>
<th>(1) Benefit Plan</th>
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<tr>
<td><strong>Member Name:</strong> John Q Sample</td>
</tr>
<tr>
<td><strong>ID #:</strong> HP0000000000</td>
</tr>
<tr>
<td><strong>Employee:</strong> John Q Sample</td>
</tr>
<tr>
<td><strong>Group Name:</strong> Employer Name</td>
</tr>
<tr>
<td><strong>Group #: Policy #</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

(6) PCP Name: Your PCP
(7) PCP Phone: (###)###-####
(8) Mailing Address for Claims:
    Network Admin
    Network Admin Address
    City, State Zip
(9) EDI Payer ID:
HMO Membership Services

Member Services: Eligibility and Benefit Verification; Grievances

Membership inquiries and grievances are to be directed to the specific Health Maintenance Organization (HMO) Member Services Department. Refer to the member’s ID card for the correct telephone number or, if the member does not have a card, the following HMO numbers may be called by the physician and/or the member:

<table>
<thead>
<tr>
<th>HMO</th>
<th>Membership Services Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantage Health Plan</td>
<td>(317) 580-8087; (800) 235-8541</td>
</tr>
<tr>
<td>Advantage Health Plan, Franciscan</td>
<td>(317) 573-6228; (800) 354-0870</td>
</tr>
<tr>
<td>Hoosier Healthwise</td>
<td>(866) 408-6131</td>
</tr>
</tbody>
</table>
SECTION III.

QUALITY ASSURANCE (QA)
UTILIZATION MANAGEMENT (UM)

- Access Standards III-2
- Medical Record Documentation III-4
- Quality Initiatives III-6
- Utilization Management Overview III-7
- Prior Auth Reference Guide III-8
- Prior Authorization Referral Form (PARF) III-9
- Referral Authorization Process III-10
- Authorizing & Obtaining DME/Diabetes Supplies & Diabetes Education III-12
  - Patient Instruction Sheet for Ordering Diabetes & Ostomy Supplies
  - Diabetes Supplies covered by Prescription Benefits by HMO
  - Diabetes Education Form Forwarded with PARF
- Authorizing Radiology Services III-16
- High Tech Imaging Request Form III-17
- Authorizing OB Services III-18
- Authorizing AHC/ICC/ER Services III-19
- Authorization Inquiry Form III-20
Quality Assurance

Access Standards

Provide appropriate and timely access to care meeting the following SFHN access standards:

A. Providers-Commercial (applies to Primary Care Physicians (PCPs) and Specialists):

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Suggested Maximum Waiting Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergency/life threatening situation</td>
<td>Immediate</td>
</tr>
<tr>
<td>• Urgent care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>• Routine, primary care appointment for illness or injury</td>
<td>Within 5 business or 7 calendar days</td>
</tr>
<tr>
<td>• Well/preventative care such as GYN exams, health assessments, immunizations, prenatal care, well child visit</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>• Access to after-hours care</td>
<td>Office phone answered 24 hours/day, 7 days/week by answering service or instructional message on how to reach physician</td>
</tr>
</tbody>
</table>

Physician Response

<table>
<thead>
<tr>
<th>Suggested Maximum Response Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergency</td>
</tr>
<tr>
<td>Members should be able to reach attending physician or designated covering physician by phone within 30 minutes for emergencies, 24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>• Routine</td>
</tr>
<tr>
<td>Members should receive a return call from the practitioner within one working day.</td>
</tr>
</tbody>
</table>

Wait Time

<table>
<thead>
<tr>
<th>Goal is not to exceed 30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Office wait time</td>
</tr>
</tbody>
</table>

B. Providers – Hoosier Healthwise (applies to Primary Medical Providers (PMPs) and Specialists):

<table>
<thead>
<tr>
<th>General Appointment Scheduling</th>
<th>Suggested Maximum Waiting Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergent care/examination</td>
<td>Immediate access 24 hours/7 days a week</td>
</tr>
<tr>
<td>• Urgent (member with symptoms)</td>
<td>Treated no longer than end of following work day after contact with PMP site</td>
</tr>
<tr>
<td>• Non-urgent “sick visits”</td>
<td>Within 72 hours of request</td>
</tr>
<tr>
<td>• Routine preventative care</td>
<td>Within 5 weeks (Care Select), 6 weeks (HHW)</td>
</tr>
<tr>
<td>• Initial Health Assessment (non-pregnant adult)</td>
<td>90 days from enrollment</td>
</tr>
</tbody>
</table>
**Specialty Care**
- Emergency services
  - Immediate access 24 hours/7 days a week
- Urgent
  - Treated no later than end of the following work day after contact with SCP site
- Initial specialty visit
  - 3 weeks
- Non-urgent routine exam
  - 8 weeks

**Prenatal & Postpartum Visits**
- 1st trimester
  - Within 14 calendar days of request
- 2nd trimester
  - Within 7 calendar days of request
- 3rd trimester
  - Within 3 business days of request
- High risk pregnancy
  - Within 3 business days of identification or immediately if an emergency exists
- Postpartum exam
  - 3 to 8 weeks after delivery

**In-Office Wait Time**
Wait time in-office reception area before patient is called to examination room
- Within 45 minutes

**Call Back Triage**
Wait time to speak to a medical professional if patient needs to be triaged
- Within 30 minutes
Medical Record Documentation Standards

Hoosier Healthwise asks physicians to meet National Committee for Quality Assurance (NCQA) standards for medical record documentation. SFHN reviews medical records every other year and randomly selects PMPs with greater than 50 members for this audit. The audits are completed to ensure network compliance with the following standards, and a plan of action for improvement is implemented when the standards are not met:

Medical Record-Keeping Practices:

For example,
1. The record is organized.
2. There is a separate medical record for each patient.
3. Medical records are protected from public access.

Medical Record Documentation Practices:

For example,
1. Each page in the record contains the patient’s name or ID number.
2. All entries are dated.
3. Significant illnesses and medical conditions are indicated on the problem list.
4. Medication allergies and adverse reactions are prominently noted in the record. If the patient had no known allergies or history of adverse reactions, this is appropriately noted in the record.
5. Past medical history (for patients seen three or more times) are easily identified and include serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood diseases.
6. Working diagnoses are consistent with findings.
7. Treatment plans are consistent with diagnoses.
8. There is not evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.
9. All diagnostic, consultative, and therapeutic services for which a member was referred by a PCP have a documented note, suggested follow-up, or result in the member's record.
10. Immunization records are included for children and adolescents.
11. Consultation notes are in the record.
12. Advance Directives for adults – the medical record documents whether or not an advance directive has been executed. If so, a copy should be presented in the record.
13. There is documentation of failure to keep an appointment.
14. Current medications list is maintained and easily accessible.
15. Information regarding the use of tobacco, alcohol, and substance abuse for patients 10 years and older.
16. Documentation of appropriate medications prescribed and lab tests ordered for chronic illnesses.
All Health Plans/SFHN:

There is documentation of accurate provider coding on the claim/encounter consistent with the care documented in the medical record.
Quality of Care/Preventative Care Measures & Pay for Performance Measures

The mission of SFHN and Hoosier Healthwise Quality Management is to provide and maintain the highest level of quality and compassionate care to the members we serve through contracts with Health Maintenance Organizations (HMOs) or Managed Care Entities (MCEs).

The following is a summary of some of the SFHN commercial HMO Quality of Care/Preventative Care Measures (NOTE: All are HEDIS Measures):

1. Breast cancer screening
2. Cervical cancer screening
3. Colorectal cancer screening
4. Comprehensive diabetes care, including annual HbA1c & LDL-C screenings
5. Timely prenatal care
6. Postpartum care timeliness

The following are the Hoosier Healthwise Quality & Pay for Performance Measures:

1. Well child visits (6 or more) in 1st 15 months
2. Well child visit, ages 3-6 years, annual visit
3. Adolescent well care, ages 12-21 years, annual visit
4. Postpartum care timeliness
5. Comprehensive diabetes care, LDL-C screening & HbA1c screening
6. ER 30 day bounce back
7. Physicians advising against smokers to quit
8. Frequency of Ongoing Prenatal Care
Utilization Management (UM) Overview

St. Francis Health Network’s Medical Director, Case Managers, and Care Coordination Manager are responsible for utilization management activities for the SFHN HMO members and the Hoosier Healthwise onsite case management program.

Request for prior authorization, authorization for referrals for specialty care, DME, home health care, hospice, rehabilitation, out-of-network services, urgent care, emergent care, and any other services and/or catastrophic case management are to be directed to the following telephone or fax numbers Monday through Friday from 8:00 a.m. to 5:00 p.m.:

**Prior Authorization/Referrals:**

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Call</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial HMOs</td>
<td>(317) 585-7777; (800) 862-3436</td>
<td></td>
</tr>
<tr>
<td>Medicaid Risk Program</td>
<td>(317) 570-6816; (800) 291-4140</td>
<td></td>
</tr>
<tr>
<td>Prior Authorization/Referral Fax Line</td>
<td>(317) 570-6818</td>
<td></td>
</tr>
<tr>
<td>Fax Toll-Free</td>
<td>(800) 747-3693</td>
<td></td>
</tr>
<tr>
<td>DME Only</td>
<td>(317) 585-7777; (800) 862-3436</td>
<td></td>
</tr>
</tbody>
</table>

**Case Management:**

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Call</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial HMOs</td>
<td>(317) 575-7588</td>
</tr>
<tr>
<td>Medicaid Risk Program</td>
<td>(317) 575-7561</td>
</tr>
<tr>
<td>Inpatient Case Manager:</td>
<td>Shannan Bowman, RN, Call: (317) 783-8744</td>
</tr>
<tr>
<td>ED Coordinators:</td>
<td>Marilyn Gaddy, RN, Call: (317) 528-7210</td>
</tr>
<tr>
<td></td>
<td>Karen Bledsoe, RN, Call: (317) 528-3710</td>
</tr>
<tr>
<td>ED Social Workers:</td>
<td>Beth Aldridge, Call: (317) 528-2311</td>
</tr>
<tr>
<td></td>
<td>Brenda Melton, Call: (317) 528-8836</td>
</tr>
<tr>
<td>Care Coordination Manager:</td>
<td>Nancy George, RN, Call: (317) 782-7698</td>
</tr>
</tbody>
</table>
Complete this form for the following services:
- All Out-of-Network Services
- All In-Patient Admissions
- Referrals to Oral/Maxillofacial Surgeons
- Referrals to Plastic/Reconstructive Surgeons
- Referrals to Reproductive Endocrinologists
- Bariatric Medical/Surgical Consult & Treatments
- Biotech/Biopharm/Biologic Drugs (except Chemo)
- Pediatric Clinic Services
- Durable Medical Equipment/Prosthetics
- All Out-Patient Services/Surgeries that require prior auth (refer to Section III, Page 8 of the SFHN Provider Manual)
- Specialty Lab Work Performed by Outside Vendors

<table>
<thead>
<tr>
<th>St. Francis Health Network, Inc.</th>
<th>PRIOR AUTHORIZATION REQUEST FORM - COMMERCIAL PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(IF NOT COMPLETED IN FULL, REQUEST WILL BE RETURNED)</td>
<td></td>
</tr>
<tr>
<td>ST. FRANCIS HEALTH NETWORK, INC.</td>
<td>PHONE (Commercial): 317-585-7777, 800-862-3436 (toll free)</td>
</tr>
<tr>
<td>700 E. Southport Road</td>
<td>FAX (Commercial): 317-570-6818, 800-747-3693 (toll free)</td>
</tr>
<tr>
<td>Indianapolis, Indiana 46227</td>
<td></td>
</tr>
<tr>
<td>Please Note: This form is not to be used for Hoosier Healthwise</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantage</td>
<td>☐</td>
</tr>
<tr>
<td>Franciscan</td>
<td>☐</td>
</tr>
<tr>
<td>REQUESTED BY:</td>
<td>DATE:</td>
</tr>
<tr>
<td>PHONE#:</td>
<td>FAX #:</td>
</tr>
<tr>
<td>PATIENT NAME:</td>
<td></td>
</tr>
<tr>
<td>ID#:</td>
<td>DOB:</td>
</tr>
<tr>
<td>PCP:</td>
<td></td>
</tr>
<tr>
<td>SCP:</td>
<td>SPECIALTY:</td>
</tr>
<tr>
<td>DIAGNOSIS:</td>
<td>ICD-9 CODE(S):</td>
</tr>
<tr>
<td>PROCEDURE:</td>
<td>CPT-4 CODE(S):</td>
</tr>
<tr>
<td>CONSULT ONLY</td>
<td>CONSULT &amp; TREAT</td>
</tr>
<tr>
<td>FACILITY LOCATION:</td>
<td></td>
</tr>
<tr>
<td>DATE OF SERVICE (if available):</td>
<td>TREATMENT PLAN/MEDICAL INFORMATION:</td>
</tr>
<tr>
<td>IF REQUESTING APPROVAL FOR NON-PARTICIPATING PROVIDER, INDICATE WHY PARTICIPATING PROVIDER CANNOT PROVIDE SERVICE:</td>
<td></td>
</tr>
<tr>
<td>IS INJURY THE RESULT OF:</td>
<td>MOTOR VEHICLE ACCIDENT:</td>
</tr>
<tr>
<td>NAME OF ADDITIONAL INSURANCE:</td>
<td></td>
</tr>
<tr>
<td>REFERRAL TYPE:</td>
<td>SELF REFERRED:</td>
</tr>
</tbody>
</table>

PLEASE DO NOT WRITE BELOW THIS LINE. FOR SFHN USE ONLY.

<table>
<thead>
<tr>
<th>SFHN MED. DIRECTOR’S DECISION:</th>
<th>REASON FOR DENIAL:</th>
<th>REASON FOR APPROVAL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPROVED</td>
<td>NOT MEDICALLY NECESSARY</td>
<td>MEDICALLY NECESSARY</td>
</tr>
<tr>
<td>DENIED</td>
<td>NOT A COVERED BENEFIT</td>
<td>COVERED BENEFIT</td>
</tr>
<tr>
<td>PENDED FOR FURTHER RESEARCH</td>
<td>SERVICES AVAILABLE IN NETWORK</td>
<td>CONTINUITY OF CARE</td>
</tr>
<tr>
<td></td>
<td>NO AUTHORIZATION RECEIVED FROM PCP/PMP</td>
<td>REFERRED BY PCP/PMP</td>
</tr>
<tr>
<td></td>
<td>OTHER, SEE ATTACHED DOCUMENTATION</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PRESENTING SYMPTOMS DO NOT SUPPORT A PRUDENT LAYPERSON REASON TO SEEK EMERGENT CARE</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL DIRECTOR’S COMMENTS/SIGNATURE:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Referral Authorization Process

Prior Authorization Referral Form (PARF)

To be completed by:
- Primary Care Physicians (PCPs) and Specialty Care Physicians (SCPs)

When requesting authorization for:
- St. Francis Health Network (SFHN) Commercial members (Advantage and Advantage Franciscan)

For the following services:
- All out-of-network services
- All inpatient admissions
- All plastic/reconstructive services
- Reproductive endocrinology services
- Bariatric medical/surgical treatment
- All oral/maxillofacial services
- All biotech/biopharm/biologic drugs (except chemo)
- Pediatric clinic services
- Durable medical equipment/prosthetics
- All OP services/surgeries that require prior authorization (see page 8)
- All observation admissions
- All emergency room visits if referral or self-referred
- High tech imaging, i.e., MRI, MRA, and CT Scans
- Specialty lab work performed by outside vendors

An authorization number must be obtained prior to the provision of a service that is to be authorized by submitting the PARF. Authorizations will be issued for a specific service on a specific date or for a specific number of services.

1. The PCP or SCP evaluates the patient and determines the need for services. (Physicians are asked to refer to the SFHN Clinical Referral Guidelines to determine if the patient meets referral criteria.)

2. The PCP or SCP requests authorization a minimum of 48 hours prior to the date of service by completing the PARF and faxing it to SFHN at 580-6818 or 800-747-3693. (The information requested on the form may also be called to SFHN’s Utilization Management Nurses at 585-7777 or 800-862-3436.)

3. The SCP, not the PCP, submits a PARF to request authorization for the services the SCP orders for the patient, e.g., procedures, testing, surgeries, and any services that require additional authorization. (Note: Some SCPs can provide services in their offices without
additional authorization. See Section V for a listing of some of the services allowed in designated SCP’s offices.)

4. SCPs and/or PCPs are to prior authorize planned inpatient admissions at least three days prior to the planned admission by either completing a PARF or calling in a request.

5. SCPs and/or PCPs submit a PARF to SFHN to request authorization for family planning services. SFHN will then forward the request for these carved-out Catholic Directive services to the patient’s HMO for approval.

6. PCPs should check the “self-referred” line found on the PARF when a patient self-refers for urgent care or emergency services, but “urges” the physician to request an authorization for the service.

7. SFHN will issue a letter of approval or denial to the PCP, SCP, patient, and facility. An authorization number will be assigned to approved referrals. **A service is not approved until an authorization number has been assigned.**

8. See detailed instructions on the following pages for authorizing DME and supplies (including diabetes and ostomy supplies), MRIs, MRAs, CT Scans, and PET Scans by submitting a PARF and other requested documents.

9. To assist you with authorizing services for diabetic patients we have provided the following guidelines:

   - Listing of diabetes supplies covered by prescription benefits by HMO Plan
   - Patient Instruction Sheet for Obtaining Diabetes or Ostomy Supplies
   - Diabetes Education Form

**Note:** Laboratory services, the majority of radiology services (when performed at St. Francis Health), and some services provided in PCP and SCP offices do not require authorization. A listing of these services is provided in this section and in Section V of the SFHN Provider Manual.
Authorizing and Obtaining Durable Medical Equipment and Supplies
(Including Diabetes Supplies)

1. Request authorization for DME/supplies by faxing a PARF to SFHN’s Utilization Management Nurse or calling the phone numbers on the PARF. The UM Nurse will offer in network provider options.

2. When you do not know the correct HCPCS number for braces, splints, or orthotics, request an in network provider contact from SFHN. The DME provider will then determine the appropriate HCPCS code and request authorization from SFHN.

3. When an authorization is approved, SFHN will fax to your office a completed PARF. **SFHN will provide** the following on the form:
   - An authorization number, the date range of the authorization, and the terms of the authorization (rental/purchase).

4. Send a copy of the form and the ordering physician’s prescription with the patient, if possible.

5. If the patient is not available, fax a copy of the order form and the ordering physician’s prescription to the DME/supply provider identified by SFHN.

6. If the DME/supply is urgently needed, SFHN will call the DME provider with the authorization number, otherwise, this information will be faxed to the provider.

7. SFHN will send the member an authorization letter notifying him/her where the DME/supply is to be obtained.

8. Diabetes supplies that are covered by a member/patient’s prescription drug benefit may not require authorization. Some supplies are covered by the prescription drug benefit; insulin pumps and pump supplies require PA and are listed in the DME benefit.
St. Francis Health Network (SFHN)

DME/Supplies/Orthotics
Order Form

Date: ___________________ Ordering MD: ___________________

Case Manager/UM Nurse: ________________________________

1. Member information:

Member Name: ___________________ Member ID #: ___________________

ICD-9 Code: ___________________ Diagnosis: ___________________

DME and explanation of supplies: ________________________________

2. Authorization information:

Authorization #: ___________________ Member Copayment Level: ____________

Date Range of Auth.: ___________________ HCPS Code: ___________________

Terms of Auth: Rental: ___________________ Purchase: ___________________

3. DME Provider information:

Provider Name: ________________________________

Pickup Address: ________________________________

Telephone #: ___________________ Fax #: ___________________

4. Physician instructions:

A. Send a copy of this form, the prescription of service from the ordering physician, with the member, if possible.
B. If member not available, fax this form to the provider listed in number 3 above, along with a copy of the prescription from the ordering physician.
C. Place a copy of this form in the patient’s medical record chart.
Diabetes Supplies that can be Purchased at an HMO Network Pharmacy without Authorization

HMO members can obtain designated diabetes supplies from a pharmacy in the HMO’s pharmacy network. Members simply take their physician’s order for diabetes supplies to the pharmacist and present it along with their ID card. No authorization is required.

Advantage Health Plan and Advantage Franciscan: Members may take their physician’s order for diabetes supplies to an Advantage Health Plan Network pharmacy where the order will be filled without prior authorization. Although the member can purchase the following supplies at an Advantage network pharmacy, the benefit will continue to be administered by Advantage as a carved-out medical benefit, not a pharmacy benefit:

- Alcohol swabs
- Glucose monitoring test strips
- Lancet devices and lancets
- Novo pen/needles
- Glucose blood test strips
- Glucose urine test strips
- BD/pen/needles syringes
- Selected glucometers

All other items (e.g., insulin pumps and supplies) are considered DME and must be authorized by SFHN and obtained as directed by SFHN. The above services may or may not include a copay.
Diabetes Education

Date of Diagnosis: _______  Type 1: _______  Type 2: _______

Complications? _____________________________________________

Date of Previous Education: _________________________________

Please check which of the following the member is being referred for:

<table>
<thead>
<tr>
<th>Type of class</th>
<th>Duration:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Diabetes Education for Life</td>
<td>18 hours</td>
</tr>
<tr>
<td>- Self-Management Services</td>
<td>12 hours</td>
</tr>
<tr>
<td>- Nutrition I and Nutrition II</td>
<td>4 hours</td>
</tr>
<tr>
<td>- Carbohydrate Counting</td>
<td>2 hours</td>
</tr>
<tr>
<td>- Gestational Counseling</td>
<td>2 hours</td>
</tr>
<tr>
<td>- Insulin Administration</td>
<td>1 hour</td>
</tr>
<tr>
<td>- Self-Blood Glucose Monitoring</td>
<td>1 hour</td>
</tr>
<tr>
<td>- Individual Counseling Available</td>
<td>Varies</td>
</tr>
<tr>
<td>- Insulin Pump Education (Only after approval of</td>
<td></td>
</tr>
<tr>
<td>pump by SFHN Medical Director)</td>
<td></td>
</tr>
<tr>
<td>- Byetta Instructions</td>
<td>1 hour</td>
</tr>
<tr>
<td>- Symlin Instructions</td>
<td>1 hour</td>
</tr>
</tbody>
</table>
Authorizing Radiology Services

SFHN does not require authorization for routine x-rays, screening mammograms, diagnostic mammograms, or ultrasounds provided at Franciscan St. Francis Health.

Prior authorization is required for the following procedures:
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiogram (MRA)
- Computerized Tomography Scan (CT Scan)
- Positive Electron Tomography (PET), and
- Out-of-network services

When requesting an MRI, MRA, PET, or CT Scan by phone or by fax, specific information is to be provided. The form on the following page has been developed for your use when requesting one of these procedures. The form may be completed and faxed along with the Prior Authorization Referral Form or the required information may be given over the telephone when you request authorization for the service.

**St. Francis Health will NOT schedule CT, MRI, and/or MRA Scans without a valid prior authorization.**
High Tech Imaging Request Form

Without Contrast
☐ MRI
☐ MRA
☐ CT

With Contrast
☐ MRI
☐ MRA
☐ CT

Mark specific area to be tested:

☐ Head & Neck  ☐ ABD  ☐ Spine
☐ Mediastinum  ☐ Pelvis  ☐ Musculoskeltal
☐ Heart  ☐ Pediatrics  ☐ Other
☐ Contrast  ☐ Without Contrast

Presenting symptoms:

• How long have symptoms been present?

• Are symptoms debilitating?

Medical history:

• Previous radiology testing done?

• Previous diagnostic procedures?

• Diagnosis:

• Seen and evaluated by PCP?

• What treatment has been tried?

• Reason for test?
Authorizations for OB Patients (Revised 3/01/12)

Effective with Dates of Service 3/01/12, an authorization is no longer required for obstetric physician or facility services, with the exception of the following:

Authorization required from provider:

- Amniocentesis
- Out of network services
- Hoosier Healthwise (HHW) ultrasounds (over 3)

Authorization handled by SFHN Clinical Care Coordinator:

- Commercial observation stays
- Hoosier Healthwise inpatient stays, longer than 4 days
- Commercial inpatient stays

NOTE: Authorization for referral of gestational diabetes patients to the SFHN diabetes/endocrinology specialists may be requested by the OB physician. This is an exception to SFHN’s requirement that specialists are not to refer a patient to another specialist without involving the primary care physician.
Authorizing After-Hours Care/Immediate Care Centers/ER Services

At the request of our participating HMOs and to meet State and Federal requirements, SFHN does not deny claims for unauthorized AHC/ICC/ER services without first reviewing for medical necessity. A member is not to receive a denial for payment for AHC/ICC/ER services if a member’s PCP or his/her covering physician referred the member.

SFHN requests that the PCP’s authorization staff:
   1. Complete a referral form for any services referred by the PCP,
   2. Indicate on the form the status of the referral (referred by PCP or on-call PCP or self-referred),
   3. Indicate that authorization has been obtained when appropriate, and
   4. Fax the form back to SFHN within three days.

Upon receipt of the fax from the PCP’s office, any AHC/ICC/ER visits reported as self-referred are forwarded to the SFHN Medical Director along with the clinical documentation to determine if the service was medically necessary. Based upon his review, the self-referred visit is either approved or denied.

In-area urgent care patients are to be referred to participating locations of the Immediate Care Centers. Participating locations are shown in Section V. ER services are to be referred to St. Francis Health’s ER locations.

Ways in which PCPs can help cut down on the amount of research time spent by their staff and SFHN’s staff to determine if the PCPs referred members for AHC/ICC/ER services:

- Have in place a process that would ensure that the PCP’s referral staff is notified to submit an authorization request when members have been referred by the PCP or the on-call PCP.

- For example, each PCP and covering PCP might complete an on-call form for each patient referred for AHC/ICC/ER services after office hours. (A sample information form is provided in this section.)

- Each morning, the PCP could give the on-call forms to his/her staff who would then 1) generate an authorization for the service or 2) in a covering situation, fax a copy of the form to the patient’s PCP so the PCP’s staff would know authorization should be requested.

- Have referral staff check with the PCP or the on-call PCP to verify that members were referred by the physician before obtaining services at the AHC/ICC/ER facility.
To: ________________

St. Francis Health Network

From: ________________

Authorization Inquiry

This form is only to be used when an authorization number or notification has not been received within 48 hours.

Fax: ________________

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SFHN Fax# (800) 747-3693
(317) 570-6818
SECTION IV.

HMO CLAIMS ADMINISTRATION

- Claims to be Filed on a 1500 IV-2
- Address to Which Claims Are to be Mailed IV-2
- Claims Payment Schedule IV-2
- Claims Filing Policy (Timeliness) IV-2
- Claims Inquiries IV-3
- Appeals or Grievances IV-3
- Rules and Policies IV-4
  - OB/GYN Copays
  - Subrogation
St. Francis Health Network
Claim Administration

Providers Are to Submit 1500 Claim Forms

- Providers are to submit a 1500 claim form or electronic billing for all services covered under capitation or paid fee-for-service.
- Providing SFHN with a 1500 or electronic billing for capitated services will allow SFHN to track encounters and gather data for the development of capitation rates and utilization reports.

Claim Submission

Claims for the HMO programs, including Medicaid Risk claims, are to be sent to the following address:

St. Francis Health Network
P.O. Box 502090
Indianapolis, Indiana 46250

Claim Payment

Claim payouts occur weekly and include an explanation of benefits (EOB) and a check for any approved fee-for-service claims.

Claim Filing Policy

Claims should be submitted in a timely manner. SFHN has a 120-day filing limit for Commercial; Medicaid has a 90-day filing limit. Claims filed after these time frames will be denied. Members may not be balance billed.
Claim Inquiries

Inquiries on pending HMO claims are to be directed to:

Customer Service
Cooperative Managed Care Services (CMCS)*
Telephone (Commercial): Local 317-596-5925/Toll Free 866-873-4515
Telephone (HHW): Local 317-596-7827/Toll Free 866-427-3197
Fax: Local 317-570-6822/Toll Free 800-616-9979

Inquiries on adjudicated (capped, paid, or denied) HMO claims may be directed to:

Terry Monroe
St. Francis Health Network
317-782-6931 or fax 317-782-6922

Commercial Member Claim Appeals or Grievances

Claim appeals for SFHN’s commercial programs are to be directed to the HMO Member Services Unit. The member should contact the Member Services Unit for instruction on how to initiate an appeal or grievance. Telephone numbers are on the member’s insurance ID card.

The HMO Grievance Procedures enacted by the Indiana General Assembly requires:

- An acknowledgment of the grievance, orally or in writing, to the enrollee or subscriber within three (3) business days.
- A grievance must be resolved within no more than twenty (20) business days, with a ten (10) business day extension upon written notification to the member.**
- Appeals of grievance decisions must be resolved not later than forty-five (45) days after the appeal is filed.
- A written description of the member’s right to file a grievance must be posted by providers in a conspicuous public location.

*CMCS is SFHN’s third party administrator.

Claims Rules and Policies

- OB/GYN Copays
The employer group service agreements held by SFHN’s HMO partners vary in the number of copayments providers may collect for obstetric care. Some HMO benefit plans limit member copayments to one copay while other plans provide for the collection of multiple copayments. When a member’s HMO benefit plan allows, the OB/GYN may collect an office visit copayment each time the member has a face to face encounter with the physician, and advanced practice nurse, or a nurse-midwife up to a maximum number of allowed copays.

SFHN deducts copayments from a physician’s final claim for obstetric care according to the HMO benefit.

- **Subrogation** – a procedure under which an insurance company can recover from third parties the full or some proportionate part of benefits paid to an insured.

Indiana insurance law dictates that a claims payer must first pay a health service which may possibly be the future liability of a third party. The claims payer may then pursue payment from that third party.

The HMO contract held with each member generally states,

- “The Covered Person shall cooperate with HMO in protecting HMO’s legal rights under these subrogation provisions.”

- “The Covered Person shall do nothing to prejudice HMO’s right under this provision…”

- “HMO may, …bring suit in the name of the Covered Person.”

- “HMO may collect, at its option, amounts from the proceeds of any settlement or judgment that may be recovered by the Covered Person or his or her legal representative, regardless of whether or not the Covered Person has been fully compensated.”
The contract held between SFHN and each HMO business partner stipulates that, “Plan agrees to use its best efforts to cooperate with Network in the collection of reimbursements from third party payers for the purposes of subrogation.”

SFHN physicians gain access to SFHN HMO members by Network membership. The physician is to cooperate with SFHN the claims payer, to pursue the third party.

SFHN subcontracts with a subrogation company to pursue payment. We only pay the subrogation company when recoveries are obtained. The recovery is returned to SFHN providers who provided health care services to the injured member.

Therefore, the role of physician office staff is critical since you often are the first to know that a patient’s injuries resulted from a situation where a third party payment may later be recovered by SFHN.

Please use the form on the next page to notify SFHN of any potential subrogation claimant.
St. Francis Health Network

700 E. Southport Road
Indianapolis, IN  46227

Fax to:  St. Francis Health Network, Attention: Peggy Homeier, (317) 782-6882

HCRI Client Name:  SFHN/CMCS

HCRI Referral Date: ______________________________________________________

Plan Member Name: ______________________________________________________

Plan Member ID# Number: ________________________________________________

Group Name: ____________________      Group ID#: _______________________

Health Plan: ____________________________________________________________

Patient Name (if other than Member): ______________________________________

Individual Patient ID#:_______________      Patient DOB: _________________

Patient/Guardian Street Address: __________________________________________

Patient/Guardian City, State, Zip: ____________________________

**Patient/Guardian Phone:**  (Home#) (___)_____-_____  (Work#) (___)_____-_____

Date of Accident/Injury: ____________     Work Related: Yes ________   No _________

Primary ICD9 Code: _________________________    Initial DOS: ________________

Remarks:____________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Documentation attached:    Yes _____      No _____

Name of person sending referral: _________________________Phone # _____________
SECTION V.

HMO Reimbursement Methodology*

*Section V information is not included in the online version of the provider manual. To access this information, please contact Diana Poore at (317) 782-6553 or Drew Thomas (317) 782-7413.
SECTION VI.
Pharmacy Services

- Prescribing Process for **Specialty Pharmacy Drugs:** Advantage, Advantage Franciscan, and HHW
  - Authorizing & Obtaining Specialty Pharmacy Drugs  VI - 2

  - Specialty Pharmacy drugs are also known as biopharm, biologics and biotech.

  - Follow the SFHN Prior Authorization (PA) process before giving a member a prescription for a Specialty Pharmacy drug or administering one from the inventory in the physician’s office.

- **Hoosier Healthwise Pharmacy Benefit Program**
  - Program Overview VI - 4
Prior Authorizing and Obtaining Specialty Pharmacy Drugs

For

SFHN’s Advantage, Advantage Franciscan, & HHW Members

WHEN ORDERING SPECIALTY PHARMACY DRUGS, PLEASE PROVIDE AS MUCH LEAD TIME AS POSSIBLE!

1. Call the SFHN Medical Management nurse with your request. They will fax you the necessary prior authorization (PA) form.

2. The SFHN Medical Management nurse will confirm planned place of service and initiate PA for place of service if needed.

3. The nurse will instruct you where to fax the completed PA form for the Specialty Drug.

4. If indicated, the SFHN Medical Management nurse will PA the medication and a visit.

   Note: When appropriate, the nurse will PA the drug to be administered by staff at the various St. Francis Outpatient Infusion Clinics.

5. Once PA obtained, ordering physician office will need to contact Specialty Drug provider with administration orders and scheduling of appointments.
Other Information:

1. Specialty Pharmacy Drugs Included: Consult the SFHN Medical Management nurse for specific listings. Be sure you state the patient is an Advantage or Hoosier Healthwise member through SFHN. If the patient has Medicare primary, bill CMS first.

2. Chemotherapy drugs: May be provided by an SFHN physician in the office, taken from office’s inventory and billed by the physician to SFHN. There may be a copayment or coinsurance to collect from the patient. NOTE: "adjunct drugs" including, but not limited to, Aranesp, Procrit, Neupogen, and Neulasta must be obtained through the PA process outlined on the previous page. If the patient has Medicare primary, bill CMS intermediary first.

3. Copayments: The provider authorized to source the drug will collect any copayment and/or coinsurance. A Specialty Pharmacy will collect it from the patient prior to the delivery of the drug. The physician office is not responsible to collect copayments on these drugs. However, the patient may have a copayment for administration of the drug. Be sure to work the EOB and collect post-visit if necessary.

4. Same Day Delivery: The Specialty Pharmacy Provider has an agreement with an Indiana provider for provision of a drug where same day delivery to your office is required. The SFHN Medical Management nurse will coordinate this service. Please try to avoid last minute requests and order the drug as far in advance of administration as possible.

5. Claims: The Specialty Pharmacy Provider will invoice SFHN for the drug delivered to your office or the member’s home. **Any claims submitted by your office for specialty pharmacy drugs that are not prior authorized by SFHN to be dispensed from your supply to a SFHN Advantage, Advantage Franciscan, or Hoosier Healthwise member will be denied for payment and the member will be held harmless.**

<table>
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<tr>
<th>IMPORTANT SFHN PHONE AND FAX NUMBERS</th>
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<tr>
<td>Medical Management Phone # (800) 862-3436 – Option 2</td>
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<tr>
<td>Medical Management Fax # (317) 570-6818</td>
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Hoosier Healthwise Pharmacy Benefit Program

The Office of Medicaid Policy and Planning (OMPP) is responsible for the administration of the pharmacy benefits for Hoosier Healthwise.

For a copy of the current Preferred Drug Listing (PDL) including those drugs that require prior authorization, please refer to http://www.indianamedicaid.com/ihcp/index.asp under Pharmacy Services.

Providers needing prescription medications for a Hoosier Healthwise member requiring prior authorization will need to either make a telephone call OR fax the completed form to ACS (Affiliated Computer Services) Clinical Call Center:

**Telephone number**
(866) 879-0106

**Fax number**
(866) 780-2198

Prior Authorization Forms can be found at http://www.indianamedicaid.com/ihcp/index.asp. Use the Pharmacy Services drop down box and select “Forms”.

For questions or appeals of services regarding the pharmacy program, please contact ACS at (866) 879-0106.

Glucometer Program

Bayer Healthcare, LLC Diagnostics Division provides blood glucose meters and test strips. MDwise members can obtain a meter at no charge by calling Bayer Healthcare, LLC Diagnostics Division at 877-229-3777. The meter will be delivered to their home.
SECTION VII.

St. Francis Employer Health Solutions

- Physician Hospital Community Organization (PHCO) VII-2
- St. Francis Wellness Services VII-3
- Premier Healthway (PH) Cardiac Program VII-4
- Samples PHCO and PH Identification Cards VII-5
General Information

Employers can contract directly with our Physician Hospital Community Organization called St. Francis Health Network for various health plan cost containment products. Working directly with St. Francis Health Network can help eliminate costly overhead, provide employers and employees with competitively priced programs and improve health plan performance.

Network Access
Self-funded employers who directly contract with the Network pay a monthly access fee to obtain deeper discounts for services from St. Francis Health, St. Francis physicians, and St. Francis ancillary providers. Under this system, employers design their health plans with incentives that steer employees to certain providers. In this case employees enjoy a lower deductible, coinsurance or copayment when they access the SFHN PHCO’s health care services.

Disease/Health Management Programs
St. Francis Health Network can also help employers contain costs through the medical management of hospitalized patients. This is done by monitoring the services patients receive to ensure the highest quality care is provided in the most cost-efficient manner possible.

Medical Management Service
The Network also operates disease management programs. These programs utilize specially trained educators to help participants gain control over challenging medical conditions and achieve optimal health.

Search for physicians participating in these products by accessing the St. Francis Health Web page at http://sites.franciscanalliance.org/sfhn.

Since this is PPO type business, St. Francis Health Network providers are not at risk. This is not a capitation program. There is no withhold. Members are not asked to select a PCP and may access SCPs without an authorization.

Prior-authorization for inpatient hospitalization is the member's responsibility.

Claims are submitted to the address shown on the member's ID card, which may be a CMCS P.O. Box. CMCS is now functioning as a TPA servicing “traditional” PPO self funded plans while continuing to administer SFHN’s risk business.
St. Francis Employee Health Solutions
Wellness Services

General Information

Unhealthy lifestyles account for nearly 88 percent of all health care insurance claims. It’s well known that, across the nation, rising employee health care costs and lost productivity due to employee illness cost employers a substantial sum of money.

A wellness program can help employees improve and maintain healthier lifestyles and become wiser health care consumers.

Employers can contract with St. Francis for wellness services. Staff from St. Francis Wellness Services work with employers to tailor a wellness program to meet the specific needs of the employer group and their employees. From smoking cessation classes to individual and group counseling to site-based medical clinics, St. Francis offers a variety of wellness options. St. Francis offers services in the following areas:

- Worksite screening with an online health risk assessment
- Health Management of Chronic Health Conditions
- Occupational Health and Traveler’s Health Services
- Weight Management Services
- Women’s Health Services
- Employee Assistance Program
- St. Francis Cardiac Screening Center
- Other Wellness Services:
  - Blood pressure, cholesterol and other health screenings
  - Smoking cessation program
  - Diabetes education and self-management classes
  - Lunch and Learn classes on a variety of health topics, as well as other on-site programming options
  - Cancer education/screenings
  - On-site stress management programs
  - Change of Heart cardiovascular health educational programs

Employers can select wellness services a la carte or in a package program. Those who select packaged services receive additional savings. For more information, call (317) 782-7096 or visit http://sites.franciscanalliance.org/sfhn.
Heart and vascular disease strike more men and women than any other illness.

The statistics are staggering: According to the American Heart Association, $329 billion is spent annually in the United States on health services for cardiovascular disease—almost 36 percent of all health care dollars spent in this country. With businesses struggling to keep employees and maintain profits, it becomes more difficult to provide those workers with good health benefits.

The best offense:
Premier Healthway can improve employees battle the cost of cardiac care with case rate pricing for services provided by St. Francis physicians and the St. Francis Heart Center. This innovative pricing arrangement includes the covered cardiac procedures, specialty physician services and related hospital care—and all for one case rate price.

Benefits to employers:
- Case rate pricing offers significant savings over the costs for cardiac services obtained from a HMO/PPO or traditional health plan.
- Reduced cardiac claims costs can assist in the purchase of more competitively priced reinsurance/stop-loss coverage.
- The covered cardiac procedures also include costs for readmission that occur within 30 days of the original inpatient cardiac case rate procedure when the readmission is due to complications directly related to that original procedure.

Benefits to health plan participants:
- No deductible, coinsurance or co-payments for covered cardiovascular procedures;
- Discounted health promotion, screening and wellness programs;
- Easy access to full service cardiac care close to home.

Excellent, experienced care:
At St. Francis Health, physicians and staff embrace the same values of joy in service held by Franciscan Alliance that have guided the hospital staff for over 90 years.

The 5-star rated St. Francis Heart Center has served south central Indiana for over 30 years and is a major tertiary referral center for comprehensive cardiovascular care.

Premier Healthway participants enjoy discounted pricing for classes on nutrition, stress management, exercise, smoking cessation, and health screenings.

To find out how Premier Healthway can assist in managing the cost of cardiac disease for an employer’s health benefit program, please call us toll free at 1-866-839-0062.
SECTION VIII.

St. Francis Health Network Hoosier Healthwise

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- Why Participate as a PMP in VIII-3
  St. Francis Health Network?
- Hoosier Healthwise Program Overview VIII-4
- Benefit Packages VIII-4
- Indiana Health Coverage Programs VIII-5 (IHCP) Overview
- Oversight and Regulating Agencies VIII-5
- Anthem Overview VIII-5
- IHCP Family Tree Diagram VIII-6
St. Francis Health Network (SFHN) Hoosier Healthwise (HHW) Program

For a detailed description of the Hoosier Healthwise Program, please refer to your Anthem Provider Manual. To obtain a copy of the Anthem Provider Manual please visit the Anthem website at http://www.anthem.com/home-providers.html.

Please, it’s very important that you always contact SFHN staff first at the following address and/or telephone number:

St. Francis Health Network
700 E. Southport Road
Indianapolis, IN 46227
Fax: (317) 782-6922

Diana Poore, Manager of Provider Relations
(317) 782-6553

Drew Thomas, RBMC Program Coordinator
(317) 782-7413
Why Participate in St. Francis Health Network?

- St. Francis Health Network, Franciscan St. Francis Health with various medical staff have been involved with the Hoosier Healthwise business since 1995, just one year after Hoosier Healthwise was created.

- SFHN reimburses Primary Medical Providers (PMPs/PCPs) with a fee-for-service Medicaid fee schedule. There is no capitation or withhold.

- SFHN processes and pays claims directly through our TPA, Cooperative Managed Care Services (CMCS), so your office will submit claims directly to us—not to Anthem or the vendor for the Indiana Office of Medicaid Policy & Planning.

- Prior Authorization and referral requirements for St. Francis Health Network members are similar to those we require for other SFHN contracted health plans.

- SFHN is directly involved with decision-making for the development of SFHN Hoosier Healthwise clinical and administrative policies & procedures, as well as pay-for-performance quality initiatives.

- SFHN has provided quality service to South-Central Indiana providers for over 17 years.

- SFHN orients every contracted St. Francis Health Network physician office and equips the staff with a Resource Kit that includes a number of helpful tools for managing patients in the St. Francis Health Network Hoosier Healthwise program.

- The work efforts of SFHN staff support St. Francis Hospital’s mission and values. We strive to listen to our providers & regard their complaints as opportunities.

**We hope your office will consider contracting with us to serve the Indiana Hoosier Healthwise members!**

**We sincerely thank our providers who already work with us today!**
**Hoosier Healthwise Overview:**

Hoosier Healthwise is Indiana’s health care program for eligible low-income families, pregnant women, and children up to age 19. The program covers medical care such as doctor visits, prescription medicine, mental health care, dental care, hospitalizations, surgeries, and family planning at little or no cost to the member or the member’s family.

**Hoosier Healthwise Benefit Packages:**

**Please Note:** Only Packages A, B, C, and P are included in Hoosier Healthwise RBMC.


- **Package B – Pregnancy Coverage Only.** Pregnancy related and emergent/urgent care services for some pregnant women. Pregnancy coverage includes: delivery, family planning services, pharmacy, prenatal and postpartum care, transportation, and treatment of conditions that may complicate the pregnancy. A condition that may complicate the pregnancy is defined as a condition manifesting itself by symptoms of sufficient severity that the absence of medical attention could reasonably be expected to result in a deterioration of the patient’s condition or a need for a higher level of care.

- **Package C – Children’s Health Plan.** Preventive, primary, and acute care services for some children ages 19 and under. To be eligible, a child must meet the following criteria:
  - The child must be younger than 19 years old.
  - The child’s family income must be between 150 and 200 percent of the federal poverty level.
  - The child must not have credible health insurance at any time during the three-month period prior to applying for the Hoosier Healthwise program.
  - The child’s family must satisfy all cost-sharing requirements.
A child determined eligible for Package C is made conditionally eligible pending a premium payment. The child’s family must pay a monthly premium. Enrollment continues as long as premium payments are received and the child continues to meet the other eligibility requirements.

- **Package E – Emergency Services Only.** Individuals enrolled in this package are only eligible for emergency services, including newborn delivery. Package E members should never be assigned to a HHW PMP. If this happens, please call Anthem Member Services at (866) 408-6131.

- **Package P – Presumptive Eligibility.** Presumptive eligibility gives short-term benefits to pregnant women until their application for Package A or B is processed. These women are found to be presumptively eligible (PE) for Medicaid.

**Oversight and Regulating Agencies:**

There are several entities within the state of Indiana that provide oversight and regulate health plans.
**Indiana Health Coverage Program (IHCP)** – IHCP is the state of Indiana’s umbrella entity that administers all Indiana Medicaid programs and other state-funded health programs.

**Indiana Family and Social Services Administration (FSSA)** – Indiana Code (IC) 12-17.2 establishes the authority for FSSA. FSSA contracts with Anthem and other health plans for the provision of Hoosier Healthwise and HIP in all counties in Indiana. Anthem then provides coverage pursuant to the state of Indiana program.

**Office of Medicaid Policy and Planning (OMPP)** – OMPP administers the Medicaid and other health care programs on behalf of FSSA, including the managed care system for Hoosier Healthwise participants.

**Risk-Based Managed Care (RBMC):**

In the risk-based managed care system, OMPP pays contracted Managed Care Entities (MCE), such as Anthem, a capitated monthly premium for each Hoosier Healthwise member in the MCE. The capitated premium is actually calculated to cover the cost of care and services provided to members in the MCE. The care of Hoosier Healthwise members enrolled in the MCE is managed by the MCE through its network of Primary Medical Providers (PMPs), specialists, and other providers of care who contract directly with the MCE.

For the period January 1, 2011, to December 31, 2014, OMPP has contracted statewide with the following RBMC plans: Anthem, Managed Health Services (MHS) and MDwise. Under this contract, PMPs may enroll with one or more Managed Care Entities. Hoosier Healthwise recipients will select the MCE and then a PMP.

**Anthem Overview:**

Anthem provides risk-based managed care to the Indiana Health Coverage Programs (IHCP) enrollees who participate in Hoosier Healthwise or HIP through the Anthem health plan. Anthem began administering covered benefits and services to participants of the Hoosier Healthwise program on January 1, 2007 and HIP program on January 1, 2008. Anthem was successfully awarded a new combined contract to continue providing services effective January 1, 2011.
SECTION IX.

QUALITY ASSURANCE (QA) STANDARDS

- SFHN and HMOs Strive to Meet Quality Standards IX-2
- The National Center for Quality Assurance (NCQA) IX-3
- HEDIS® IX-5
- SFHN and Hoosier Healthwise Report Cards IX-5
- SFHN and HMOs Health Management IX-6
- Hoosier Healthwise Care Management Program IX-7

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
SFHN and HMOs Strive to Meet Quality Standards

National Center for Quality Assurance (NCQA) Standards for Quality Health Plans:

The standards for quality health plans fall into one of the following six categories. St. Francis Health Network is accountable for meeting all standards listed except members’ rights and responsibilities.

- **Quality Improvement:** Does the Plan fully examine the quality of care given to its members? How well does the Plan coordinate all parts of its delivery system? What steps does it take to make sure members have access to care in a reasonable amount of time? What improvements in care and service can the Plan demonstrate?
- **Physician Credentials:** Does the Plan meet specific NCQA requirements for reviewing the training and experience of all physicians in its network? Does the Plan look for any history of malpractice, Medicare or Medicaid sanctions, or fraud? Does the plan keep track of all physicians’ performance and use that information for ongoing monitoring and their periodic evaluations?
- **Members’ Rights and Responsibilities:** How clearly does the Plan inform members about how to access health services, how to choose a physician or change physicians, and how to make a complaint? How responsive is the Plan to members’ satisfaction ratings and complaints?
- **Preventive Health Services:** Does the Plan encourage members to have preventive tests, procedures, and immunizations? Does the Plan make sure that its providers are encouraging and delivering preventive services such as screening mammograms, colorectal cancer screenings, well child care visits, and others?
- **Utilization Management:** Does the Plan use a reasonable and consistent process when deciding what health services are medically appropriate for individuals’ needs? When the Plan denies payment for services, does it respond to member and physicians appeals?
- **Medical Records:** How consistently do the records kept by the Plan’s physician meet NCQA standards for quality care? For instance, do the records show that physicians follow up on patients’ abnormal test findings? Do the records document the medical and treatment history, medication history, completed and updated problem list, and other information?
- **Health Management:** Does the Plan actively work to improve the health status of its members with chronic health conditions such as asthma, diabetes, coronary artery disease (including hypertension and high cholesterol), arthritis, and chronic back pain? The health plan has the responsibility of meeting their members’ health needs and intervenes to assist.

These standards apply to medical services.
What is NCQA?

The National Center for Quality Assurance (NCQA) is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, including health maintenance organizations (HMOs). NCQA is governed by a Board of Directors that includes employers, consumer and labor representatives, health plans, quality experts, regulators, and representatives from organized medicine.

NCQA’s mission is to provide information that enables purchasers and consumers of managed health care to distinguish among plans based on quality, thereby allowing them to make more informed decisions. NCQA’s efforts are organized around two activities, accreditation and performance measurement (report cards), which are complementary strategies for producing information to guide choice.

NCQA’s Mission Statement:

NCQA promotes improvement in the quality of patient care through managed health plans. NCQA’s primary function is to develop and apply oversight processes and measures of performance for health plans. NCQA is committed to providing information on managed care quality to the public, consumers, purchasers, health plans, and other interested parties.

Accreditation:

It is very important for the HMO to receive NCQA Accreditation. Several large employer groups choose an HMO based on NCQA Accreditation.

SFHN Responsibility

SFHN is not accredited with NCQA. However, we work very closely with our contracted health plans to help them receive NCQA accreditation. SFHN is requested at times to provide medical records, authorization requests, and credentialing files for an NCQA reviewer to review during the accreditation process. All of this information is kept confidential and shredded after the audit.
NCQA’s Quality Compass™

NCQA’s Quality Compass is a national database of comparative information about the quality of the nation’s managed care plans. Quality Compass will make health plan quality data available to thousands of small to mid-size employers that were previously unable to gain access to such data.

The Quality Compass database contains both HEDIS® and accreditation information on health plans. This data support direct, plan-to-plan comparisons on a variety of different measures ranging from a plan’s financial performance to quality of care to utilization of services.

Bringing together data from hundreds of health plans has enabled NCQA to generate national and regional averages for various aspects of plan performance for the first time. A select group of the national averages will be updated regularly and posted on the NCQA website (www.ncqa.org) (regional averages are available to purchasers of Quality Compass). While users are encouraged to compare plans to these averages, it is important to realize that the averages cover HMOs only (i.e., no point-of-service plans or preferred provider organizations), and that not all health plans participated in Quality Compass. Non-participating plans may have been able to generate HEDIS® data, unwilling to submit to public scrutiny, or may have elected not to participate.
HEDIS®

Health Plan Employer Data Information Set (HEDIS®) is a set of standardized performance measures designed to allow for the reliable comparison of the performance of managed health care plans. HEDIS® covers a broad range of areas: Effectiveness of care, accessibility and availability of care, satisfaction with the experience of care, cost of care, stability of the health plan, informed health care choices, use of services, and plan descriptive information.

The Health Plan Employer Data and Information set (HEDIS®) is a registered trademark of NCQA.

SFHN’s Report Card

SFHN is not delegated by the HMO health plans to perform HEDIS® standards. However, the HMO and SFHN work together to assist the providers with meeting HEDIS goals to improve quality of care. Therefore, the HMOs directly contact physicians to arrange a time to perform medical record audits for HEDIS®. The health plans may send the provider his/her HEDIS results. These audits are specific to preventive care indicators (e.g., the type of care rendered to diabetics by monitoring an annual HgA1c and LDL-C, breast cancer and cervical cancer screenings, and many others).

These HEDIS® chart audits are completed for the purpose of health care operations according to HIPAA guidelines, therefore all SFHN providers should cooperate with the health plans.

SFHN, however, annually reviews the Network’s performance on HEDIS® preventive care measures and reports these outcomes to our providers.

SFHN and the contracted health plans work together on quality of care initiatives to improve compliance rates for these HEDIS measures even though the health plans have not delegated quality management to SFHN. For example, SFHN and Franciscan St. Francis Health have developed a 2013 Quality Improvement Campaign for employees and their spouses and dependents insured with Franciscan Health Plan.

Hoosier Healthwise Report Card

SFHN is not delegated to perform HEDIS® standards for the Hoosier Healthwise program. However, several predefined quality indicators are measured through claims data, ManagedCare.com, and other sources. These quality of care/preventive measures are part of HEDIS and the Office of Medicaid Policy and Planning (OMPP) Pay for Performance Program. Therefore, SFHN publishes their Hoosier Healthwise quality of care rates in this annually published report card.

Anthem Hoosier Healthwise has delegated quality management to SFHN, so the Network will work with provider offices on initiatives to improve care and rates.
SFHN and HMOs (Commercial Health Plans)
Health Management Programs

St. Francis Health Network and our HMOs have implemented health management programs for our members. These programs are a benefit provided as part of the member’s health insurance plan.

These programs are designed to help educate, inform, and assist members to self manage their asthma, diabetes, arthritis, chronic low back pain, and coronary artery disease, including hypertension and high cholesterol.

Components of these programs include, but vary according to program:

- Initial assessment and risk stratification
- Resource and educational materials
- Participant education
- Individualized, intensive case management
- Coordination of care with physicians
- Protocols and clinical management guidelines
- Follow up care and monitoring of participant’s progress
- Data collection
- Identification of goals
- Reassessment and stratification at a minimum of 6 months and 12 months
- Quarterly educational materials
- Outcome monitoring (aggregate)
- Self management skills

If you would like to refer a patient to one of these programs, please call:

- CMCS @ 1-888-504-5556 x7511
  or
- SFHN @ 782-6852
Hoosier Healthwise Care Management Program

Hoosier Healthwise has implemented a care management program for members to better coordinate their health care needs and management. This program includes three levels of care based on the member’s health care and psychosocial needs. The three levels include population management, case management, and care management. The previous health management program has been integrated into the new care management program. The chronic health conditions have been expanded to include asthma, diabetes, CAD, CHF, and COPD.

Some of the components for these program levels of care include but vary according to the program:

**Population Management**: -low level services
- mailing of educational materials
- administration of Health Risk Assessment on all members
- 24 hours/7 day week nurse call line
- 24 hour nurse line to assist with ER visits and ER 30 day bounce back

**Case Management**: -mid level services
- population management services as well as interventions addressed to a specific group of members
- services to address members with short term needs
- reminding members about annual tests
- education on appropriate use of ER services

**Care Management**: -high level services
- complex case management
- completion of an initial and follow-up assessment on member at a minimum of three months and re-stratification in CMCS care management application system
- assessment and interventions for physical, social, behavioral, preventative, and other needs
- development of care plan specific to member’s needs