



**Hoosier Alliance**



# 2011 Provider Workshop

# Agenda

Who We Are

HEDIS

Patient-Centered Medical Home

Cultural Awareness

Practice Management

Deficit Reduction Act

Administration

Closing



# Mission Statement

*We help people:*

Get care

Stay well

Build healthy communities

*We have a special concern for those who are poor.*



# AmeriHealth Mercy Family of Companies



The AmeriHealth Mercy Family of Companies

PerformCare

PerforMED\*

PERFORMRx



KEYSTONE.MERCY  
HEALTH PLAN



CBHNP



# Delivery System Model

Managed Care Entity (MCE) ►

**MDwise**



Eight Delivery Systems ►

Hoosier Alliance  
Methodist  
Select Health Network  
St. Catherine  
St. Margaret  
St. Vincent  
Total Health  
Wishard

# What We Do

- Network contracting
- Network development
- Credentialing
- Case and disease management
- HEDIS improvement
- Member advocacy
- Prior authorization
- Claims processing
- Practice management consultation
- Integrated medical management
- Support NCQA standards



# Network Management

- Account Executive
  - each practice/facility has an assigned Account Executive
  - liaison between Hoosier Alliance and your practice/facility
  - Account Executives visit PMPs regularly
  - specialists receive visits twice per year
- Office visits can include:
  - review of HEDIS reports
  - review of financial statement
  - site surveys
  - PQI reviews and follow up
- Office staff can provide feedback after each visit via survey



# Network Management

- Account Executives cover eight territories

A: Doreen Beard -- 317-519-6999

B: Lisa Mihalow -- 317-519-9332

C: Denise Edick -- 317-697-6750

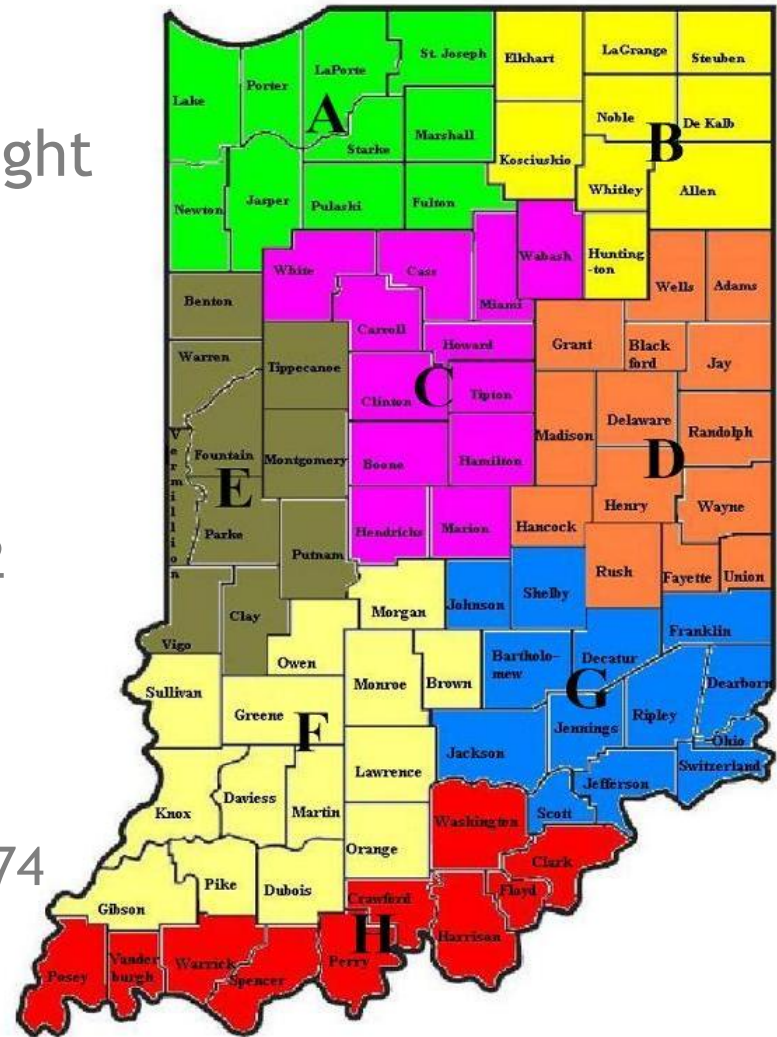
D: Jennifer Burch -- 317-697-7882

E: Dionne Embry -- 317-502-6539

F: Lisa Baker -- 317-519-7598

G: Kami Hughes -- 317-519-9331

H: Susan McCamish -- 317-607-3074





HEDIS

# What is HEDIS?

Healthcare  
Effectiveness  
Data &  
Information  
Set

HEDIS is a set of standardized performance measures that assess the quality of health care -- much like a **report card**.



# HEDIS and Hoosier Alliance

- Why we use it
  - aligns with our values
  - provides an internal evaluation process
  - offers accreditation
  - is a regulatory necessity
  - offers financial incentives
- How we measure it
  - administrative outcomes (claims, encounters, lab results)
  - medical record review

# OMPP-Designated 2011 HEDIS Measures

Measures in red are new for 2011.

## Well-child Visits (HHW)

- 0 to 15 months
- 3 to 6-year-olds
- Adolescents (12 to 21 years)

## OB/GYN (HHW)

- **Cesarean delivery rate**
- Postpartum visit

## Diabetes (HHW)

- LDL-C lab

## Preventive Services (HIP)

- **Percentage of members who obtain exams**

# OMPP-Designated 2011 HEDIS Measures

Measures in red are new for 2011.

## Behavioral Health (HHW)

- Follow up after hospitalization for mental illness

## ER

- Return to ER within 30 days (HHW)
- Admissions per 1,000 MM (HIP)

## Pharmacy (HHW, HIP)

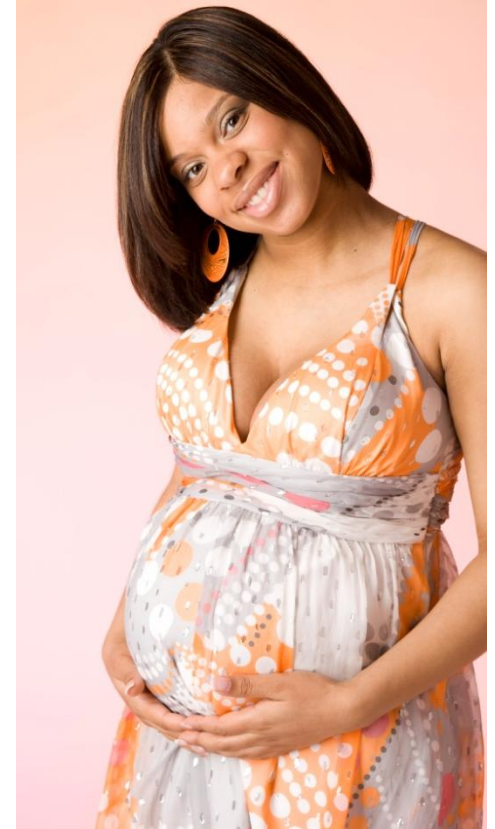
- Generic dispensing rate

## Smoking Cessation (HHW, HIP)

- Advise smokers and tobacco users to quit

# C-Section Rate

- We are working with providers to reduce the rate
  - State initiative to keep rate below 27%
- Here's what we're doing:
  - peer-to-peer outreach with our Medical Director and an OB consultant
  - hospital outreach
  - review policies and procedures
  - updating OB/pregnant member reports and reviewing with provider



# Hoosier Alliance, HEDIS and Your Practice

- We can help you help your patients by:
  - offering case management
  - conducting member outreach, including phone calls and mailings
  - placing checkup reminder calls and sending mailings to your patients
  - tracking patients who need services
  - providing patient transportation or transportation referrals
  - providing quick links to quality resources via [Hoosieralliance.org](https://www.hoosieralliance.org)

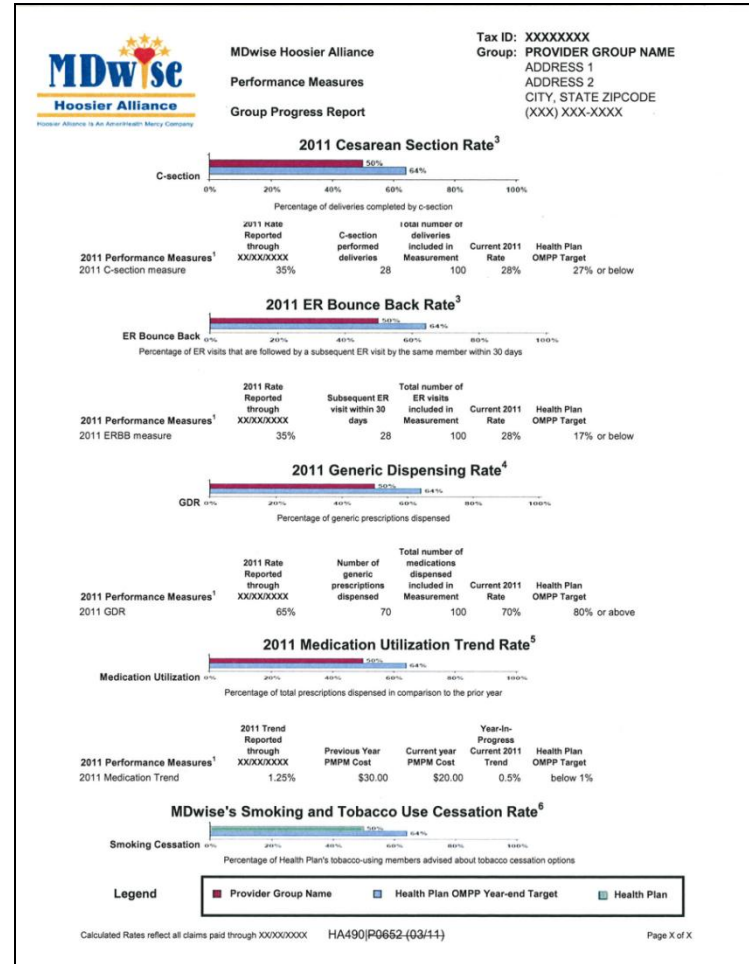
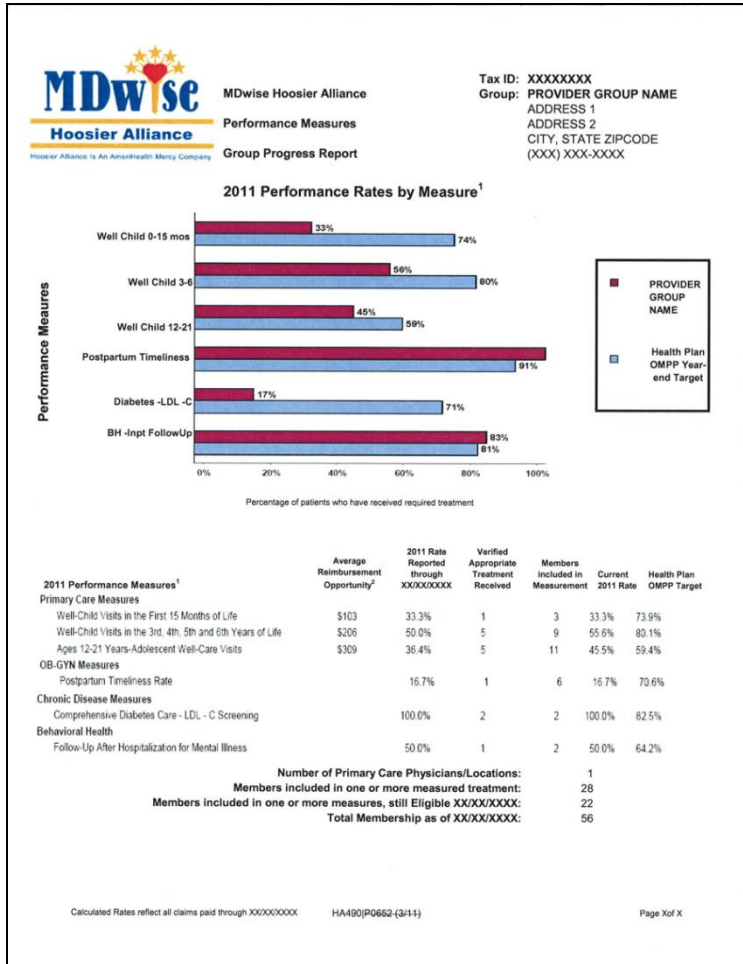


# Hoosier Alliance, HEDIS and Your Practice


- We provide monthly HEDIS reports, which:
  - illustrate your performance measures in easy-to-read, graphic format
  - are based on claims paid in previous months
  - compare your practice to OMPP targeted goals
  - contain patient-specific measurement information



# Sample HEDIS Report -- Group Progress



# Sample HEDIS Report -- Member Detail



**MDwise**  
Hoosier Alliance  
Hoosier Alliance is An AetnaHealth® Member Company

**MDwise Hoosier Alliance**

Performance Measures  
Group Progress Report

Tax ID: XXXXXXXX  
Group: PROVIDER GROUP NAME  
ADDRESS 1  
ADDRESS 2  
CITY, STATE ZIPCODE  
(XXX) XXX-XXXX

**Physician Member Profile**  
Physician Summary for: Provider Last Name, Provider First Name (Provider ID#)

|  | Average Reimbursement Opportunity <sup>1</sup> | 2011 Rate Reported Through XXXXXXXX | Verified Appropriate Treatment Received | Members Included in Measurement | Current 2011 Rate | Health Plan CMPF Target |
|--|--|-------------------------------------|---|---------------------------------|-------------------|-------------------------|
| <b>2011 Performance Measures<sup>1</sup></b>                 |  |                                     |   |                                 |                   |                         |
| <b>Primary Care Measures</b>                                 |  |                                     |   |                                 |                   |                         |
| Well-Child Visits in the First 15 Months of Life             | \$103  | 0.0%                                | 0                                       | 2                               | 0.0%              | 73.9%                   |
| Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life | \$257  | 22.2%                               | 3                                       | 8                               | 37.5%             | 80.1%                   |
| Ages 12-21 Years-Adolescent Well-Care Visits                 | \$257  | 25.0%                               | 2                                       | 7                               | 28.6%             | 59.4%                   |
| <b>Chronic Disease Measures</b>                              |  |                                     |   |                                 |                   |                         |
| Comprehensive Diabetes Care - LDL - C Screening              | \$26   | 0.0%                                | 0                                       | 1                               | 0.0%              | 82.5%                   |
| <b>Behavioral Health</b>                                     |  |                                     |   |                                 |                   |                         |
| Follow-Up After Hospitalization for Mental Illness           |  | 100.0%                              | 1                                       | 1                               | 100.0%            | 64.2%                   |

**Patient Profile for: Provider Last Name, Provider First Name (Provider ID#) - Preventive Care**

| RID   | Name                      | DOB    | Address                              | Phone           |
|---|---------------------------|--------|--------------------------------------|-----------------|
| xxxxxx  | Member Last, Member First | xxxxxx | Street Address, City, State, Zipcode | (xxx) xxx -xxxx |
| Well-Child 0-15 mos is required by XXXXXXXX. Last one was performed: XXXXXXXX (X of X visits Completed) |                           |        |                                      |                 |
| xxxxxx  | Member Last, Member First | xxxxxx | Street Address, City, State, Zipcode | (xxx) xxx -xxxx |
| Well-Child 3-6 yrs is required by Last one was performed: XXXXXXXX                                      |                           |        |                                      |                 |
| xxxxxx  | Member Last, Member First | xxxxxx | Street Address, City, State, Zipcode | (xxx) xxx -xxxx |
| Well-Child 12-21 yrs is required by XXXXXXXX. Last one was performed: XXXXXXXX                          |                           |        |                                      |                 |
| xxxxxx  | Member Last, Member First | xxxxxx | Street Address, City, State, Zipcode | (xxx) xxx -xxxx |
| LDL-C Screening is required by XXXXXXXX. Last one was performed: XXXXXXXX                               |                           |        |                                      |                 |
| xxxxxx  | Member Last, Member First | xxxxxx | Street Address, City, State, Zipcode | (xxx) xxx -xxxx |
| Well-Child 0-15 mos is required by XXXXXXXX. Last one was performed: XXXXXXXX (X of X visits Completed) |                           |        |                                      |                 |
| xxxxxx  | Member Last, Member First | xxxxxx | Street Address, City, State, Zipcode | (xxx) xxx -xxxx |
| Well-Child 3-6 yrs is required by Last one was performed: XXXXXXXX                                      |                           |        |                                      |                 |
| xxxxxx  | Member Last, Member First | xxxxxx | Street Address, City, State, Zipcode | (xxx) xxx -xxxx |
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| xxxxxx  | Member Last, Member First | xxxxxx | Street Address, City, State, Zipcode | (xxx) xxx -xxxx |
| LDL-C Screening is required by XXXXXXXX. Last one was performed: XXXXXXXX                               |                           |        |                                      |                 |

Eligible Members Needing Services ##

Calculated Rates reflect all claims paid through XXXXXXXX      HA490|P0652-(3/11)      Page X of X



# HEDIS and Your Practice

- You can help your patients by:
  - undergoing a paradigm shift: Well Care vs. Sick Care
  - calling them to schedule appointments
  - engaging patients as soon as they are assigned to your practice
  - conducting live appointment reminder calls
  - building care gap “alerts” into electronic medical records
  - scheduling extra time so well-child checkups can be added to other visits
  - instituting the Patient-Centered Medical Home Model



# Best Practice Examples

- Engage members when assigned to your practice
- Identify or assign one staff member to be the “Quality Team Lead”
  - can be a contact for an Account Executive
  - can develop patient outreach strategies
- Each month, place a “warm call” to all new Hoosier Alliance members assigned to the practice
- Consider alternative patient communication methods, such as postcards, internal “Coaches” who collaborate with external resources, etc.
- Send a letter to the parents of all patients overdue for a well-child check





# Patient-Centered Medical Home

# What is A Patient-Centered Medical Home?

The National Committee for Quality Assurance (NCQA) defines a Patient-Centered Medical Home as:

*A model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship.*



# What is the Goal?

- To provide care that is more:
  - personalized
  - coordinated
  - effective
  - efficient



# How is it Achieved?

- A practice that follows the medical home model does so by:
  - providing comprehensive primary care, including care coordination, to ensure procedures are necessary and efficiently performed
  - conducting regular patient exams designed to identify health crises and initiate treatment/prevention measures that ward off the necessity for costly emergency procedures later on
  - considering patient’s environmental and genetic risk factors and making preventive care recommendations accordingly
  - helping patients make healthy lifestyle choices
  - providing a high level of patient accessibility (e.g., expanded hours and open scheduling)

# How is it Achieved?

- carrying out effective patient communications that utilize a variety of vehicles, including conducting consultations via e-mail and telephone
- utilizing the best in information technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance
- maintaining updated electronic personal health records
- taking personal responsibility and accountability for the on-going care of patients



# Do Medical Homes Work?

*According to several studies cited by NCQA, medical homes help improve patient access and reduce unnecessary medical costs.*



# Medical Home Outcomes

- 14 percent reduction in hospital admissions relative to the control group\*
- “Trend toward a 9 percent reduction in medical costs” after two years\*
- 29 percent reduction in ER visits\*\*
- 11 percent reduction in ambulatory sensitive care admissions\*\*
- 50 percent reduction in ER visits\*\*\*
- 15 percent reduction in inpatient hospitalizations\*\*\*

NCQA cited sources:

*\*PA Geisinger Health System*

*\*\*Group Health Cooperative at Puget Sound*

*\*\*\*Genesee Health Plan HealthWorks model in Michigan*



# For More Information About Medical Homes

Visit NCQA's Web site

[ncqa.org](http://ncqa.org)





# Cultural Awareness

# What is Diversity?



# Diversity Is . . .

- The condition of having or being composed of differing elements: variety; **especially: the inclusion of different types of people** (as people of different races or cultures) in a group or organization <programs intended to promote *diversity* in schools>
- An instance of being composed of differing elements or qualities: an instance of being diverse <a *diversity* of opinion>

# What is Culture?

- The sum total of the way of living, including:
  - shared values
  - beliefs
  - standards
  - language
  - thinking patterns
  - behavioral norms
  - communications styles, etc.
- Guides decisions and actions of a group through time

# What is Cultural Competence?

- A set of congruent *behaviors, practices, attitudes and policies* that come together in a system or agency or among professionals, enabling effective work to be done in cross-cultural situations

# Benefits of Culturally Competent Care

- Patient's comfort level increases
- Better understanding of physician's orders improves health outcomes
- Reduction of misdiagnosis and unnecessary testing translates into fewer health risks due to improper treatment and lower costs
- Reduces patient no shows
- Improves overall practice management effectiveness by reducing unproductive and redundant staff-to-patient interactions
- Allows provider to focus on the whole individual and reduce potential liability

# What Can We Do?

- Make every contact patient friendly
- Communicate in an easy-to-understand language
- Create and use member-friendly written materials
- Repeat important instructions
- Utilize the teach-back method





# Deficit Reduction Act

# Deficit Reduction Act of 2005 (DRA)

- Focuses heavily on the health care industry and those who contract with the government
- Includes provisions to eliminate fraud and abuse in Medicaid
- States that receive \$5 million or more in Medicaid money annually must educate contractors and agents about the federal False Claims Act and other state and federal laws regarding false statements



# Medicaid Laws

- The False Claims Act (Federal)
- Administrative Remedies for False Claims and Statements Statute (Federal)
- Whistleblower Protections DRA (Federal & State)
- Indiana Code 5-11-5.5 (False Claims and Whistleblower Protection)



# False Claims Act DRA (Federal)

- A person who acts with intent to deprive the federal government of taxpayer money can be made to pay:
  - civil monetary penalties ranging from \$5,000 to \$10,000 for each false claim submitted
  - an additional fine of three times the amount of damages to the federal government is also assessed

# False Claims Act DRA (Federal)

- Liability may be reduced if a person:
  - tells the federal government of the violation before 30 days have passed
  - fully cooperates with the investigation
  - comes forward, there is no active criminal prosecution, civil action or administrative action
  - does not realize the government was already aware of a potential violation
- This is also true for violations of Indiana state law

# Administrative Remedies for False Claims and Statements Statute (Federal)

- A federal law, similar to the False Claims Act, that outlines federal penalties for a person who:
  - has actual knowledge that a claim is false or fraudulent
  - acts in deliberate ignorance of the truth or falsity of the claim or statement
  - acts in reckless disregard of the truth or falsity of the claim or statement, and no proof of specific intent to defraud is required
- These intent standards are exactly the same as those included in the False Claims Act

# Administrative Remedies for False Claims and Statements Statute (Federal)

- A civil penalty of \$5,000 or less, as well as an assessment of up to twice the amount of the claim, is applied to anyone who makes, presents, or submits a claim that the person “knows or has reason to know” is:
  - false or fraudulent
  - includes or is supported by a written statement that includes a material fact which is false or fraudulent
  - includes or is supported by any written statement that omits a material fact, is false based on an omission, is a statement when the person has duty to include a material fact
  - for the payment for the provision of property or services which the person has not provided

# Whistleblower Protections (Federal & State)

- Whistleblower is a popular term for someone who observes or learns of illegal activity, or activity believed to be unlawful, and reports it to either:
  - a supervisor, compliance office, or legal counsel in the organization where the whistleblower is employed
  - to a government agency with responsibility to investigate or enforce laws regarding the alleged wrongdoing
  - to a judge during a legal hearing
  - to the media



# Whistleblower Protections (Federal & State)

- Whistleblowers are also protected by federal and state laws:
  - False Claims Act
  - other federal whistleblower statutes
  - state laws regarding whistleblowers



# Indiana Law Related to DRA Section 6032

- Indiana Code 5-11-5.5-2 (False Claims) defines a person as being in violation of this code if he or she:
  - presents a false claim to the state for payment or approval
  - makes or uses a false record or statement to obtain payment or approval of a false claim from the state
  - with intent to defraud the state, delivers less money or property to the state than the amount recorded on the certificate or receipt the person receives from the state
  - with intent to defraud the state, authorizes issuance of a receipt without knowing that the information on the receipt is true



# Indiana Law Related to DRA Section 6032

- receives public property as a pledge of an obligation on a debt from an employee who is not lawfully authorized to sell or pledge the property
- makes or uses a false record or statement to avoid an obligation to pay or transmit property to the state
- Violators of the Indiana law are liable to the state for:
  - a civil penalty of at least five thousand dollars (\$5,000) and for up to three (3) times the amount of damages sustained by the state
  - costs of a civil action brought to recover a penalty or damages



# Legal Protections

- False Claims Act includes a provision to protect any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee
- Employee is entitled to all relief necessary to make him/her whole
- Relief can include reinstatement, double back pay, and compensation for any special damages, including litigation costs and reasonable attorney fees
- Indiana state law is consistent with federal law





# Practice Management

# Network Developments

- NaviNet
  - clinical summary
  - claims submission
  - panel rosters
- Care gaps enhanced onscreen view
  - claims status
  - member coverage
  - recommended HEDIS-measured services for members
- Transition from Milliman to InterQual guidelines (Nov. 1, 2011)
- Electronic Remittance Advice (ERA) improvements



# 2011 Technologies

VoiCert®

NaviNet

Electronic Funds Transfer (EFT)

Emdeon Automated Eligibility Services

Emdeon Web-based Claim Filing

MDwise Provider Portal



# VoiCert®

To use VoiCert® contact:

The White Stone Group Inc.

800-864-2378

[tracecommunication.com](http://tracecommunication.com)



# NaviNet

- NaviNet can be your gateway to:
  - eligibility verification
  - claims status
  - care gap information
  - claims correction
  - clinical summaries
  - claims processing
  - important notices
- If you are interested in signing up for NaviNet, contact your Account Executive or log in to [navinet.net](https://navinet.net)



# Electronic Funds Transfer (EFT)

- Receive Hoosier Alliance payments securely and quickly
- Maintain your preferred banking partner
- Reduce paper processing
- Eliminate the risk of checks getting lost or delayed in the mail
- View multiple payers using one application
- Visit [emdeon.com](http://emdeon.com) to learn more



# Emdeon Automated Eligibility Services

- Available to providers with a practice management system
- Verify Hoosier Alliance member eligibility and benefits in real time
- Send single or multiple requests simultaneously
- Verification results auto post to your system
- Visit [emdeon.com](http://emdeon.com) for more information



# Emdeon Web-based Claim Filing

- NO Practice Management System needed
- Internet connection/Web access is all that's required
- NO specialized software needed
- NO costs or per-transaction fees
- File outpatient claims, including HCFA
- Electronic filing allows for:
  - auto-population of patient demographic information
  - quick payer submission -- usually within 24 hours
  - online claim status checks
- Register by accessing the Emdeon portal at [hoosieralliance.org](http://hoosieralliance.org) or [navinet.net](http://navinet.net)



# myMDwise Provider Portal

- Securely view member:
  - eligibility information
  - delivery system information
  - PMP information
  - Right Choices Program indicator
- Visit [MDwise.org](https://MDwise.org) to register for access





Administration

# Submitting Hoosier Healthwise Claims

- Electronic Data Interchange (EDI)
  - Hoosier Alliance Electronic Payor ID is 20475
  - EDI Technical Support 866-426-7690, prompt 4
  - [Billing Bulletin](#)
- Electronic Funds Transfer (EFT)
  - [Enrollment Form](#)
  - Or call 877-363-3666
- Paper Claims

MDwise Hoosier Alliance  
P. O. Box 7303  
London, KY 40742



# Submitting Healthy Indiana Plan Claims

- WebMD/Emdeon
  - Institutional Payer ID is [12K81](#)
  - Professional Payer ID is [SX172](#)
  - [Billing Bulletin](#)
- McKesson/Relay Health
  - Institutional Payer ID is [4976](#)
  - Professional Payer ID is [4481](#)
- Electronic Funds Transfer (EFT)
  - [Enrollment Form](#)
  - Or call 877-363-3666



# Submitting Healthy Indiana Plan Claims

- Paper Claims  
MDwise HIP Claims  
P.O. Box 78310  
Indianapolis, IN 46278

# Submission Timeframe

- Claim submission timeframe is 90 days for Hoosier Healthwise and Healthy Indiana Plan contracted providers
  - timely filing requirement is waived in instances involving third-party liability or presumptive-eligibility member
  - for third-party payer claims, timely filing is defined as 90 days from primary carrier paid date

90-Day  
Filing Limit

# Hoosier Healthwise Third-Party Claims

- January 1, 2011 -- Hoosier Alliance adopts OMPP-requested 90-Day Insurance Rule
  - when member is insured by another carrier, provider must first submit claims to that carrier
  - if third-party carrier fails to respond within 90 days of the provider's billing date, provider can submit claim to Hoosier Alliance for consideration



# Hoosier Healthwise Third-Party Claims

- Paper claims submitted to Hoosier Alliance as a result of a third-party carrier's failure to respond must include the following information as an attachment, in bold:
  - date of the filing attempt
  - the phrase “no response after 90 days”
  - member identification number (RID)
  - provider's National Provider Identifier (NPI)
  - name of primary insurance carrier billed



# Hoosier Healthwise Third-Party Claims

- Electronic claims submitted to Hoosier Alliance as a result of a third-party carrier's failure to respond must have the following information documented in the Claim Note Segment of the 837P transaction:
  - date of the filing attempt
  - the phrase “no response after 90 days”
  - member identification number (RID)
  - Indiana Health Coverage Programs (IHCP) provider number
  - name of primary insurance carrier billed



# Hoosier Healthwise Provider Claim Disputes

- Providers must file dispute within 60 days of receipt of Explanation of Benefits (EOB)
- Par providers should submit claims disputes to:  
MDwise Hoosier Alliance  
Attn: Claims Disputes  
200 Stevens Drive, Suite 350  
Philadelphia, PA 19113-1570
- Par providers can download a [Claims Dispute Form](#) directly from the Hoosier Alliance Web site



# Hoosier Healthwise Provider Claim Disputes

- Non-par providers should submit claims disputes to:  
MDwise  
Attn: MDwise Grievance Coordinator  
P.O. Box 441423  
Indianapolis, IN 46244-1423
- Non-par providers can download a [Claims Dispute Form](#) from MDwise.org



# Hoosier Healthwise Provider Claim Appeals

- Providers must file appeals within 60 days from the date of the dispute resolution
- Appeals should include:
  - basis of appeal (written on provider letterhead)
  - all supporting documentation
  - medical records, if applicable
  - Explanation of Benefits (EOB) or Electronic Remittance Advice (ERA)
- Mail to:

MDwise Hoosier Alliance  
Attn: Appeals Coordinator  
5604 Fortune Circle South Drive, Suite N  
Indianapolis, IN 46241



# Healthy Indiana Plan Provider Claim Disputes

- Both par and non-par providers should submit claims disputes to:  
MDwise  
Attn: MDwise Grievance Coordinator  
P.O. Box 441423  
Indianapolis, IN 46244-1423
- Providers can download a [Claims Dispute Form](#) from MDwise.org



# Prior Authorization (PA)

- To request PA, please use the [Universal PA Request Form](#)
  - complete the most current PA form
  - fax to 888-465-5581



# Adding a Provider to a Participating Group

- Complete the [Universal Provider Enrollment Form](#)
- Copy provider's W-9
- Notify Account Executive that enrollment form and W-9 are complete
- Mail, e-mail or fax documents to:  
MDwise Hoosier Alliance  
Attn: Contract Specialist  
5604 Fortune Circle South Drive, Suite N  
Indianapolis, IN 46241  
[providers@hoosieralliance.org](mailto:providers@hoosieralliance.org)

866-465-2985



# Adding a Non-Participating Provider

- Contact the Account Executive responsible for provider contracting in your county

A: Doreen Beard -- 317-519-6999

B: Lisa Mihalow -- 317-519-9332

C: Denise Edick -- 317-697-6750

D: Jennifer Burch -- 317-697-7882

E: Dionne Embry -- 317-502-6539

F: Lisa Baker -- 317-519-7598

G: Kami Hughes -- 317-519-9331

H: Susan McCamish -- 317-607-3074



# Right Choices Program (RCP)

- Members currently in RCP
  - RCP follows the member
  - member remains in program regardless of MCE
- Members new to RCP
  - follow the same process you currently use (see State RCP Program Manual)
- Answers to your questions
  - Hoosier Alliance has a dedicated staff for RCP
  - toll free: 888-961-3100, option 4
  - facsimile: 317-829-7818
  - e-mail: [HIPlanRCP@hoosieralliance.org](mailto:HIPlanRCP@hoosieralliance.org)



# MDwise Provider Manual

- Contents include:
  - overview of programs
  - credentialing standards
  - preventive health and practice guidelines
  - EPSDT screening schedule
  - medical records audit guidelines
  - claims submission and reimbursement procedures for Hoosier Healthwise and Healthy Indiana Plan
- Can be found by accessing [hoosieralliance.org](http://hoosieralliance.org)



# Annual Surveys

- **Provider**
  - tells us how well we meet providers' expectations and needs
  - conducted by an independent research firm
- **Member**
  - tells us how well we're meeting members' health care expectations and goals
  - tells us which areas of service have the greatest effect on member satisfaction
  - conducted by an independent research firm





**Thank you for your time.**



Hoosier Alliance looks forward to partnering with your practice!